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Idaho Carrier Questions and Answers, Part 4 – August 8, 2013

The following questions have been received by the Idaho Department of Insurance from health insurance carriers 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 of applicable federal and state law requirements. 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.

The answers to questions 1, 27, and 49 from prior Q&A releases have been revised as shown below. The remaining questions are new.

1. What is the Idaho exchange user fee?
   A. (Revised 8/8/2013) The Idaho Health Insurance Exchange Board set the 2014 fee during the June 28, 2013 board meeting at 1.5% of premium.

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. (Revised 8/8/2013) In the individual market, deductibles and maximums must accumulate on a calendar year basis. In the small group market, federal regulations do not provide guidance, so deductibles and maximums can continue to accumulate on a calendar year or renewal year basis. "Exchange certified" stand-alone dental plans have the same accumulator requirements as medical QHPs.

49. What is the filing deadline for off-exchange only, non-QHPs?
   A. (Revised 8/8/2013) Due to the considerable changes to plan requirements and limitations, the DOI is unable to provide assurance that the review and acceptance of filings will be fully completed by October 1 if a filing is submitted after August 31. Therefore, DOI strongly suggests that rates and forms for new ACA-compliant plans to be sold only off-exchange be filed with the DOI no later than August 31.

In accordance with federal regulation and guidance, non-QHPs must be filed at the same time as QHPs. Please see CMS FAQ released April 18, 2013, question 50 and CMS FAQ released April 24, 2013, question 29 for additional details.

Please note that if an individual plan is not available for purchase throughout the full open enrollment period as stipulated by 45 C.F.R § 147.104(b)(1)(ii), the carrier will not be able to limit enrollment outside of the open enrollment period and instead must enroll any individual who applies at any time during the following calendar year.

Similarly, if a small group plan is not available for purchase during the full November 15 to December 15 annual enrollment period when minimum participation and contribution rates cannot be imposed, the carrier must not apply a minimum participation or minimum contribution rate to any small group applicant during the following calendar year.

53. When can plans be added to either the individual or small group market?

A. Since the market-wide index rate must reflect all plans in the single risk pool, all plans in the risk pool have to have their rates approved at the same time, both on and off the Exchange. Therefore new plans must be submitted with all other plans within the same market at the same time the market-wide index rate is changed. The proposed Program Integrity rule includes 45 C.F.R. § 156.80(d)(3), stating that carriers (selling inside or outside an Exchange) may adjust the individual market-wide index rate annually and the small group market-wide index rate quarterly. However, quarterly adjustments in the small group market are not available until after the HHS issues notification that the FF-SHOP can process quarterly rate updates.

54. When is the Plan Preview for plans that are participating in the Idaho Exchange?

A. The Plan Preview for the Idaho Exchange extends from August 8 to August 23, 2013. During this period, the participating carriers can review a selection of their submitted carrier and plan data that will be displayed to consumers. Carriers can review the information through HIOS, and any requests for changes should be sent to the XOSC Help Desk by August 16, 2013, by email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515. Once the change is approved by the Idaho DOI, the carrier will make the change through SERFF.

Please see https://www.regtap.info/ann_view.php?id=22 and https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf for more details.

55. Under what circumstances can a small group plan exceed the annual deductible limit of $2,000 for an individual or $4,000 for a family specified in 45 C.F.R. § 156.130(b)?
    A. According to 45 C.F.R. § 156.130(b)(3), "a health plan's annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage as defined in § 156.140 of this subpart without exceeding the annual deductible limit." The Idaho DOI and CMS sub-regulatory guidance agree that bronze metal level plans cannot reasonably reach the actuarial value without exceeding the annual deductible limit, and therefore are exempt from this requirement. Silver, gold, and platinum plans must not exceed the limit.

56. Are conversion plans required after January 1, 2014, even with guaranteed-issue in the individual market? If conversion will still need to be offered, will it have to conform to all ACA requirements for other non-grandfathered plans, i.e., EHB's, metal plan level, etc.?
    A. Unless the DOI releases additional future guidance, conversion plans are no longer required. The purpose of a conversion plan is met through the ACA-compliant individual market plan options. Current conversion plans are permitted to discontinue consistent with Idaho DOI Bulletin 13-01. An EHB compliant replacement conversion plan is not required.

57. Is small group composite rating allowed at certain group sizes, as long as the total is equal to the allowable per-member rating at issue and renewal?
    A. At this time, it appears that federal regulations and Idaho code allow the carrier to determine the size at which composite rates are offered outside the Exchange. Additionally, it appears acceptable to modify the composite rates only at issue and renewal, as long as the total premium is equivalent to the allowed per-member rating at those times. Additional federal guidance is expected to address this more directly.

58. Is there an updated version of the Idaho Small Employer Application that conforms to the requirements of the ACA (i.e., removal of health status questions, etc.)?
    A. The updated version is being worked on and will be posted to the Idaho DOI website when finalized and approved.

59. What requirements exist for brokers / producers who wish to participate in the Idaho Exchange?
    A. The Idaho Exchange's proposed Consumer Connector Program (CCP) includes defined roles and requirements for producers who wish to participate in the Exchange. Once the CCP is finalized and approved by the Exchange Board, the Exchange will communicate the details to the producer community. The proposed CCP utilizes the producers as the

recipient of referrals from those needing recommendations or additional guidance while accessing information on-line or through the call center, or while working with the community based In-Person Assisters. For the 2013 open enrollment period, the Idaho Exchange will not be adding additional requirements to the producer community beyond the federal requirements, but it will make the CCP Training available for their use.

60. How will carriers be notified if a producer is certified to sell through the Exchange?
    A. The Idaho Exchange has adopted the producer registration and training procedures as explained at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/agent-broker-5-1-2013.pdf. After completing the required training, producers will be issued a certificate of completion, which they will present to carriers along with their identification number.

61. For the transition of non-grandfathered off-exchange moving to EHB medical coverage, can a carrier automatically enroll an individual or group onto an Exchange-certified stand-alone dental plan to ensure compliance, if the carrier can't obtain a definitive response from the member or group that they have purchased an Exchange-certified stand-alone dental plan?
    A. Yes. Per federal guidelines, the carrier is responsible for becoming "reasonably assured" that policy holders obtain the full set of ten EHBs, and the carrier must include coverage for the pediatric dental EHB if that assurance is not obtained. According to the EHB final rule (78 FR 12834), the carrier could potentially be found non-compliant with EHB requirements if the carrier does not ensure full coverage of EHB.

62. For off-exchange shoppers wanting to purchase medical coverage, how should carriers enroll an individual or group onto a QHP pediatric product?
    A. If a carrier does not embed the pediatric dental benefit in their off-exchange plan offerings, the carrier has the responsibility to offer the full EHB or be reasonably assured that an individual has obtained the pediatric dental EHB through an Exchange-certified stand-alone dental plan. As discussed in questions 43 and 44 of the May 17, 2013 Idaho Carrier Questions and Answers, Part 2, carriers must decide how they fulfill that responsibility in order to be found compliant with EHB requirements.

63. If a family drops a dependent eligible for the pediatric dental benefit and the carrier cannot become reasonably assured that the dependent has an Exchange-certified stand-alone dental plan through another carrier, will the medical policy also need to be terminated for the entire family or just the dependent?

    A. The carrier should not permit a family to discontinue pediatric dental EHB coverage for a member without first obtaining reasonable assurance that an Exchange-certified stand-alone dental plan will replace the coverage.

64. If an off-exchange member/group does not provide the evidence requested by the medical carrier to be reasonably assured that they have an Exchange-certified stand-alone dental plan, will the medical carrier that is not providing the pediatric dental EHB be forced to terminate the member/group as non-compliant?

    A. The medical carrier should offer only the full EHB to applicants if it is not reasonably assured that the pediatric dental EHB is being met through a separate Exchange-certified plan. Enrolling an applicant in a plan which lacks coverage of the pediatric dental EHB without reasonable assurance of other acceptable coverage would violate the EHB regulations.

65. How often does a carrier have to track or certify compliance with covering the pediatric dental EHB?

    A. The carrier is responsible for designing procedures to achieve compliance with EHB requirements to offer full EHB or be reasonably assured that all EHB are covered, as described in the final EHB rule.

66. Will groups that purchase on the Idaho SHOP be able to make multiple plan options available to their employees? Does the same apply for stand-alone dental plans available on the Idaho SHOP?

    A. For plan years that begin prior to January 1, 2015, the group purchasing through the SHOP will select only one medical and up to one stand-alone dental plan to which all members of the group will have access. For plan years beginning on or after January 1, 2015, Idaho SHOP is expected to offer employee choice and premium aggregation, which would allow groups to allow employees to select among a subset of the plans offered on the SHOP.