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DEPARTMENT OF INSURANCE

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Idaho Carrier Questions and Answers, Part 1– May 3, 2013

The following questions have been received by the Idaho Department of Insurance regarding the Idaho Health Insurance Exchange and SHOP (Idaho Exchange), the filing process, Qualified Health Plan standards, and other related topics. The answers are intended to offer guidance on current issues based on the DOI's current understanding. If you have any concerns regarding the accuracy of any of the guidance, please contact Wes Trexler at the DOI by phone or email at 208-334-4315 or weston.trexler@doi.idaho.gov. The DOI will continue to release additional information and revise these responses as needed.

1. What is the Idaho exchange user fee?
 - A. The fee has not yet been set by the Idaho Exchange Board.
2. What fee should carriers use in QHP filings prior to the Idaho Exchange Board setting the exchange user fee?
 - A. For filings made prior to the board's decision, carriers should use what they reasonably expect for the exchange user fee. Once the fee is determined, and if different than that contained in the filing, the DOI will submit an objection to the filed exchange fee through SERFF, allowing carriers the opportunity to modify the templates and documents as needed to reflect only the change to the fee. If for whatever reason, modifications are not sufficient, the DOI will allow new filings after May 31, 2013 for the narrow purpose of fixing the exchange fee used in the rate development. Changes to the Unified Rate Review Template (URRT) or the actuarial memorandum will also need to be resubmitted through HIOS. Please be aware that all objections will need to be resolved with sufficient time for the DOI to complete its review and certification of QHPs by the DOI's July 31, 2013 deadline.
3. What are the names of the rating areas so that we can input them in our rating template? The bulletin identifies how the areas are defined but will there be a standard naming convention that will be used by all the carriers?
 - A. Please see <http://cciiio.cms.gov/programs/marketreforms/id-gra.html> for the standard naming convention of the Idaho geographic rating areas.

4. What is the minimum number of medical plans that a carrier may offer through the Idaho Exchange?
 - A. A carrier must at a minimum offer a silver and gold plan in each market in which the carrier wishes to participate. Variant plans are required under Federal law for the Cost-Sharing Reductions for the Silver metal level and the two Indian variant plans for all metal levels.
5. Will the Notice of the Ten (10)-Day Right to Examine a Policy requirement be applicable to the QHPs?
 - A. Idaho Code and Rule 30 provisions will be applicable unless preempted by federal law. The notice of the ten-day right to examine a policy is not considered preempted.
6. Must the SERFF filing of the policies, Outlines of Coverage (OOCs) and/or Summaries of Benefits and Coverage (SBCs) be “filed” before we can associate the filings in the binder or can the policies just be submitted and in the review at the DOI process when we create the binder?
 - A. The SERFF process involves first filing the materials and then associating the filings to the binder. The materials do not have to be accepted as filed prior to being associated with a binder. Additionally, all materials are not required to be filed simultaneously.
7. Will the DOI be using the FFE standards to determine network adequacy?
 - A. We plan on using network adequacy standards similar to the FFE standards.
8. If the state has a question regarding a deficiency, will this be handled like an objection in SERFF?
 - A. Yes, that is the current expectation. SERFF filing guidelines and procedures for QHP binders are the same as all other filings.
9. We have been advised in CCIIO meetings the Medical Loss Ratio & Uniform Rate Review Template (URRT) will need to be sent to HIOS as well as SERFF. Are you aware of additional templates that will also need to be submitted to SERFF?
 - A. The URRT and the actuarial memorandum must be filed with HIOS at the same time as the filing with SERFF.
10. Has a date been set for the filing of dental products for 2014?
 - A. The March 26, 2013 [Notice to Carriers](#) also applies to dental products. The QHP filing deadline given in that notice is May 31, 2013.

11. Rate filings must be filed through SERFF by May 31. What is the timeline for forms such as our contracts or certificates?
- A. The May 31, 2013 “soft” filing deadline in the March 26, 2013 [Notice to Carriers](#) applies to contracts and certificates, as they are part of a complete SERFF binder filing.
12. Have you established a filing deadline for non-exchange products?
- A. Non-exchange QHPs should also be filed by May 31, 2013. There is no established deadline for non-QHPs. However, please be aware that the single risk pool standard requires that all plan rates be based on the same URRT.
13. For Individual, will there be opportunities to change rates after they are filed? Once we have submitted our products and rates, can we drop them? What is the cutoff date?
- A. Rates, forms, and templates can be modified through May 31, 2013. After that date, modifications that are not made at the request of the DOI may result in the modified plan/product being moved in priority behind non-modified plans/products. Carriers can withdraw QHP applications through July 31, 2013.
14. For Small Employer, the ACA and regulation (45 CFR § 155.705(b)(6)(i)) allows for rates to be changed on a quarterly, monthly, or annual basis. What will the filing timeline be for quarterly changes?
- A. Regarding the 2014 calendar year, the DOI recommends that carriers file quarterly trend adjustments with the initial submission, including each set of quarterly rates on separate sheets of the Rate Template. At this time, it is unclear if the Idaho SHOP will be prepared to accept additional adjustments to rates effective during the 2014 calendar year, beyond expected quarterly trend.
15. Do rate manuals need to be included with the QHP filings?
- A. Idaho Code requires a rate manual be filed with the DOI prior to use. The DOI will consider a complete QHP filing, which includes all requested templates, to have met this requirement.
16. Since Idaho does not have a rule or law on minimum participation and has allowed the carriers to make their own participation rules in the past, is Idaho going to continue to allow this procedure in 2014 or are we going to be required to follow the exchange minimum?
- A. The Idaho Exchange Board has the authority to set a minimum participation requirement for the Idaho SHOP. At this time, no requirement has been established.

17. Regarding the SHOP in Idaho, is the DOI going to limit options?

- A. The DOI does not plan to limit options on the SHOP, outside of the finite departmental resources explained in the March 26, 2013 [Notice to Carriers](#).

18. ~~Is the no rider/endorsement hold for outside the exchange too?~~

- ~~A. Optional riders with corresponding additional premium will be permitted outside the exchange. Plans offered in and out of the exchange must charge the same premium prior to any optional riders. (Answer was revised in Idaho Q&A, Part 2 - 5/17/2013)~~

19. When, at what stage of the filing process in SERFF, do filings become public?

- ~~A. The DOI will maintain current public access standards. Per Idaho Code § 9-340D(1), the DOI generally considers records as proprietary or “trade secret” any rates or rating information that is flagged as confidential within a filing. While such a designation by a company does not necessarily conclusively resolve the question, it does assist the DOI and has been referenced in [Bulletin 95-2](#). Form filings become publicly accessible upon receipt of the filing. We have no information regarding public access to information filed through HIOS. (Answer was revised in Idaho Q&A, Part 2 - 5/17/2013)~~

20. Below are some of the areas where it looks like the requirements of Rule 30 could require richer benefits than are required under the benchmark plan. Please clarify if the benchmark plan limits apply to individual plans (preempting Rule 30) or if Rule 30 still applies to individual plans, with the restrictions shown in the table?

Benefit	Group Plan	Individual Plan
Chiropractic care	Limits on coverage	No limits on coverage
Diabetes education	Limits on coverage	No limits on coverage
Hospice	Limits on coverage	No limits on coverage
Neurodevelopmental Therapy	Not covered	Combined benefit with rehab
Nutritional counseling	Limits on coverage	No limits on coverage
Pediatric dental	Limits on coverage	No limits on coverage
Pediatric vision	Limits on coverage	No limits on coverage
Rehab (outpatient)	20 visits per year	20 visits per year for each type of therapy (speech, physical, occupational)
TMJ	Not covered	No limits on coverage
Habilitative (once Defined)	Could have limits	No limits on coverage

- ~~A. The general preemption guideline is that a state law is preempted by the ACA only where complying with it would result in non-compliance with the federal act or regulation. Regarding the specific case, the DOI is reviewing this and will provide guidance shortly. (Answer was revised in Idaho Q&A, Part 2 - 5/17/2013)~~

21. Will there be specific questions that we should ask prospective members?
- A. Yes. Please see the federal application for preliminary guidance. The Idaho Exchange Board may decide to provide additional guidance with the Exchange application.
22. Will short term policies be limited to transitional membership only?
- A. Correct. There is no change in the intended use of short term policies.
23. Per Bulletin 13-02, the state allows SHOP rating on a per member basis. Does this also extend to premium billing as well, or do premium rates have to be billed at the subscriber level? If subscriber-level billing is required, can premium rates be billed separately for different levels of dependent coverage (e.g., Employee Only, Employee & Child, Employee & Spouse, Employee & Family) or must they be billed for employee only coverage versus employee plus family coverage (i.e., 2-tier rating)?
- A. As stated in [Bulletin 13-02](#), small group premiums can be, but will not be required to be based on average enrollee amounts. Per the final market rules, this means that issuers are permitted to develop the premium on a per-member basis or use average enrollee amounts. Average enrollee amount premiums are permitted as long as the total is equal to the per-member build up premium total. Average enrollee amounts can be set using multiple tiers (including more than two), as long as the tier factors are standardized and are applied consistently.
24. Does Bulletin 13-01 apply to stand alone dental plans?
- A. The bulletin applies to all carriers that write disability in the individual and small employer market, which includes dental, vision, and health insurance. Since dental plans are not grandfathered, we expect current dental plans that cover pediatric dental to be discontinued and replaced with an ACA compliant (i.e. Idaho benchmark plan) pediatric dental plan, in compliance with [Bulletin 13-01](#).
- ~~25. Is minor variability allowed for something like contact information?~~
- ~~A. This is allowed in form filings. Group language can be variable, but individual language other than company contact information cannot be variable. (Answer was revised in Idaho Q&A, Part 2 - 5/17/2013)~~
- ~~26. Is Idaho going to insist on having coverage for Non-Emergency Care When Traveling outside the U.S.?~~
- ~~A. This is part of the benchmark plan, and therefore a required EHB. Standard preauthorization and notification requirements can apply. If no network is available outside the U.S., the coverage can be offered at out-of-network coverage levels. (Answer was revised in Idaho Q&A, Part 2 - 5/17/2013)~~

27. Does ACA say that individual plans will all be based on calendar year accumulators (for deductibles/OOP maxes) and small group will be based on plan year accumulators? Does the same apply to dental plans?

- A. Yes, those accumulator periods apply to all QHPs including dental, per the Establishment of Exchanges and QHPs final rule.