2015 Company Compliance ACA Rate and Form Filing FAQ

Indiana Department of Insurance

Updated: April 30, 2015

Binders / SERFF Plan Management

Clarification from IDOI: **(Updated 4/30/15)** For major medical, both individual and small group, it appears we have an incorrect link in the BINDERS under supporting documents for IDOI EHB verification Template and the IDOI rate and crosswalk template. The fix for this is to go to our website, (the link will be included in our FAQ today), and download these documents from our website. You will then complete these and attach under supporting documents in the binder. We are working with SERFF to fix these links. At this time **DO NOT USE** the document link through the SERFF binder. You will need to download these from our website. Any new requirements listed in the Plan Management General Instructions will still need to be completed/followed. These new requirements include:

1. Actuarial Memorandum Outline
2. IDOI Rate and Crosswalk Template
3. IDOI EHB Verification Template
4. The latest version of all federally required Plan Management templates.

All of the newest IDOI specific templates, outlines, and instructions for Rate related filings can be found at: http://www.in.gov/idoi/2813.htm

Question 1: **(Updated 4/9/15)**

Q. Do all of the items marked with an "X" in the "Only Off Marketplace Major Medical Submission" need to be completed/submitted for a Rate Change or only those items related to rates?

A. Yes. All items marked with an "X" need to be provided.

Question 2: **(Updated 4/23/15)**

Q. Do small group off exchange forms require a binder?

A. YES. Binder submissions are required by Indiana for all ACA compliant non-grandfathered plans (non-QHPs & QHPs)(Dental and Major Medical)(Small Group and Individual). Binders do not apply to grandfathered or transitional filings. Please reference the A&H Rate Filing and Plan Management Binder Information and Instructions link then

scroll down to "Plan Management Binder Submissions and click "Indiana Plan Management General Instructions for more information on binder submissions.

Question 3: (Updated 4/23/15)

Q. Do we send URRT's to the compliance@idoi.in.gov email when we initially submitted them or updated them. Is this required this year? Or should we just be submitting the URRT's in SERFF?

A. This year, all filers need to submit their URRT in their SERFF Binder and in HIOS.

Question 4: (Updated 4/23/15)

Q. For the IDOI major medical specific memorandum instructions. Do you want a separate actuarial memorandum with only these items? Or should we be including those items in the actuarial memorandum that follows the federal guidance?

A. The IDOI expects the IDOI specific actuarial memorandum as well as the federal actuarial memorandum to be submitted in the SERFF Binder.

Question 5: (Updated 4/30/15)

Q. Per the SERFF Plan Management Instructions binder submission are required for all ACA non –grandfathered plans. If a carrier is discontinuing existing plans and not mapping to a 2016 plan how should that be represented on the crosswalk template?

A. With our IDOI Rate and Crosswalk Template, if you are discontinuing a plan in a county, please include the current plan and county in the 2015 data fields. For 2016, show "discontinued" in the Plan ID field.

HIOS

Question 1: (Updated 4/2/15)

Q. Will our Small Group off-exchange only forms be required to have a HIOS upload? Or were you only referring to rates being uploaded in HIOS per slide 29 – "For Non-QHP forms will they only go through SERFF for these off-exchange products."

A. Off Marketplace form filings should be made via SERFF. QHP form AND rate filings should be made via SERFF and HIOS simultaneously.

Question 2: (Updated 4/23/15)

Q. Where do carriers get a HIOS submission tracking number?

A. First, please note there is a difference between a HIOS ID and a HIOS submission tracking number. A HIOS ID is given to a carrier when they initially register for HIOS. A HIOS submission tracking number is generated each time a carrier makes a Unified Rate

Review "URRT" filing submission via HIOS. You will need to save this generated HIOS submission tracking number and enter into the Rate Review Detail Section of your SERFF filing. This does not apply to dental filings.

Question 3: (Updated 4/16/15)

Q. In Section 4.1 Redacted Actuarial Memorandum of the 2016 Unified Rate Review Instructions provided by CMS (attached), health insurance issuers are required to upload (to HIOS) an un-redacted version for CMS **and** a redacted version, which excludes any information that is "trade secret or confidential commercial or financial information" and will be made available to the public. Will the IDOI release the un-redacted version of the actuarial memorandum to the public?

A. The requirements above are federal. The IDOI only requires the "un-redacted" version. Pursuant to Indiana Public Access Laws, all information submitted within a SERFF filing is not confidential and will be released to the public.

Question 4: (Updated 4/23/15)

Q. Are student health plans required to file in HIOS?

A. Yes, student health plans are required to file a Rate Review Justification (RRJ) in HIOS for rate increases of 10% or more. Information pertaining to this requirement may be found here.

Question 5: (Updated 4/23/15)

Q. Are transitional health plans required to file in HIOS?

A. Yes, transitional health plans are required to file a Rate Review Justification (RRJ) in HIOS for rate increases of 10% or more. Information pertaining to this requirement may be found here.

SADPs (Stand Alone Dental Plans)

Question 1: (Updated 4/9/15)

Q. If we only have minor form revisions to the 2015 SADP product, impacting a few policy/booklet forms for existing customers for their 2016 plan year or a new customer beginning 1/1/16, can we file those impacted forms as insert pages? Or do you want all policy/booklet forms submitted for review and approval?

A. The answer here would be whether those insert pages affect benefits. If you are just extending age 26 or 19 age off to the end of the month or other "administrative" details, the IDOI is OK with this approach. If it affects the benefits such as adding ortho or something, then it would need to be filed as a "4-corners" product.

Question 2: **(Updated 4/9/15)**

Q. Is a SERFF filing required or only associate PM to the 2015 approved forms and rates if the stand alone dental has no form or rate changes?

A. You need to submit anything submitted to HIOS within your SERFF Binder Filing. Please reference your prior approved SERFF tracking number.

Question 3: **(Updated 4/9/15)**

Q. If there are rate changes only for 2016, can we refile rates only and associate PM with the 2015 form and new 2016 rate SERFF filings?

A. Yes. Please submit the prior approved SERFF tracking number for the form.

Question 4: **(Updated 4/23/15)**

Q. Do dental plans require a binder?

A. YES. Binder submissions are required by Indiana for all ACA compliant non-grandfathered plans (non-QHPs & QHPs)(Dental and Major Medical)(Small Group and Individual). Binders do not apply to grandfathered or transitional filings. Please reference the A&H Rate Filing and Plan Management Binder Information and Instructions link then scroll down to "Plan Management Binder Submissions and click "Indiana Plan Management General Instructions for more information on binder submissions.

Question 5: **(Updated 4/23/15)**

Q. Can you file a dental plan for "ON" marketplace ONLY?

A. Yes. You can file a dental plan for "ON" marketplace only. This is acceptable because the dental plan is considered an excepted benefit. This is not acceptable for major medical.

SHOP

Question 1: **(Updated 4/23/15)**

Q. With the definition of small group increasing to include up to/including 100 employees effective 1/1/2016, when we file our experience data as part of the rate filing should be including groups that meet this definition? Or should the experience just be "small group" as defined prior to 2016?

A. The IDOI is going to allow a transition so 51-100 can be continued as large group should you decide to do this through renewal in 2016. For current small group filing, the URRT should be based on the current small group experience only. The current 51-100 group is not part of the single risk pool as it does not have a plan ID or a specific metal level. For your pricing you should use what is appropriate for your expected experience.

Child Only Policies

Question 1: (Updated 4/2/15)

Q. Can you please clarify the webinar slide 5 – "Do not submit a separate filing for child only policies- these are included within the filed form" and does that mean this should only be filed in one filing with the group?

A. The filing for either individual or small group should include a form that is inclusive for adult and child at the same time. We do expect all forms for the market segment to be included in single filing. This pertains to major medical filings.

Riders

Question 1: (Updated 4/2/15)

Q. Can we offer pediatric dental riders off exchange in Indiana?

A. In the webinar, the IDOI referred to not being able to utilize benefit riders. This is due to the federal definition of "product" which applies to major medical products. The federal rules give special instructions regarding how pediatric dental benefits must be offered off-Marketplace. For off-Marketplace filings, pediatric dental can either be embedded or bundled. As such, a major medical carrier is required to be "reasonably assured" that the person purchasing the policy has pediatric dental. If the base major medical policy has an embedded dental benefit, the benefit cannot be via a rider. Stand alone dental plans in and of themselves are an excepted benefit and can be included as a rider to another dental policy.

Question 2: (Updated 4/2/15)

Q. During the webinar yesterday the DOI advised that small group products may not utilize riders. I understood that this decision is based, at least in part, on guidance from CMS. Am I correct that forms offered in the large group market would not be subject to the CMS guidance and therefore riders continue to be permitted for large group products?

A. The guidance provided by the IDOI during our webinar is in reference to the definition of product which is a market reform issue that was placed into final rule on July 24, 2014. In reference to 45 C.F.R §144.103:

" For purposes of guaranteed availability and guaranteed renewability, the term "product" means a discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type (for example, health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), point of service (POS), or indemnity) within a service area."

http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf

All benefits offered must be contained within the four corners of the policy to which benefit riders are NOT allowed. As such, large group markets are subject to guaranteed availability and renewability and must follow the definition of product.

Question 3: (Updated 4/2/15)

Q. My question relates to a small group medical plan's obligation to include pediatric dental benefits in the off exchange market. We understand that if the medical carrier receives reasonable assurance that the purchaser will purchase a certified off exchange SADP then the medical coverage does not need to include the pediatric dental benefit. Is it permissible for the policy form to have the pediatric dental benefit filed as a variable so that the benefit can be added in the event reasonable assurance is not provided?

A. In the webinar, the IDOI referred to not being able to utilize benefit riders. This is due to the federal definition of "product." The federal rules give special instructions regarding how pediatric dental benefits must be offered off-Marketplace. For off-Marketplace filings, pediatric dental can either be embedded or bundled. As such, a major medical carrier is required to be "reasonably assured" that the person purchasing the policy has pediatric dental. If the base major medical policy has an embedded dental benefit, the benefit cannot be via a rider. With or without pediatric dental needs to be TWO distinct products.

Question 4: (Updated 4/2/15)

Q. Can you include riders for dependent child coverage running to the end of the month rather than birthdate? Credible coverage explanation changes? Cost sharing changes?

A. Dependent child coverage running to the end of the month rather than birthdate could be done with an amendment. Credible coverage explanation changes could be done with an amendment. Cost sharing changes is just part of the summary of benefits page. For example: The prohibition on riders refers to the definition of product. As such, the above examples do not fall into the category of benefits that would create a new product. Changes to cost-sharing, however, would result in different plans.

Question 5: (Updated 4/9/15)

Q. If carriers are not allowed to use riders, how do they handle the must-offers like morbid obesity for large group?

A. Each carrier writing large or small group must have at least one product that includes morbid obesity. There only needs to be one plan under this product, but it must be a separate product as morbid obesity is a distinct benefit over and above our EHB benchmark. Large group is also subject to:http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf**. As such, benefit riders cannot be separate from the policy. Any distinct benefit must be included in the "four corners" of the product. Any change in cost**

sharing is a plan differentiation and does not need a separate rider or product, but has cost sharing differences in the schedule of benefits

Question 6: (Updated 4/9/15)

Q. You have stated that Large Group was no longer able to offer riders. Does this apply to all new plans? Can we keep our old plans as is? Are we able to continue to actively sell pre 2016 plans with riders as we do today?

A. This applies to all plans that are subject to the definition of product as stated in the Market Reforms 2015 and Beyond Final Rule. These cannot include riders because all products that are in force and are subject to the definition of product must comply with federal guidelines. No, you are not able to continue to actively sell pre 2016 plans with riders. The plans do not comply with federal guidelines and the Department expects carriers to bring these policies into compliance asap.

Question 7: (Updated 4/23/15)

Q. Does the IDOI consider the Religious Opt out option of contraceptives to be a rider?

A. (1.) For the religious opt out, you can use one form with the contraceptive section being bracketed. (2.) For the benefits, you will need an additional product with the contraceptive benefit not in that product. (3.) Since CMS does require the contraceptives to be covered, the carrier would do this outside using an extra contractual process. (4.) The carrier does need to include a notice to the employer indicating how the covered members can get access.

Templates

Question 1: (Updated 4/2/15)

Q. Can you please provide the location to download the current IDOI EHB Verification Template and IDOI Rate and Crosswalk Template?

A. The IDOI EHB Verification Template and the IDOI Rate and Crosswalk Template will be found within the link of the SERFF plan management instructions. The links are also available on the IDOI website. IDOI EHB Verification Template IDOI Rate and Crosswalk

Question 2: (Updated 4/30/15)

Q. At the seminar it was stated that the Plans & Benefits Template is pulling down incorrectly. "Dental Anesthesia - Use a Variance Reason of additional EHB." Does this apply to Stand-Alone Dental products?

A. This requirement is for major medical products. The 2016 plans and benefit template add-in file does not correctly reflect EHB requirements for Indiana. The two incorrect

benefits include "Nutritional Counseling" and "dental anesthesia" please show each benefit as "covered" with and EHB variance reason of "Additional EHB Benefit".

Question 3: (Updated 4/2/15)

Q. I took away from the conference last week that the Indiana crosswalk is specific to rates and that you still want the CMS crosswalk completed as well.

A. This is correct. Both crosswalks must be completed and included as part of your binder filing.

Clarification from IDOI: (Updated 4/2/15)

In the webinar we mentioned that all drugs need to be included in the template. We are clarifying that even medical drugs need to be in the template. In the first sheet with formulary id's there is a spot to describe a drug as a medical drug only. The new drug template allows for a medical service drugs tier type. However, we expect that there are drugs that carriers may cover that simply don't have an RxCUI. If that is the case, then those drugs would not need to be included in the drug template.

Question 4: (Updated 4/16/15)

Q. Will the Indiana Department of Insurance utilize the CMS State Authorization of 2016 Plan ID Crosswalk form as it pertains to the Plan ID Crosswalk Template and the requirement for Issuers to submit evidence that the state has authorized submission of the Template to CMS?

A. Yes. The IDOI will utilize the federal authorization form.

Attestations

Question 1: (Updated 4/2/15)

Q. As a stand-alone dental carrier intended to offer certified pediatric dental plans on and off the exchange in Indiana are we required to submit the attestations referenced in the Small Group Qualified Health Plans (QHPs) Filing Instructions for Major Medical, HMO and Dental?

A. Any attestation provided to CMS either in HIOS or by email to CMS needs to be included in your supporting documents.

EHB's

Question 1: (Updated 4/2/15)

Q. We would like to get some clarification around the EHB requirement you included in your webinar presentation for separate & distinct pt/ot/st visit limits habilitative & rehabilitative services. According to our research of Federal rules, prohibition of a combined limit doesn't go

into effect until 2017 (see below). Is the department looking to implement this requirement for 2016 plans?

The requirement to have separate benefits for rehabilitative and habilitative services in terms of the state EHB benchmark is not new for Indiana. Please refer to question 20 page 5 from last year's q and a:

http://www.in.gov/idoi/files/2014_03_18_QuestionAnswer.pdf

Additionally, we note that the federal requirement is in place for plans effective 2017. It does not make sense for Indiana to revert backwards to having a combined rehabilitative and habilitative service limit for one year and move forward to having separate limits again in 2017. This has been in effect in prior years.

Question 2: (Updated 4/30/15)

Q. Can you please confirm that the Plans and Benefits Add-In file correctly reflects EHB requirements for IN and no manual corrections need to be made to the EHB information auto-populated into the P&B Template.

A. The add in file is not correct for Indiana. The two benefits that are incorrect are 1) nutritional counseling and 2) dental anesthesia. Please show this benefit as "covered" with an EHB Variance Reason of "Additional EHB Benefit."

Rate Certifications

Question 1: (Updated 4/2/15)

Q. If there are no changes to rates, is a rate certification stating no impact/changes to rates is acceptable for the plans we are renewing in our form and rate filings? If no changes to rates, will the Experience Workbook still be required? Or, would rate information only need to be included in the Binder submission?

A. In this case, HIOS would require a new filing. As such, we would ask that they submit all documents in SERFF binder that are submitted to HIOS. In the first paragraph of the actuarial memorandum, a statement would indicate that there is no change in rates or benefits from last year.

No Experience Workbook would be required. Also no crosswalk would be needed.

We ask that everything submitted in HIOS also be submitted in the Binder. No traditional SERFF filing need be filed.

Compliance

Question 1: (Updated 4/2/15)

Q. If the group was in-force and rated as a large group prior to 1/1/16 they can remain rated as a large group even if they have changed carriers? Furthermore, they should be able to renew up to 10/1/16 and stay rated as a large group until 10/1/17? Not subject to community rating? If we rate a group with 51-99 employees after 1/1/16 they should be rated as a small group?

I believe the only way they could do this is if all the benefits within the plan remain unchanged. This could be done easier in a large group than SG, but still difficult. The new provider would basically have to take the prior contract and follow it completely

If it is a conversion from another carrier and every benefit and cost share within the plan remains the same, then it can be a LG, otherwise, only as a SG

Question 2: (Updated 4/2/15)

Q. May a state allow issuers to round premiums for non- single risk pool compliant plans in the individual or small group (or merged) markets in their respective state to the nearest dollar?

Per CCIIO Technical Guidance – Yes. Premiums for non-grandfathered plans in the individual or small group (or merged) markets generally are rounded to the nearest penny. However, states enforcing the federal single risk pool and fair health insurance premiums requirements under 45 CFR §§ 156.80 and 147.102 may allow issuers to round premiums to the nearest dollar, as long as certain conditions are met.

- The premiums are based on unrounded rates, which are calculated based on an index rate for the market and applicable plan level adjustments and premium rating factors in compliance with the single risk pool and fair health insurance premiums requirements under 45 CFR §§ 156.80 and 147.102.
- Premiums are rounded to the nearest dollar only based on unrounded rates, plan level adjustments, and premium rating factors. This means that premiums can only be rounded one time and only after all of the permitted plan level adjustments and applicable premium rating factors have been applied to the rate (i.e., after family size, geographic rating factor, age rating factor, and, if applicable, tobacco rating factor are taken into account). Issuers may not round rates at intermediate steps in the rate development process.
- The practice of rounding premiums is done consistently across the risk pool. If an issuer rounds premiums for one plan in the risk pool, the issuer must round premiums for all plans in the risk pool.
- Fractions of $0.50 or higher are rounded up to the nearest dollar and fractions of less than $0.50 are rounded down to the nearest dollar. If the rounded premium rates vary by more

than 3:1 for like individuals who are age 21 and older who vary in age, or by more than 1.5:1 for like individuals who vary in tobacco use, the issuer must adjust the rates to bring them into compliance with the 3:1 age rating factor limit and the 1.5:1 tobacco rating factor limit.

Table 1: Example of Rounding Premiums **Category**	**Unrounded Premium** (after applying all rating factors and plan level adjustments using full precision)	**Rounded Premium**	**Revised Rounded Premium** (to avoid exceeding the 3:1 and 1.5:1 maximum variation for age and tobacco use, respectively)
21 year old non-tobacco user	$100.40	$100	$100
64 year old non-tobacco user	$301.20	$301	$300
21 year old tobacco user	$150.60	$151	$150
64 year old tobacco user	$451.80	$452	$450

In direct enforcement states, HHS enforces the single risk pool and fair health insurance premiums provisions. In these states, issuers must continue to round premiums to the nearest penny unless instructed otherwise in future guidance. Currently, direct enforcement states are Alabama, Missouri, Oklahoma, Texas, and Wyoming.

Please refer to the CCIIO bulletin **here** for the conditions and additional information.

Question 3: (Updated 4/9/15)

Q. What are plans and issuers expected to provide as preventive coverage for tobacco cessation interventions?

A. Please see Question # 5 http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html

Question 4: (Updated 4/9/15)

Q. Can you please confirm that all forms, including rates, can be updated through the correction windows over the summer of 2015?

A. No. Rate and form must be in final form on May 15, 2015. If the IDOI, after reviewing assumptions, feels your rates are inadequate or changes need to be made to the forms, then we may request you to make changes. You may not submit a request to the Department to make changes. Again, your rates must be in final form when submitted on May 15, 2015.

Question 5: **(Updated 4/23/15)**

Q. With the definition of small group increasing to include up to/including 100 employees effective 1/1/2016, when we file our experience data as part of the rate filing should be including groups that meet this definition? Or should the experience just be "small group" as defined prior to 2016.

A. The IDOI is going to allow a transition so 51-100 can be continued as large group should you decide to do this. For current small group filing, the experience should be based on the current small group experience only. The current 51-100 group is not part of the single risk pool as it does not have a plan ID or a specific metal level.

Student Health Plans

Question 1: **(Updated 4/16/15)**

Q. Will Indiana require student health plans to adopt rate parity in 2015-16?

A. Yes. Indiana will require student health plans to adopt rate parity per the student health insurance coverage federal regulation (http://www.gpo.gov/fdsys/pkg/FR-2012-03-21/pdf/2012-6359.pdf) which indicates that student health coverage is individual insurance product and is subject to the premium rating requirements of the ACA. This is further clarified in FAQ # 6 (http://www.acha.org/topics/affordable_care_act/faqs_for_individualcoverageclassification.cfm). Student health plans are subject to the rating rules of individual ACA plans. The premium rating requirements of the ACA only allow rating differences for age, sex, geographic region and family composition. With this understanding, rating parity, would seem to indicate that there is no difference in rates for student vs. dependent. Indiana does not have any specific definition of rate parity.

Question 2: **(Updated 4/23/15)**

Q. Is a short term product offered to students considered a Student Health Major Medical product? Is there a difference in the rate filing requirements for a short term plan versus a student health plan? Or do student health plans follow the rate filing guidelines for individual plans?

A. No, a short term product offered to students is not considered a student health major medical product. Yes, there is a difference in the rate filing requirements for a short term plan and a student health plan. Student health plans follow individual guidelines for rating rules and must submit a Rate Review Justification (RRJ) in HIOS for rate increases of 10% or more. Information pertaining to this requirement may be found here.

Question 3: **(Updated 4/23/15)**

Q. Are student health plans required to file in HIOS?

A. Yes, student health plans are required to file a Rate Review Justification (RRJ) in HIOS for rate increases of 10% or more. Information pertaining to this requirement may be found here.

Network Benefits

Clarification from IDOI: (Updated 4/30/15)

As a reminder, a subject that has come up concerns out of network benefits. Some carriers have asked about limiting out of network benefits with a lifetime or annual $ limit for EHB. CMS has determined that this is not allowed and that all covered EHB benefits, either in or out of network must be covered without annual or lifetime limits.

***Document subject to change pending further guidance from HHS.**

Questions should be directed to compliance@idoi.in.gov

2014 Company Compliance Rate and Form Filing Question & Answer

Indiana Department of Insurance

Updated: April 25, 2014

Transitional "Grandmothered" Policies (IDOI Bulletin 205)

Question 1: (Updated 4/11/14)

Q. We are hearing that carriers may be able to early enroll groups who early enrolled last year and use the groups experience rather than base it on community based rating. Is this possible? If so, what is the logic?

A. Yes. Please refer to Bulletin 205. Any products that are renewing, either under a grandfathered plan, or a transitional plan, will continue to follow the same guidance followed under our existing small group regulation I.C. 27-8-15.

Question 2: (Updated 4/4/14)

Q. Can carriers buy down benefits to keep premiums the same or is this a material modification?

A. This question refers to the transition program for small group. Any change in benefits is considered a plan modification and would result in an ACA product being required. The IDOI encourages issuers to review the Exchange and Insurance Market Standards Proposed Rule released on March 18, 2014 which proposes standards defining whether certain modification to a policy would constitute "uniform modifications" or would constitute the "withdrawal" of an existing product and the creation of a new product.

Question 3: (Updated 4/4/14)

Q. For Individual and Small Group, can a carrier offer a different renewal date and stay within the guidelines?

A. For the transitional policies, the Department does not regulate changes in renewal dates. Please note that a renewal period cannot extend more than 12 months.

Question 4: (Updated 4/4/14)

Q. To confirm, small groups retaining grandmothered policies can continue to be rated as they have in years' past? And do not have to be switched over to the new ACA rating platform?

A. This is true. They need to continue complying with Indiana small group regulations. With this, though, there cannot be a "buy-down" process to change cost sharing under a plan. Please refer to Question 2.

Question 5: (Updated 4/4/14)

Q. Requesting clarification on the application of Bulletin 205, issued March 31, 2014, to standalone dental plans ("SADPs"). Our understanding is that standalone dental plans which only offer the essential pediatric dental benefits cannot be considered grandfathered or grandmothered because they cannot be considered ACA-compliant as not offering all essential health benefits (EHB), and therefore cannot be considered non-ACA-complaint either.

A. Bulletin 205 does not apply to "Excepted Benefits" i.e. Stand-Alone Dental Plans ("SADPs").

Compliance

Question 6: (Updated 4/25/14)

Q. Are provider agreements required to be executed by the date of filing the QHP template forms?

A. No. However, the IDOI will require a finalized Network Adequacy template if the provider agreements are altered after the initial filing.

Question 7: (Updated 4/25/14)

Q. We plan to revise some of 2014 plans for 2015 to combine the out-of-pocket (i.e. loss of the Transition Rule for Rx), increase the MOOP from $6350 to $6600, etc. Will these minor tweaks constitute a "new plan"? Will we have to report the previous 2014 versions as terminated? Or can we simply adjust the 2014 plans we have on file for 2015?

A. No. These tweaks will not constitute a new plan. No. You will not have to report the previous version as terminated. As stated in our April 4, 2014 Q&A Session, the IDOI encourages issuers to review pages 37-40 of the Exchange and Insurance Market Standards Proposed Rule released on March 18, 2014 regarding Product Withdrawal and Uniform Modification of Coverage Exceptions to Guaranteed Renewability Requirements. This rule proposes standards defining whether certain modification to a policy would constitute "uniform modifications" or would constitute the "withdrawal" of an existing product and the creation of a new product.

Question 8: (Updated 4/17/14)

Q. When you refer to small group off marketplace non-grandfathered filings, do you mean entire product filings? If we have a few rider filings amending the forms approved for the 2014 plan year, do we need to notify you now about those rider filings?

A. For plans subject to the ACA, the policy must include all provisions. Rider amendments are NOT allowed and therefore must be incorporated into the policy itself.

Question 9: (Updated 4/17/14)

Q. We are working on a blanket student health product that will be compliant with ACA. Because this is considered an individual health product under federal law, does the department require that we submit the form filing as an individual form filing or would we continue to file as blanket?

A. You would continue to file as a blanket.

Question 10: (Updated 4/17/14)

Q. Are we required to file a checklist if we are re-filing our summary and declarations page only? What supporting documentation are we required to file?

A. A checklist is not required if you are re-filing a summary and declarations page only but you must submit a filing via SERFF.

Question 11: (Updated 4/17/14)

Q. In 2015 for Small Group, can we combine our Grandfathered and Grandmothered filings? We will be rating these blocks the exact same way so I would think we could combine these filings in 2015.

A. We will accept a single filing for grandmothered and grandfathered. We would expect that a single filing should include all experience for all plans. If this is done, we will need experience from inception as we still need to make sure the lifetime loss ratio exceeds our lifetime minimum standards. If any of the blocks or plans have different increases requested, the experience would need to be split by for each plan. We will require the major medical experience workbook that is on our website to be submitted with the filing. In talking with CCIIO, the grandmothered experience will also need to be shown with the ACA 2015 business in the URRT. This experience will be shown in the historical experience, but will not have any projected experience.

Question 12: (Updated 4/4/14)

Q. Do the rates and forms have to be filed together for large group?

A. Yes, the Department require rates and forms to be filed together. If you have a form filing that is a minor endorsement, it can be filed without rates.

Question 13: (Updated 4/4/14)

Q. Will we be required to file the templates for 2015 that we filed with our 2014 exclusively off marketplace plans if we are making no changes to the forms?

A. No. If there are NO changes to the forms, you will NOT be required to file templates for 2015 that you filed with your 2014 exclusively off marketplace plans.

Question 14: (Updated 4/4/14)

Q. We understand that the Form/Rate filings are due by August 16, 2014 for off-exchange plans. Is that correct?

A. Off-Marketplace Non-QHP Major Medical form/rate filings are due at least 90 days prior to the November 15th open enrollment.

Question 15: (Updated 4/4/14)

Q. Does the issuer of the benchmark plan make the billing codes available to support the essential health benefits covered in that plan?

A. No, billing codes are not provided

Question 16: (Updated 3/25/14)

Q. Do forms (contracts & certificates of coverage) and rates have to be filed together? Or can they be filed separately?

A. Forms and rates MUST be filed together in the same SERFF filing.

Question 17: (Updated 3/25/14)

Q. Do policy forms need to be re-filed if the forms are staying the same?

A. For SERFF, if there are no changes we do not need a new form.

Please indicate in the rates cover letter that there were no changes in the form.

For any form filing changes, we will ask for a red-line copy in addition to the clean copy.

Question 18: (Updated 4/17/14)

Q. Do plan binders need to submitted annually?

A. Yes. Carriers are required to submit NEW binders for 2015 Marketplace Major Medical filings. Binders will not accept new submissions until May 27, 2014 in SERFF. No. Indiana does not charge a filing fee for a binder. Binders are not required for dental products.

Question 19: (Updated 3/25/14)

Q. Do policy forms need to be associated with the plan binders if they are no changes from the previous year's filing?

A. Yes. Include policy forms in associated schedule items.

Question 20: (Updated 3/25/14)

Q. If a carrier wants to offer identical coverage on and off the marketplace, does Indiana require two separate policies to be filed (one for ON the marketplace and one for OFF the marketplace)?

A. IF they are the same, carriers may file ONE policy form with any variable language added using brackets to accommodate the differences between on and off the marketplace.

Question 21: (Updated 3/25/14)

Q. Are carriers required to file ON and OFF Marketplace forms in the same filing?

A. Yes. For 2015, carriers should submit one filing with any variable language added using brackets to accommodate the differences between on and off the marketplace. All variability possibilities to be used within brackets must be shown.

Question 22: (Updated 3/25/14)

Q. Are carriers required to file rates in the same or separate filing as forms for ON/OFF Marketplace?

A. Forms and rates MUST be filed together in the same filing.

Question 23: (Updated 3/18/14)

Q. Is the limit of one base rate change throughout the year for group insured? Is this in effect right now, or is it going to be effective in the future?

A. Per CCIIO Guidance released on April 8, 2013: "For plans beginning or renewing on or after 1/1/2014, issuers may change rates on a quarterly trended basis by submitting a plan's trended rates in accord with the example provided in the Unified Rate Review Template Instructions.

These trended rate changes may be filed once per year, to be effective upon the plan's renewal date after 1/1/2014.

The rating tables submitted to CMS must reflect each quarterly change, in accord with the instructions provided. Issuers can continue to file quarterly trend increases with their annual filing, which is a common practice today.

~~**Due to system limitations, until further notice, additional rate changes in the small group market (other than quarterly trending described above) can be processed only on an annual basis, similar to the individual market.**~~

~~**Accordingly, the system cannot accept new quarterly or monthly rate changes until further notice. In the interim, we request that issuers offering plans in the small group market,**~~

~~**whether through the Marketplaces or otherwise, refrain from seeking rate changes more frequently than annually, until notified that the system capability to process more frequent rate changes is operational.**~~

~~**Once the system can process rate changes more frequently than annually, rate changes will require re-submission of the entire risk pool data set prior to the effective date of the rate change.**~~

All small group issuers will have the opportunity to submit rate changes when system capability to do so becomes operational."

Question 24: (Updated 3/18/14)

Q. What is the timeline for the carriers who only offer products off the Marketplace?

A. For products offered EXCLUSIVELY off Marketplace, filings will need to be submitted at least 90 days prior to the date you wish to start writing your products. If you would like your off Marketplace product available for open enrollment on November 15, 2014, an August 16th filing deadline will apply.

Question 25:

Q. Will you be releasing the Indiana ECP list or will it be HHS?

A. HHS will release ECP list.

Question 26:

Q. Does Indiana prohibit a company from offering coverage off the Marketplace if the insurer has no plans to be on the Marketplace? Does Indiana preclude a company from selling in the state unless they also sell on the Marketplace?

A. Carriers do not have to participate on the Federally Facilitated Marketplace (FFM). Carriers are able to offer new coverage for major medical products off the Marketplace.

Question 27: (Updated 3/25/14)

Q. Can I file a major medical form to be used with both grandfathered and non-grandfathered? Can I file a major medical form to be used with both small and large group in one filing and include both of the checklists?

A. Grandfathered forms for Small Group and Individual need to be submitted as a separate filing. Non-grandfathered forms for Small Group and Individual need to be submitted as a separate filing. For Large Group, Grandfathered and Non-grandfathered may be filed together.

Question 28:

Q. When do filings become available to the public, upon submission or upon approval/denial? How is the binder information going to become available? What is the process for requesting the filings?

A. Filings are available to the public upon submission. SERFF will notify states when the filing information submitted in the binder will be available. Filings may be viewed in person via a public records request or online at Rate Watch and the Health Filing Access Interface (HFAI).

Market Reform

Question 29: (Updated 4/4/14)

Q. Can the insurance company offer ACA rates to renewals if they are lower?

A. For small group, a company can sell an ACA compliant product to a small group outside of open enrollment if the participation rate (70%) is met. For Individual, consumers can only purchase an ACA product if they have a Special Enrollment Period from an existing policy.

Question 30: (Updated 4/19/13)

Q. Where can I find Indiana's Geographical Rating Areas? How many rating factors can issuers use in a single geographic area?

A. Please reference Bulletin 197 for Indiana's Geographical Rating Areas. http://www.in.gov/idoi/files/20130322151459265.pdf Only one factor per rating area, per risk pool may be used by the issuer.

Question 31: (Updated 4/19/13)

Q. What are the allowed rating factors? What rating areas should be used for small group plans – the employer's or employee's location? What rating areas should be used for non-group plans if family members are in different locations?

A. Age, Tobacco Usage, Family and Geography are the allowed rating factors. The employer business location should be used for rating small group plans regardless of employee's residential location. The residential location of the primary subscriber should be used regardless of the location of additional covered family members.

Question 32:

Q. Will risk adjustment, varying by plan, be an allowed rating factor? How do you anticipate risk adjustment to affect the rates?

A. No, risk adjustment will not be an allowed rating factor.

Question 33: (Updated 3/18/14)

Q. Will the full 1.5 tobacco rating factor be permitted in Indiana or has a more restrictive range of tobacco factors been defined? Is there a plan to define a more restrictive range?

A. Indiana does not intend to use a narrower factor than that which has been proposed by HHS.

Question 34: (Updated 4/19/13)

Q. Can the rates in the Marketplace be trended quarterly for both individual and small group?

A. Trend is not allowed in the Individual Market. Please see updated Question 23 regarding Small Group.

Question 35: (Updated 4/2/13)

Q. For the schedule of benefits that accompany a certificate of coverage, can we use bracketing to reflect range of benefits we are offering? Or do you require a separate hard coded schedule of benefits for each benefit plan/metal plan offering?

A. Yes, bracketing is allowed, however all covered benefits must be listed for each specific dollar amount within the range provided as a part of the Actuarial Memorandum.

Dental & Vision

Question 36: (Updated 4/25/14)

Q. Do stand-alone dental carriers need to complete the EHB Crosswalk Tool?

A. Yes. For stand-alone dental, complete those items that apply to dental & mark the other items n/a.

Question 37: (Updated 4/25/14)

Q. Are any of the federal templates required for an exchange-certified, stand-alone dental plan filing?

A. Issuers would complete the templates needed for federal certification of a certified stand alone dental plan. Please refer to the 2015 Final Letter to Issuers.

Question 38: (Updated 4/17/14)

Q. Will a small group SADP off the exchange that enrolled on April 1, 2013 be required to renew its policy on a calendar year basis (meaning 1/1/14) or can they continue this policy using the 2014 MOOP (700/1400) until the group's renewal date of March 31, 2015 and replace it with the 350/700 MOOP at that time?

A. Small group renewals are policy year to policy year. If the policy year does not change until March 31, 2015, they would continue using the 2014 MOOP (700/1400) until March 31, 2015.

Question 39: (Updated 4/17/14)

Q. If we are seeking QHP certification for our off-Marketplace SADP, would we need to file by the May 11, 2014 deadline? Or 90 days in advance of November 15, 2014?

A. Yes. An Exchange Certified Stand Alone Dental Plan must file your forms and rates to the IDOI by May 11, 2014. HHS is still in the process of finalizing templates to which we request the templates to filed within 7 days of the release of the finalized QHP templates (this includes validation capability of the "Data Integrity Tool"). Validation is not expected to be complete prior to May 27, 2014. Please see April 9, 2014 Industry Updates. CCIIO has not set a definitive date for release of these templates. Please refer to the 2015 Final Letter to Issuers. The 90 days prior to open enrollment applies to non-certified plans OFF the Marketplace.

Question 40: (Updated 4/11/14)

Q. IDOI indicated that binders are not required for dental products. Do we still need to file for certification via HIOS?

A. The non-requirement of binders for Dental products is an Indiana policy. Yes, you will file for certification via HIOS.

Question 41: (Updated 4/11/14)

Q. For a certified off-Marketplace GROUP SADP, what checklists are required to be filed with the form and rate filing?

A. http://www.in.gov/idoi/2778.htm

Question 42: (Updated 4/11/14)

Q. For a certified off-Marketplace INDIVIDUAL SADP, what checklists are required to be filed with the form and rate filing?

A. http://www.in.gov/idoi/2775.htm

Question 43: (Updated 4/4/14)

Q. Are family stand-alone dental policies still able to apply waiting periods to specific services?

A. Family dental can have waiting periods for adult dental. However, Pediatric dental has no waiting period.

Question 44: (Updated 4/4/14)

Q. Are medical plans still required to produce credible coverage documents even though 2014 small group policies may imbed dental?

A. For Dental, they will continue to need to provide evidence of credible coverage. For Medical, this will be necessary for Grandfathered and Grandmothered policies going forward.

Question 45: (Updated 4/4/14)

Q. If we sell a certified dental product off-exchange, are we required to submit a binder?

A. Binders are not required for dental products.

Question 46: (Updated 4/4/14)

Q. Does the IDOI require specific language in our requirements that defines orthodontia benefits in SADPs?

A. No, this is up to each individual carrier to define and relay to their insureds via advertising, etc. The IDOI informs insured's that call the Department that orthodontia is only required under medical necessity guidelines.

Question 47: (Updated 4/4/14)

Q. Is it permissible for a stand-alone dental plan that has family coverage on the Indiana FFM to cover dependents only up to age 19?

A. The pediatric benefit would cover only up to Age 19. After Age 19, the dependent would be covered under family coverage to Age 26.

Question 48:

Q. Does the Anthem BCBS Benchmark plan contain the pediatric dental and vision requirements under EHB?

A. No, the EHB benchmark has been supplemented using the Federal employees dental and vision insurance program (FEDVIP) dental and FEDVIP vision.

Question 49: (Updated 3/18/14)

Q. Does the child benefit have to be included in the medical plan both on and off Marketplace?

A. Pediatric vision must be embedded in the benefit plan both on and off the Marketplace.

Pediatric dental will need to be embedded OR bundled in the benefit plan off the Marketplace. If pediatric dental is not embedded OR bundled in the benefit plan, it must be purchased as a certified stand-alone pediatric dental plan.

When an issuer is reasonably assured that an individual has obtained such coverage through an Marketplace-certified stand-alone dental plan (Qualified Dental Plan) offered outside an Marketplace, the issuer would not be found noncompliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Marketplace-certified stand-alone dental plan, ensures full coverage of EHB.

Question 50:

Q. The pediatric Dental and Vision are part of the benchmark plan, but on-Marketplace plans do not have to include these, because of the stand alone plans available, correct?

A. This is correct for dental, but not vision.

Question 51:

Q. For QHP and non-QHPs, do carriers have to offer pediatric vision as part of the medical plan or can that be a stand-alone vision plan?

A. No. HHS has not allowed for a stand-alone pediatric vision plan.

Question 52:

Q. Can stand alone dental for adult be offered off the Marketplace only?

A. Yes, there are currently stand alone dental plans for adults that are offered in the outside marketplace.

Question 53: (Updated 3/18/14)

Q. If I offer a stand-alone dental product outside the Marketplace, does this allow us to avoid including pediatric dental in our medical plans offered outside the Marketplace?

A. Pediatric dental will need to be either embedded OR bundled in the benefit plan off the Marketplace or in cases in which an individual has purchased stand-alone pediatric dental coverage offered by a Marketplace-certified stand-alone dental plan off the Marketplace, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through a Marketplace-certified stand-alone dental plan offered outside the Marketplace, the issuer would not be found noncompliant with EHB requirements if the

issuer offers that individual a policy that, when combined with the Marketplace-certified stand-alone dental plan, ensures full coverage of EHB.

A family dental plan may be able to meet the pediatric dental plan requirement if the pediatric dental benefits contained within the plan meet the pediatric dental Marketplace certification standards and are in accordance with the pediatric benchmark requirements from the FEDVIP dental plan.

Mental Health Parity

Question 54:

Q. Are the visit limits or limit quantities offered separate for Outpatient Rehabilitation and Habilitation Services?

A. The limits must be separated for rehabilitation and habilitation services to meet EHB requirements. There must be coverage for Outpatient Rehabilitation PT, OT & ST for a minimum of 20 visits each (20/20/20) AND coverage for Outpatient Habilitation PT, OT & ST for an additional minimum of 20 visits each (20/20/20).

Question 55:

Q: Do limits apply to ABA coverage for the treatment of Autism?

A: No. Behavioral therapies such as Applied Behavioral Analysis ("ABA") may not be subject to limitations that apply to rehabilitative services such as physical, occupational or speech therapy.

IDOI Bulletin 136 remains in effect and benefits will remain covered under the new plans.

Conversion Products

Question 56: (Updated 4/4/14)

Q. For 2014 we were allowed to direct members to the Federally Facilitated Marketplace in lieu of offering an individual conversion policy. Will this still be allowed for plan years beginning on/after 2015 or do the "traditional" individual conversion policies have to be reinstituted?

A. The "traditional" conversion policies will need to be continued. This is allowed and NOT considered a "Guaranteed Availability" or "Guaranteed Renewability" product. This is consistent with the provisions of 42 U.S.C.A. § 300gg-41(e)(ii): A health insurance issuer offering health insurance coverage in connection with group health plans under this subchapter shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy. This change should be made in your 2015 filings.

Question 57: (Updated 4/11/14)

Q. We were under the impression that if the member didn't want a policy on the Marketplace that we would be in compliance if we offer any individual coverage we currently market to satisfy the conversion requirement. Is this still correct?

A. Yes, this is correct, but the policy must be ACA compliant.

Question 58:

Q. Will small group carriers still be required to offer conversion policies in 2014?

A. Yes, as stated in our insurance statute. Per 42 U.S.C.A § 300gg–41(e)(ii), a health insurance issuer offering health insurance coverage in connection with group health plans under this subchapter shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

SHOP

Question 59: (Updated 4/17/14)

Q. Does Indiana plan to request to delay employee choice for 2015?

A. This decision has not been made at this time. The IDOI will communicate a decision to the industry soon.

Question 60: (Updated 3/18/14)

Q. Has Indiana issued any specific guidance related to Composite Rating/Billing in the Small Group market?

A. Indiana does allow composite rating/billing in the Small Group market. IDOI has not issued specific guidance however the Department does discuss with the carrier how you will be performing composite rating. Carriers intending to write through the SHOP next year should familiarize with Marketplace rules that have been established at the federal level around composite rating and whether the employer has allowed employee choice or not.

Question 61: (Updated 3/18/14)

Q. If the SHOP Marketplace offers open enrollment throughout the year; can the filed rates vary by month of enrollment? If so can these rates be revised through a new filing throughout 2014?

A. No. Small group rates will function as they currently do now in which implementing an 18 month trend is permitted with prior approval. If you change the base or adjust trend beyond 18 months you must re-file for approval at both the state (traditional rate review) and the federal level (completion of data templates). You must file for trend in the INITIAL filing and can only implement 4 trend rate increases per year.

Additionally, please see updated Question 23.

HIOS

Question 62: (Updated 4/4/14)

Q. What is the deadline for the HIOS filings?

A. The HIOS deadline may be confirmed in the Final Letter to Issuers from CMS, which we encouraged all issuers to review during our March 18, 2014 Webinar.

Associations

Question 63: (Updated 4/17/14)

Q. Can states define coverage sold to individuals and small groups through an association as large group coverage and hence avoid subjecting such coverage to the single risk pool and other requirements of the individual and small group market?

A. No. For purposes of Title XXVII of the PHS Act, including the market reforms, any state law that defines coverage sold to individuals and small groups through an association as large group coverage would be preempted by federal law. Refer to Question 8 in the following document: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

According to CMS, the following 9/1/11 Bulleting is still the most current guidance regarding association coverage.
http://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf

Question 64: (Updated 4/17/14)

Q. Can a bona fide association under a fully insured MEWA be rated as a large group outside community rating?

A. No. A bona-fide association is considered an Individual policy and cannot be rated as a large group.

According to CMS, the following 9/1/11 Bulletin is still the most current guidance regarding association coverage.
http://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf

Also see Question 8 of this document: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

QHP Templates

Question 65: (Updated 4/17/14)

Q. Do you know when the QHP templates are expected to be validated?

A. The data templates released on 4/17/14 are NOT final and will NOT validate. Since QHP Template VALIDATION is not expected to be complete prior to May 27th, 2014, Validated Templates are now due on June 3rd, 2014 by 11:59 PM Eastern, 7 calendar days post May 27th validation. Carriers are encouraged to begin working on the 2015 templates now.

Carriers are encouraged to begin working on the 2015 templates now. Copy/paste can be used from template to template to help with the data entry. However, we urge extreme caution from the issuers when doing that. For example, last year we saw issuers paste $X copay into inpatient hospital or SNF benefits when the template is looking for per day or per stay copay values. That can create problems for reviews using the tools and for display to consumers. We just want to urge caution and awareness from issuers to be careful when using copy/paste.

Binders

Question 66: (Updated 4/17/14)

Q. Can you please clarify when we should submit Binders in SERFF?

A. SERFF will NOT accept new BINDER submissions until May 27, 2014. If an issuer submits a binder in SERFF prior to May 27, 2014, the binder will be rejected. Therefore, the IDOI asks issuers to WAIT until May 27, 2014 to begin submitting binders. The deadline to submit binders in SERFF is June 3, 2014 at 11:59 PM Eastern. Binders are not required for Dental Products

Question 67: (Updated 4/25/14)

Q. Are 2015 SERFF binders limited to 250 plans? Or was this amount increased?

A. Per CCIIO Guidance you may file up to 1100 plans in your 2015 binder.

Wellness Programs

Question 68: (Updated 4/25/14)

Q. Are wellness programs permitted in Individual coverage offered on the Marketplace?

A. On June 3, 2013, the Departments of the Treasury, Labor and Health and Human Services jointly issued final rules 45 CFR Parts 146 and 147 regarding proposed amendments to regulations, to be consistent with the Affordable Care Act (ACA), relating to wellness programs in group health coverage. The final rules were first proposed on Nov. 26, 2012.

The wellness program exception to the prohibition on discrimination under the existing rules and the ACA apply to group health plans (and any health insurance coverage offered in connection with such plans) but does not apply to health insurance coverage offered in the individual market. The final rules apply to all grandfathered and non-grandfathered fully insured and self-funded group health plans for plan years beginning on or after Jan. 1, 2014.

The ACA does not allow wellness programs in the individual market, but it does authorize a 10-state demonstration project for wellness programs in the individual market beginning no later than July of 2014. By July 1, 2014, HHS is required to establish the demonstration project. Participating states would offer wellness programs in the individual market. This may be the only way wellness programs can be offered to individual and family purchasers.

***Document subject to change pending further guidance from HHS.**

Questions should be directed to compliance@idoi.in.gov