A Look at Some ACA Regulations

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Proposed and Final MEC Regs: (3)

- HHS and the IRS released on January 30, 2013, two proposed rules and a final rule relating to the ACA's requirement that individuals maintain "minimum essential coverage" (MEC) or be subject to a "shared responsibility" payment.
- Due to the subject matter, define MEC…" Under the ACA, an individual with employer-sponsored coverage is not considered to have "minimum essential coverage" (making the individual eligible for tax credits) if; 1) employer premiums are "unaffordable, meaning the employee's contribution for an individual plan exceeds 9.5 percent of household income; or 2) the employer coverage does not provide minimum value. This means the employer contribution is less than 60 percent of the plan's actuarial value.

The Three Rules… (4)

- IRS Final Rule on Health Insurance Premium Tax Credits : The 1/30/2013 final rule clearly defines "affordability" of coverage for the employee under an employer-sponsored group health plan is determined based on self-only coverage (and not family coverage).
- IRS Proposed Rule on Shared Responsibility for Individuals:

  addresses (1) the obligation each taxpayer has to make a "shared responsibility payment" for himself, herself and any dependents who, for a calendar month, do not have MEC, and (2) exemptions to this payment obligation. The limited exceptions for this payment obligation include individuals who lack access to affordable MEC.

HHS Proposed Rule (5)

HHS Proposed Rule on the Exchange Functions: Eligibility for Exemptions; and Miscellaneous Minimum Essential Coverage Provisions:

The HHS sets forth standards and processes by which a health insurance Exchange will make eligibility determinations and grant exemptions from the shared responsibility payment. This proposed rule also (1) identifies certain types of coverage deemed to be MEC, and (2) sets forth standards by which HHS may designate certain health benefits coverage as MEC. (3) The Rule outlines Exchange functions in the Individual Market Exchange to handle exemptions, the verification process, the redetermination process during the calendar year, reporting requirements, and the individual's right to appeal.

MEC Impact on Subsidy Eligibility: (6)

- Lots of confusion about eligibility for tax credit through the Exchange. Who can qualify:
  1) Income of 100 or 138% FPL (based on state's Medicaid expansion decision) to 400% FPL;
  2) Can't have minimum essential coverage (MEC)
  3) Regarding the minimum essential coverage requirement, the IRS proposed regulations make the following clarifications:

  A.) An employee is treated as eligible for MEC for each month in the plan year where the employee could have enrolled in the plan due to an open or special enrollment period.

Minimum Essential Coverage: (7)

B.) Premium credits are not paid for months in which individuals are eligible for "minimum essential coverage," which includes government coverage such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and veterans' health programs and ESI.

C.) If two members of a family are employed and their respective employers offer self-only and family coverage under eligible employer-sponsored plans, each individual determines the affordability of their coverage by using the premium for the self-only coverage offered by the individual's employer.

D.) Employee who is eligible for coverage under an eligible employer-sponsored plan, the employee's required contribution is the portion of the annual premium he would pay for the lowest cost self-only coverage.

Eligible for Exchange Subsidies? (8)

- With regard to individuals who are offered employer-sponsored coverage, the law states that in order to qualify for the premium tax subsidy, the ESI must be unaffordable, defined by the IRS as an employee contribution requirement for self-only coverage that exceeds 9.5 percent of household income.
- For employees who do not have ACA defined affordable ESI, their dependents are eligible for exchange subsidies (based on FPL determination).
- The remaining question was whether uninsured family members of employees with access to affordable self-only employer coverage can qualify for a premium tax credit.

Subsidy Eligibility? (9)

- The ACA also provides that regardless of whether coverage is deemed "affordable," premium tax credits are unavailable if an employee actually enrolls in the employer's plan. So, an employee waives premium tax credit eligibility by enrolling in an employer plan, even if unaffordable.
- Individuals eligible for COBRA, or similar state or federal continuation of coverage, can decline the continued coverage and qualify for premium tax credits.
- Specifies that affordability is to be defined only in relation to the cost of individual coverage. (This was contested in earlier regs but not changed.)
- Coverage for a family is defined as "Affordable"….even if the coverage cost exceeds the 9.5 percent threshold, as long as coverage of the individual (employee) is considered affordable.

Exchange Subsidies cont.: (10)

- Government Accountability Office has estimated that this interpretation of the ACA would leave about 6.6 % of children uninsured, since they can't access premium tax credits and cost sharing subsidies in a case where employer-sponsored family coverage is unaffordable.
- Some of these kids will be Medicaid and CHIP eligible.
- The State's decision on Medicaid expansion will really impact these families….especially uninsured spouses.

Affordable Clarified: (11)

- The final rule states that an employer sponsored plan will be deemed affordable for a related individual if the portion of the employee's required contribution for self-only coverage does not exceed 9.5% of household income.
- Premium subsidies and cost-sharing assistance will not be available to the uninsured spouses and children of employees who have access to affordable self-only coverage but who cannot afford dependent coverage because the premium exceeds 9.5 percent of household income.

Individual Mandate: (12)

- Starting in 2014, the individual shared responsibility provision calls for each individual to have basic health insurance coverage (minimum essential coverage), qualify for an exemption, or make a shared responsibility payment when filing a federal income tax return.
- Individuals will not have to make a payment if coverage is unaffordable, if they spend less than three consecutive months without coverage, or if they qualify for an exemption for several other reasons, including hardship and religious beliefs.
- Goal is to ensure that the payment applies only to the limited group of taxpayers who choose to spend a substantial period of time without coverage despite having access to affordable coverage.
- Hardship Example…Individuals who would be eligible for Medicaid but for a state's choice not to expand Medicaid eligibility.

Hardship exemptions from Mandate: (13)

- Individuals who cannot afford coverage;
- Taxpayers with income below the filing threshold;
- Members of Indian tribes;
- Individuals who experience short coverage gaps;
- Violates religious conscience;
- Members of a health care sharing ministry;
- Incarcerated individuals; and
- Individuals who are not lawfully present.

***The same fact sheet also noted findings from the Congressional Budget Office that less than 2 % of the American public will have to make a payment under the mandate. ($95 -$695 by 2016)

Coverage of Contraception (14)

- On February 1, 2013, IRS, DOL and HHS issued a proposed rule on ACA provisions relating to the provision of contraceptive services without cost sharing.
- The proposed rule expands the definition of the "religious employers" exempt from or eligible for accommodation from the requirement to provide contraceptive coverage without cost sharing.
- The religious employer definition in the 2012 final rules would be broadened to include any nonprofit entity described under the existing tax code definition which applies to group health plan houses of worship. (would include a house of worship that operates a soup kitchen or parochial school…)

Proposed Contraception Rule Cont. (15)

- This new definition would include non-profits that consider themselves to be a religious organization that is opposed to providing coverage for some or all contraceptive services on account of religious objections. These eligible organizations would "self-certify" as to status.
- The proposal is to allow separate contraceptive coverage without cost sharing for plan participants and beneficiaries of eligible organizations while protecting these objecting organizations from having to in any way contract or pay for contraceptive coverage.

Accommodations for Organizations (16)

- **Process for Fully-insured Group Plans:**
  1) Eligible organization to provide self-certification to the issuer.
  2) Issuer to ensure that the contraceptive coverage described in the self-certification are not in the policy or group's premium.
  3) The issuer would provide the contraceptive coverage via an individual health insurance policy. (Proposed to be new category of excepted benefits).
  4) Beneficiaries would then be enrolled in separate individual health insurance policies. The regulations suggest that the coverage is "cost neutral" because issuer would experience less cost from improvements in women's health and fewer childbirths.

Self-insured Plans: (17)

- **Process for Self-insured Groups**

  1) Eligible organization would provide self-certification to the TPA (if there is one).

  2) TPA arranges separate individual health insurance policies for contraceptive coverage from an issuer providing such policies.

  3)The issuer providing the coverage would receive an adjustment in the user fees otherwise charged by a federally-facilitated exchange.

  4) The issuer would share part of the adjustment with the TPA as a "reasonable charge" for arranging for the policies.

Notes on Proposed Rule: (18)

- The Depts. have alternative plans for comment on how self-insured plans would handle the coverage.
- Notice Requirements with model language.
- Issuers providing separate individual health insurance policies for contraceptive coverage at no additional cost would be required to provide notice with model language directly to plan beneficiaries with enrollment and re-enrollment.

Wellness Overview…. (19)

1) 2006 HIPAA regulations put wellness programs into two groups. The first are programs that are available to all similarly situated individuals and do not require the individual to meet any standard related to health status to receive a reward.

2) The second category requires an individual to meet a health standard to obtain a reward. These programs must meet five HIPPA conditions.

3) "The ACA expands employers' ability to reward employees who meet health status goals or require employees who don't meet these goals to pay more for their employer-sponsored health coverage.

4) Health Affairs "Some consumer advocates argue that this ability to differentiate in health coverage costs among employees is unfair and will amount to employers' policing workers' health."

Wellness Overview cont.: (20)

- November 26, 2012 proposed regulation will significantly increase the rewards (and penalties) with wellness.
- Current law allows 20% of the total cost (including both employer and employee contributions) of coverage.
- Proposed reg. suggests maximum rewards (or penalties) may reach up to 30% of the total cost (including both employer and employee contributions) of coverage authorized for plan years beginning on or after January 1, 2014.
- May reach up to 50% for wellness programs designed to prevent or reduce tobacco use in 2014.
- Rule will apply to both grandfathered plans and non-grandfathered plans, fully-insured and self-insured, private-sector employers and governmental employer plans, plans offered by for-profit and nonprofit employers and church plans.

Wellness Timing: (21)

- The proposed increased wellness rewards (and penalties) are authorized for plan years beginning on or after January 1, 2014.
- Current rules limit wellness rewards (and penalties) to 20% of total plan costs for employee-only coverage (or employee-plus-dependent coverage) did apply to the 2012 and will apply all through 2013 plan years.
- The Department of Labor had previously indicated its intent to adopt and implement the PPACA's increased wellness reward limit prior to 2014, but has decided not to do so in the new proposed rule.

Wellness Key Implications: (22)

- Proposed rule implements provisions of the ACA that will significantly expand employers/ insurers' ability to incent employees and dependents to maintain or to pursue changes in their health status and behaviors.
- Proposed rule “adjusts” other requirements for maintaining a legally compliant wellness program (e.g., the "reasonable alternative standard" that must be offered in certain cases).
- Provides sample language to satisfy the requirement for alternative means to qualify for the incentive reward (must be in all plan materials describing the wellness program).

Additional Wellness Notes: (23)

- For plan years on or after January 1, 2014, employers will be able to offer rewards/penalties for participation in wellness programs in a group health plan with a value up to 30%...50% for programs to prevent/reduce tobacco use (gross coverage cost).
- Proposed regulation revises and restates the 5 categories of requirements in the current HIPAA health nondiscrimination rules that must be satisfied to offer the enhanced rewards.
- Consistent with current rules, the proposed regulation divides wellness programs into two categories:
  - Participatory wellness programs
  - Health-contingent wellness programs

Participatory Programs Examples: (24)

- Program that reimburses all/part of the cost of membership in a fitness center.
- Diagnostic testing program that has reward for participation not reward based on outcomes.
- Program that encourages preventive care through the waiver of the copayment or deductible requirement : example… well-baby visits.
- Program that reimburses/rewards employees for participating in smoking-cessation program, whether or not they quit smoking.
- Program that provides a reward for attending a monthly no-cost health education seminar.
- Program that provides a reward to employees who complete a health risk assessment without any further action required.

Health-contingent Wellness: (25)

- Imposes a premium surcharge based on tobacco use.
- Uses a biometric screening or a health risk assessment to identify employees with specified medical conditions or risk factors and provides a reward to employees identified as within a normal or healthy range.
- Requiring employees who are identified as outside the normal or healthy range to take additional steps (health coach, taking a health or fitness course, health improvement …) to obtain the same reward.
- Health-contingent programs permitted only if the "Five Special Conditions for Health-Contingent Wellness Programs" are met :

  1) First, the plan must be designed to be available to all similarly situated individuals, who must be given a chance at least once a year to qualify.

Health-contingent Rules Cont.: (26)

2) Second, the size of the reward cannot exceed 30 percent of the total cost of coverage, including both the employer and employee's contribution. If dependents may participate in the wellness program, the reward cannot exceed 30 percent of the cost of family coverage.

3) Third, wellness programs must provide a "reasonable alternative standard" or waiver of the health-contingent standard for individuals who find it unreasonably difficult to meet the applicable standard because of their medical condition, or for whom it is medically inadvisable to attempt to satisfy the standard.

“Reasonable Alternative Standard” (27)

(The below new requirements are not reflected in the current HIPAA-related wellness program rules.)

- Completion of an educational program: plan/issuer must make the program available instead of onus on the individual to find.
- Diet program: the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.
- The plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's physician with regard to medical appropriateness.
- May impose standard cost sharing under the plan or coverage for medical items and services furnished in accordance with the physician's recommendations.

Reasonable Alternative Standard: (28)

- Plan or an issuer may require verification (statement from personal physician) that the health factor is too difficult or medically inadvisable for the individual to meet.

  4) Fourth, health-contingent wellness programs must be reasonably designed to promote health or prevent disease, not be overly burdensome, not a form of health status discrimination. A program would have to offer a different, reasonable means of qualifying for the reward to any individual who does not meet the set standard.

  5) Fifth, the program must notify employees of the ability to seek other qualification standards for reward or the possibility of waiver of a standard.

  *****This notice is not required if plan materials mention the availability of a wellness program without describing it. (New, simplified language for employee notices is provided in the proposed regulations.)*

Wellness Notes: (29)

- With family coverage, any premium variation for tobacco use must be applied to the portion of premium attributable to each family member.
- Innovation encouraged…comments requested if "reasonable design" should be evidence-based.

Essential Health Benefits: (30)

- EHB package means benchmark benefits and all cost sharing.
- November 26, 2012 HHS published a proposed reg. that clarifies:

  A) how each state will identify its own essential health benefits (EHBs), which must be covered by policies sold in the individual market and the fully-insured small group market (up to 50 or up to 100 employees) in the respective states for plan years on or after 1/1/2014…inside and outside the Exchange).

  B) EHBs help with the actuarial value (AV) of policies that will be determined in connection with the four metal levels (bronze, silver, gold and platinum) set forth in the ACA.

  C) Plans must include all ACA preventive coverage without cost sharing.

  D) Must offer the same EHB package in policies offered on the individual or small group market inside and outside the Exchange.

EHB Background: (31)

* 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 …(to age 19)

State's Base Benchmark Plan: (32)

Identifying which services must be covered within these 10 EHB categories falls to the states…which have four options for the "base benchmark plan":

A) the plan with the largest enrollment for any of the three-largest small group insurance products in the state's small group market.

B) One of the state's three-largest state employee plan.

C) One of the three-largest FEHBP options.

D) The state's largest non-Medicaid HMO.

****A state's base benchmark plan must be supplemented if it lacks services in any of the 10 EHB categories that are not otherwise covered by the plan.*

Habilitative Services: (33)

- Habilitative services has been identified as one of the EHB mandated coverage areas that may be problematic or lacking definition from the reference plans.
- Habilitative services, like rehabilitative services, generally include occupational and physical therapy, as well as speech-language services.
- However, unlike rehabilitative services, which aim to recover capacities lost, habilitative services help people acquire, maintain, or improve skills for functioning in normal daily living.
- Despite legislation with broad support in both the Ohio House and Senate, Gov. Kasich released a letter on Dec. 21, 2012 calling for Autism coverage.
- The letter states “Habilitative services benefits shall be determined by the individual plans and must include, but shall not be limited to, Habilitative Services to children (age: birth to 21) with a medical diagnosis of Autism Spectrum disorder which at a minimum shall include:

States Habilitative Services: (34)

1) Out-Patient Physical Rehabilitation
   a) Clinical Therapeutic Intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis.
2) Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation.
3) Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and treatment plans, 30 visits per year total.

*(*Ohio has looked at Autism as a necessary part of the Habilitative Services. Ohio Chamber of commerce has not!)*

Impacted Plans and Timing: (35)

- HHS' proposed regulation will directly affect health insurers in the design of the policies they will offer in the individual market and the small group market beginning in 2014.
- However, HHS' new proposed regulation has significant indirect implications for employer group health plans in the large group market (generally over 100 employees), whether insured or self-insured.
- The proposed regulation applies to plan years (in the small group market) beginning on or after January 1, 2014, and to policy years (in the individual market) beginning on or after January 1, 2014.

Key Implications for Large Group: (36)

- Insured and self-insured group health plans in the large group market will be indirectly affected by the proposed regulations:
  - no annual or lifetime dollar limits will be permitted on EHBs that happen to be included in a large employer group health plan.
  - coverage offered by an employer must meet a minimum 60% AV standard to avoid penalties under the employer play-or-pay mandate.
  - federal regulators have clarified that the $2,000/$4,000 maximum deductible requirement will *not* apply to self-insured or insured plans in the large group market. *(*There has been disagreement about this interpretation.)*

Large Group Implications Cont.: (37)

- Large group and self-insured plans include many categories of EHB in their coverage and no lifetime or annual dollar limits will be permitted on EHBs for plan years beginning on or after January 1, 2014.
- No requirement that self-insured and insured large group health plans offer all categories of EHB or conform to any of the EHB benchmark plans.
- Large group plans can consider all benefits included in EHB benchmark plans when calculating MV (even can include non-essential benefits).

EHB Notes: (38)

- In the individual and small group market insurers can substitute actuarially equivalent benefits for benefits that are included in a state's EHB benchmark, with the exception of Rx drug benefits.
- Plans must cover at least the same number of drugs in each category and class as the EHB-benchmark plan.
- Half the states have identified base benchmark plans. The default benchmark plan is the largest plan by enrollment in the state's small group market.
- The rule provides that state benefits mandates enacted as of December 31, 2011 will be considered part of the EHB package for plans … at least during a transition period from 2014 through 2015. This would relieve states from having to pay additional subsidies for their mandated benefits.
- Permitting states to determine EHBs and preserving additional pre-2012 state benefit mandates causes variability state by state in covered benefits.

EHB Notes cont.: (39)

- EHB does not have to include adult routine dental and eye exam or custodial care, even if the benchmark plan does cover these services.
- Insurers offering any metal plan under the ACA, now must also offer child-only coverage at the same level. (This is because many insurers dropped child-only coverage in 2011 as the ban on preexisting conditions for children was implemented.)
- ER services paid the same in network and out of network.
- Pediatric dental can be offered as a stand-alone dental plan on the Exchange. If so, then can be excluded from EHB.

Cost Sharing Limits: (40)

- Cost-sharing is any expense by or on behalf of an enrollee for EHBs. ***Includes: deductibles, coinsurance, copayments, or similar charges, ***Excludes: Premiums, balance billing amounts. cost-sharing for out-of-network providers and spending for non-covered services.
- Maximum Out of Pocket (MOOP) cannot exceed $6,450/$12,900 in 2014.
- Deductible cannot exceed $2,000/$4,000 in 2014 for small group market.
- But insurers can exceed annual deductible limits that the ACA puts in place for the small group market if plans "cannot reasonably reach" the actuarial value the law sets for a given level of coverage without doing so.
- HHS says in a recently proposed rule that responds to industry concerns that the limits could make it very difficult to offer "bronze" plans starting in 2014.
- Limits are increased each year after 2014 via premium adjustment percentage published by HHS.

More Cost Sharing: (41)

- ACA's caps on deductibles for small group market plans inside and outside of the exchange -- $2,000 for individual coverage and $4,000 for family coverage ….combined with essential health benefit requirements expanded even more by absorbing state mandates meant insurers might not be able to offer plans within the Bronze tier.
- HHS proposes to use a “reasonableness” standard and seeks comments on the evidence or factors that should be required from insurers and considered in determining whether the standard is met with respect to insurance coverage subject to the health law’s reforms.
- HHS adds that an alternative would be to use the actuarial value calculator to determine a reasonable increase to the amounts that can be used by all plans in the small group market.

Actuarial Value: (42)

- Each health plan issued in the individual and small group market must have an actuarial value that fits into one of the four metal tiers: bronze, 60 percent; silver 70 percent; gold, 80 percent; or platinum, 90 percent. A de minimis variation of plus or minus 2 percent is permitted from these levels.
- Actuarial value is defined as "the percentage paid by a health plan of the total allowed costs of benefits" for a standardized population and is a measure both of the value of services covered by the plan and of the cost-sharing that a plan member must cover.
- To avoid pay or play penalties all plans need to have at least 60% actuarial value.

Actuarial Value cont.: (43)

- HHS also published on November 20, 2012 its AV calculator along with an explanation of the methodology.
- The AV calculator only considers in-network utilization, based on a judgment that out-of-network care is only a small part of total utilization.
- Employer contributions to HSA and HRA arrangements can be counted toward medical spending to the extent they are expected to be spent in a benefit year.
- The proposed rule reflects the earlier HHS guidance and does not provide full value for employer contributions to HSAs and HRAs. HHS' position is that since the full amount of the employer HSA or HRA contribution won't be used by all employees in the year the employer contribution is provided, credit is only being given in the AV calculation for the amount expected to be used, on average, in the year of the contribution.
- No credit is being provided in the AV for the amounts of the employer account contribution carried forward and used in future years.

Minimum-Value Requirements: (44)

- Large employer and self-insured plans are not required to provide the EHBs.
- Still if they fail to provide minimum actuarial value (60%) employees can go to the exchange and receive premium tax credits, and large employers will have to pay a penalty if this occurs.
- HHS and the IRS provided a minimum value calculator based on a standard self-insured employer plan population.
- Employers will also be able to use an array of design-based "safe harbors" that will be published by HHS and the IRS as a checklist.
- Employer can provide the certification of an actuary that their plan meets the minimum value standards.

Market Rules and Rate Review: (45)

- November 26, 2012…"Patient Protection and Affordable Care Act: Health Insurance Market Rules; Rate Review"
- Adjusted/ modified community rating on or after Jan. 1, 2014

A) Age

1) Rate variation limit of 3:1

2) National uniform age curve

3) States may elect to implement a state uniform age curve instead of the national uniform age curve

4) Issuers must set actuarially justifiable child rates using a standard population, to prevent unjustified premiums that would potentially prevent individuals under age 21 from access to their guaranteed availability rights

5) "Enrollee's age bands should be determined based on an enrollee's age at policy issuance and renewal, so that age rating factors are applied on a consistent basis by all issuers…"

6) "Children: A single age band covering children 0 to 20 years of age, where all premium rates are the same";

Community Rating Cont.: (46)

b) "Adults: One year age band starting at age 21 and ending at age 63."

c) "Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same."

- Tobacco use:
  1) Rate variation limit of 1.5:1.
  2) States may elect to implement more stringent tobacco use variation limits.
  3) Allowed to vary by age band.
  4) Wellness programs not required in individual market to use tobacco rating….but must be offered in small group.

Community Rating rules: (47)

- Geography: limited to no more than seven rating areas
- States may elect one of the following:
  1) One rating area for the entire state.
  2) Rating areas based on counties or three-digit zip codes.
  3) Rating based on metropolitan statistical areas (MSAs) and non-MSAs.
  4) Other rating areas (must be submitted to CMS by the state).
  5) All the sections of a rating area are NOT required to be geographically adjacent.
- "Must transition all non-grandfathered small group and individual market coverage issued prior to January 1, 2014, to these adjusted community rating rules in the first plan year (small group market) or the first policy year (individual market) beginning on or after January 1, 2014."
- Premium-per-member rating only (no composite rating) – "any premium variation for age and tobacco use must be applied to the portion of premium attributable to each family member."

More Community Rating: (48)

- Non-grandfathered, fully-insured health insurance coverage offered through associations and MEWAs is subject to the community rating rules based on applicable market size.
- Cannot charge different rates for family members based on their status as the policyholder, spouse, or dependent.
- Currently issuers may determine a family premium rate based upon the policyholder or oldest adult's age…now.
- Insurers will need to price each adult family member individually and up to the three oldest children under age 21 to create a family rate.

Rate Review/ Guaranteed Issue: (49)

- Change in rate review procedures is not applicable to grandfathered or self-funded business.
- Standardizes data requirements in the rate reviews.
- Must file ALL rate increase >0% rate increases are only reviewed when increases >=10%.
- Guaranteed Issue applies to individual, small group and large group market (not GF individual plans).
- In group market, an issuer may decline to offer coverage to a plan sponsor that is unable to comply with employer contribution or group participation rule.
- Catastrophic Plans: under 30 or can't afford other coverage.
  - A) for family coverage each individual must qualify
  - B) Provides EHB once the annual limitation on cost sharing is reached
  - C) Coverage for at least three primary care visits per year before high deductible

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Family of Companies Websites: (51)

Medical Mutual

- MedMutual.com

Consumers Life

- ConsumersLife.com (Health Products)
- ConsumersLifeInsurance.com (Life and Disability Products)

Carolina Care Plan

- CarolinaCarePlan.com

Questions (52)

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