



Consumer Affairs | Medicare Services | Agent/Agency Services | ODI Services | Newsroom | Policy &amp; Legislation

## Plan Management Toolkit

Please note that this page will be updated regularly. If you would like to receive email notifications when an update is released, please add your email address in the registration box below. To easily identify the new information, the date the question/answer was added or edited is noted after the end of each response. The email notifications will also include which questions are new.

The Department is also welcoming plan management questions. We will not be responding to submitted questions, one by one, but rather placing the question and answer on this page so all stakeholders will be able to see the information. Please send appropriate questions to [planmanagementquestions@insurance.ohio.gov](mailto:planmanagementquestions@insurance.ohio.gov).

Register for our mailing list.

Email

\*Please note, the information on this page was for the 2013 filing year and is not applicable for 2014. Please visit <http://insurance.ohio.gov/Company/Pages/planmanagementtoolkit.aspx> for 2014's filing guidance and deadlines.

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## ***Rating Questions***

1. When will ODI release the definition of rating areas?

- ODI submitted to HHS, 17 rating areas for the individual and small group markets as permitted under the Final Market Rule. Using data from carrier rating factors, ODI defined these areas to minimize disruption both across the entire state's market and within the carriers. Based upon this work these areas represent ODI's submission. Click [here](#) for the final approved rating area map. *updated 4/8/13*

2. When will ODI release its plans regarding any more narrow ratios for tobacco use?

- As permitted in the Health Insurance Market and Rate Review Rule, Ohio does not plan to adopt more narrow ratios for tobacco use at this time. The final regulation can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf>. *updated 3/22/13*

3. Will ODI decide to collect transitional reinsurance fee for fully insured groups in Ohio?

- No, the Benefits and Payment Parameters Proposed Regulation states that HHS will collect reinsurance funds under the national contribution rate from health insurance issuers and self-insured group health plans in all States, including States that elect to operate their own reinsurance programs. The final regulation can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf>. *updated 3/22/13*

4. Does Ohio plan to advocate for the phasing in of the 3:1 rating rules?

- Yes. ODI has been advocating both the phasing in of rules and overall state flexibility in the rules to limit market disruption through our participation in the National Association of Insurance Commissioners comment process. However, the rule has been finalized without a phased in approach. *updated 2/1/13*

5. Which rating factors will apply to: a) employers with employees residing across the state or out-of-state; and b) students that are out of state and covered under their parents' plan?

- In determining which rating factors an issuer must apply to employers with employees residing across the state or out-of-state and employee dependents living out-of-state, the issuer must apply the rating factors applicable to the employers' principal place of business. *updated 4/26/13*

6. What are the applicable timelines for rate filings?

- ODI will not accept rate filings for QHP/exchange products after May 31, 2013. *updated 5/13/13*

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### ***Filing Process Questions***

7. What are the applicable timelines for form filings?

- ODI will not accept form filings for QHP/exchange products after May 31, 2013. *updated 5/13/13*

8. For a non-grandfathered small group filing with an entity solely operating off the exchange, can filings be done after 5/31/2013?

- Yes, non-grandfathered small group forms and rate filings can be done after 5/31/13. However, issuers should follow federal guidance on the open enrollment period for small group which starts 11/15/13. *updated 5/13/13*

9. Can forms be approved and used prior to rate submission approvals?

- Forms will be reviewed and contingently approved prior to rate submission approvals so long as the issuer indicates an expected submission date for the rate submission. However, forms may not be used until the rates have also been approved. *updated 5/30/13*
10. Are there any differences for the coordination of form and rate review for HICs?
- The coordination of review will be the same for HICs and PPO/Indemnity Issuers. *updated 5/30/13*
11. Where are issuers required to file form and rate submissions for ODI review?
- All forms and rates will continue to be filed through SERFF. *updated 4/05/13*
12. Will ODI continue to allow matrix filings?
- No, ODI does not intend to permit matrix filings for the individual or small group market. Due to the level of validation that is required to review forms under the new market rules, matrix filings are no longer a feasible option. *updated 2/12/13*
13. Will issuers be permitted to bracket language within our contract documents?
- Yes, within parameters that were released with the filing guidance and provided the reviewer can ensure compliance with applicable laws. *updated 3/22/13*
14. What process do you envision for receiving and reviewing product and rate filings beginning in 2014?
- ODI will be using SERFF for receiving and reviewing all product and rate filings. *updated 1/25/13*
15. Does the Department plan to use any type of standardized compliance forms for contract filings similar to what was used for ACA filings in 2010?
- No, due to the extensive and substantive nature of the regulatory changes, standardized compliance forms are not feasible. *updated 1/25/13*
16. Is there a plan to increase ODI staffing resources to accommodate increased filings?

- ODI has allocated resources in order to mitigate the impact of the increase in volume of filings. However, we expect to see up to 90% of the existing product re-filed in addition to new filings. Since ODI typically sees 5-10% of the product re-filed annually, it will simply not be possible to mitigate the entire impact of the increase in volume. *updated 2/1/13*

17. What other steps is ODI taking to mitigate the impact of the increase in volume of filings?

- ODI has released checklists and filing guidelines for use by companies to ensure filings are complete and correct at submission. These efforts are meant to preserve the robust market during the shortened filing and review periods of 2013. *updated 5/13/13*

18. Are there steps companies can take to shorten the review timeframe?

- Yes. It is important to ensure that filings are complete and correct at the time of submission. ODI released checklists and filing guidelines for use by companies to assist you with these efforts. These documents can be found in the Resources section on this page. Additionally, you can shorten review times by promptly responding to requests or concerns raised by ODI. *updated 3/22/13*

19. How do you expect the filing timeline to be impacted by the volume of filings?

- By the end of 2012 the average review time by ODI of a Life and Health filing was 35 days. We expect this average time to increase to 60-90 days over the next few months. We will regularly update you via this webpage as to the current filing review time and any efforts that you can make to shorten your timeframe. In order to reduce your review time, it is important to ensure that filings are complete and correct at the time of submission. Additionally, you can shorten review times by promptly responding to requests or concerns raised by ODI. *updated 2/1/13*

20. Have you considered separating rate review and product review in lieu of reviewing these items together?

- Yes, ODI is considering eliminating the rate and form filing type ONLY for major medical filings that must be ACA compliant. Issuers are strongly encouraged to submit form filings separate from and before the corresponding rate filings. Separating the filings in this way will help make the process more efficient and facilitate timely responses for submitted filings. However, we are taking comments on this approach, please send comments to [planmanagementquestions@insurance.ohio.gov](mailto:planmanagementquestions@insurance.ohio.gov).  
*updated 2/1/13*

21. Where possible we are striving for consistent text and consistent formats/templates for our contracts. Would you be willing to review our revised contract templates before we actually file our products so that issues with the templates can be addressed even before benefits are finalized?

- o No, ODI cannot provide a cursory review of previously filed language or revised contract templates, prior to actual filing submissions. However, as usual, ODI staff is available to answer questions or discuss general concepts. *updated 1/25/13*

22. Will ODI continue to allow the use of the "Hospital/Surgical/Medical Expense" Type of Insurance (TOI) codes in SERFF for indemnity major medical filings?

- o To ensure that insurers receive the appropriate filing guidance and checklists in SERFF, indemnity major medical filings that are required to be ACA compliant must use the "Major Medical" Type of Insurance (TOI) codes and will not be permitted to use other TOIs. Health Insuring Corporations (HICs), also known as Health Maintenance Organizations (HMOs), should continue to use appropriate "HOrg02" TOIs. *updated 4/05/13*

23. How will ODI handle filing requirements for EHB compliant plans where there is another carrier involved with the pediatric dental component?

- o Generally speaking, ODI requires filings from which ever carrier is taking the insurance risk for the product.

As ODI understands this issue currently, there are multiple ways that carriers can choose to handle the pediatric dental component:

- A stand-alone plan where the dental plan is sold on its own in the market
  - An embedded plan where the major medical carrier underwrites the entire product, including the dental (though they may contract with a dental carrier via an ASO type arrangement to administer the dental component)
  - A bundled plan where the products are separate but sold together as one
- o For a stand-alone plan, the underwriting carrier would submit the form and rate filing. For an embedded plan, the major medical carrier would submit the rate and form filing. For the bundled plan, both carriers should submit their portions of the plan, and the major medical carrier would reference the other filing so ODI can determine that the filings taken together will be a complete EHB product. *updated 3/27/13*

24. For grandfathered plans, will ODI allow matrix filings?

- o Yes, for grandfathered small group and individual plans ODI will continue to accept matrix filings for the time being. *updated 3/27/13*

25. Are On Exchange and Off Exchange products required to be filed at the same time?

- o It is ODI's understanding that companies with the same plan being sold on and off the exchange or companies with plans that are being sold exclusively on the exchange must have plans filed and approved by July 31, 2013 in Ohio. Plans that are exclusively sold off the exchange can file at a later time, provided the rates are calculated based on the index rate that has already been filed and approved. The chart below demonstrates our understanding at this time:

Please note: This chart is just a general representation. See questions 6, 7, 8, 44, & 45 for ODI specific deadlines.

| <b>2013 Filing Deadlines</b>   |                      |                                 |                        |  |
|--|----------------------|---------------------------------|------------------------|--|
| <b>Fully Insured Health Coverage</b>   |                      |                                 |                        |  |
| <b><u>Grandfathered Status</u></b>   | <b><u>Market</u></b> | <b><u>Entity</u></b>            | <b><u>Deadline</u></b> | <b><u>Off HIX New Plan Extension</u></b> |
| <b>NonGF</b>   | Individual           | Solely On & Both On and Off HIX | 7/31/2013**            | Yes*                                     |
| <b>NonGF</b>   | Individual           | Solely Off HIX                  | None                   | Yes*                                     |
| <b>NonGF</b>   | Small Group          | Solely On & Both On and Off HIX | 7/31/2013**            | Yes*                                     |
| <b>NonGF</b>   | Small Group          | Solely Off HIX                  | None                   | Yes*                                     |
| <b>GF</b>  | Individual           | All Entities                    | None                   | N/A                                      |
| <b>GF</b>  | Small Group          | All Entities                    | None                   | N/A                                      |
| <b>*New plan offered off HIX must comply with Index Rate and Single Risk Pool Requirement. Plan can be filed without any deadline.</b> |                      |                                 |                        |  |
| <b>** 7/31/2013 is when all data must be sent to HIX. Filing deadline is up to individual states.</b>                                  |                      |                                 |                        |  |

updated 3/27/13

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## **Dental Questions**

26. Where are dental issuers required to file forms and rates for ODI review?
- All dental forms and rates must be filed through the System for Electronic Rate and Form Filing (SERFF) system for ODI review. *updated 5/30/13*
27. When is the deadline for submitting forms and rates for Stand-Alone Dental Plans (SADPs) and off-Exchange certified dental plans?
- Forms and rates for SADPs must be filed with the Department no later than May 31, 2013. *updated 5/30/13*
28. Where are dental issuers required to file their Exchange certification applications?
- Dental plans that are seeking Exchange certification must be submitted through SERFF for ODI review. *updated 5/30/13*
29. When is the deadline for submitting QHP Binders for SADPs and off-Exchange certified dental plans?
- QHP Binders that include a SADP must be submitted with the Department no later than June 21, 2013. Please note that this includes SADP that seek Exchange certification, but will be sold solely outside of the Exchange. *updated 5/30/13*
30. Can an Issuer be certified to offer SADPs solely off-Exchange?
- Yes. If an issuer would like to offer a Stand-Alone Dental Plan solely off-Exchange but still receive Exchange certification so that it meets the EHB Pediatric Dental standard, then the issuer must select the “off-Exchange” option in the dental-specific plan and benefits template. This process would provide a Stand-Alone Dental Plan with the “Exchange-certified” status outlined in the final EHB regulation where a health insurance issuer could offer a health plan without the pediatric dental EHB to an individual if the issuer is reasonably assured that the individual has obtained pediatric dental EHB coverage through an Exchange-certified Stand-Alone Dental Plan. *updated 5/30/13*
31. In terms of filing requirements, are there any substantial differences between SADPs that will be sold on the Exchange and Exchange-certified pediatric dental plans that will be sold solely off-Exchange?
- The only difference between the two is where the plan will be marketed. All filing requirements, including deadlines, are applicable in the same manner to both SADPs and Exchange-certified pediatric dental plans. *updated 5/30/13*

32. Do any SADP issuers intend to participate in the Ohio-based FFE?
- o Yes, a total of six SADP issuers have submitted intent to participate in the FFE to CCIIO. For more information, please see <http://www.cms.gov/CCIIO/Resources/Files/Downloads/voluntary-dental-reporting-list-1-28-13.pdf>. *updated 5/30/13*

33. What parts of the Exchange certification application do SADP issuers complete?
- o SADP issuers must complete all sections of the QHP application except for the pharmacy template, the accreditation template, and the unified rate review template. All of the templates for the certification application are the same for SADPs as for QHPs, except for the modified dental plan and benefits template. Issuers should use the dental plan and benefits template 1.32 or later in order to activate the modifications that are specific to SADPs.

In addition, SADP issuers are required to complete the “SADP – Description of EHB Allocation” and the SADP – Actuarial Value Supporting Documentation and Justifications” forms. Finally, SADPs are also required to complete the program attestation section that relates to pediatric dental.

For technical information, issuers should refer to the Instructions for Stand-Alone Dental Plan Applications. Those instructions can be found at [http://www.serff.com/documents/plan\\_management\\_dental\\_submissions\\_ch\\_15.pdf](http://www.serff.com/documents/plan_management_dental_submissions_ch_15.pdf). *updated 5/30/13*

34. Do Market Reforms apply to SADPs?
- o No. SADPs are considered excepted benefits under HIPAA. With the exception of the applicability of annual and lifetime dollar limits to pediatric dental benefits, ACA market reforms do not apply to excepted benefits. However, if an issuer chooses to embed pediatric dental benefits within its major medical plan, then market reforms would apply to those pediatric dental benefits. *updated 5/30/13*

35. How do rating tables and business rules apply to SADPs?
- o In order to be Exchange certified, SADPs are required to complete the rates table and associated business rules table. However, as excepted benefits, SADPs are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP rating tables and business rules template. SADPs may adjust premiums based on other rating factors.

The modified dental plan and benefits template will have a data field where SADP issuers may indicate whether they are committing to the rates reported in the rating template or if they are reserving the option to charge additional premium amounts. *updated 5/30/13*

36. Outside of the Exchange, does the medical plan need to provide dental benefits if an individual provides reasonable assurance to an issuer that he/she has already purchased an Exchange-certified Stand-Alone

Dental Plan that covers the pediatric EHB?

- No, in that situation, an issuer would not be required to include the pediatric dental portion of the EHB within their medical plan. *updated 5/30/13*

37. How does a medical issuer attain reasonable assurance?

- Reasonable assurance could be obtained by requiring proof of coverage from the individual or establishing a method of confirming coverage directly with a dental issuer that is offering a Exchange-certified Stand-Alone Dental Plan. The issuer is responsible for the method of obtaining assurance and demonstrating compliance. *updated 5/30/13*

38. For off-Exchange business, if an individual does not purchase an Exchange-certified pediatric dental plan, does the issuer have to embed the pediatric dental benefit into the medical plan?

- Outside of the Exchange, an issuer should embed pediatric dental services if the issuer is not reasonably assured that the individual is enrolled in an Exchange-certified pediatric dental plan. *updated 5/30/13*

39. Will issuers be required to file a separate network name for products that have embedded dental?

- Issuers are not required to file a separate network for products that have embedded dental. The Network ID for a network with dental providers can be used for both QHPs with embedded dental and QHPs without embedded dental. However, if the issuer would like to offer a QHP with a network including dental providers, and a second QHP that excludes those providers, then the issuer will need to set up two different network IDs. *updated 5/30/13*

40. Are SADPs subject to the same minimum thresholds as medical plans in regards to Essential Community Providers?

- Yes, dental plan issuers are subject to the Essential Community Provider thresholds. For more information on the ECP thresholds, please see the Annual Letter to Issuers in Federally-facilitated and State Partnership Exchanges at: [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf).

For a list of Ohio ECP Dental Providers, please see:

[http://insurance.ohio.gov/Company/Documents/Ohio\\_Dental\\_ECP\\_List.pdf](http://insurance.ohio.gov/Company/Documents/Ohio_Dental_ECP_List.pdf) *updated 5/30/13*

41. Are SADPs subject to the same actuarial value requirements as medical plans, i.e. bronze, silver, gold, platinum?

- No, SADPs are not required to meet the same AV thresholds as medical plans. Instead, dental issuers are required to offer either a low-option SADP with an AV of 70% or a high-option SADP

with an AV of 85%. Both of these thresholds allow for a de minimis variation of +/- 2 percentage points. *updated 5/30/13*

42. Are SADPs subject to the same annual limitation on cost-sharing amounts as medical plans?
- No, SADPs are not subject to the same annual limitations on cost sharing as medical plans. Rather than meeting the specific dollar limits that apply to comprehensive medical plans, Exchange-certified SADPs are required to demonstrate that they have a reasonable annual limitation on cost-sharing in place. CMS has interpreted the word “reasonable” to mean any annual limit on cost-sharing that is at or below \$700 for a plan with one child or \$1,400 for a plan with two or more child enrollees. *updated 5/30/13*
43. What is the definition of medically-necessary orthodontia?
- Issuers are responsible for developing standards to define medically-necessary orthodontia. *updated 5/30/13*

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### **Qualified Health Plan Questions**

44. Understanding that the Ohio Department of Insurance must have all QHP's to CCIIO prior to July 31, 2013, is the Department going to impose a timeline on QHP filings?
- Yes, ODI will not accept QHP binder filings after June 21, 2013. *updated 5/13/13*
45. Can an issuer add plans to a QHP Binder after submission?
- No, additional plans cannot be added to a QHP Binder after it is submitted in SERFF. Additional plans would require withdrawal and a complete resubmission of the QHP Binder. Please take this into consideration when planning your QHP Application Binder submissions. *updated 5/13/13*
46. Where will issuers be required to file QHP submissions?

- o All QHPs are required to be filed with ODI through SERFF. However, before a QHP can be submitted to ODI through SERFF for review, issuers will be required to register on the Health Insurance Oversight System (HIOS) and generate a HIOS issuer ID (if the issuer does not already have one) and any applicable HIOS Plan and Product IDs for each proposed QHP the issuer intends to market. These IDs are required in the various federal templates that will be used for filings. ODI strongly encourages issuers to register on HIOS as soon as possible.

*updated 4/05/13*

47. How will ODI conduct network adequacy review of QHPs?

- o For purposes of satisfying the QHP network adequacy certification standard, QHPs must have a network in place that includes a sufficient number and types of providers to ensure that all services are available without unreasonable delay. In Ohio, all issuers will be required to submit applicable federal templates and attestations that confirm compliance with the network adequacy standard. HICs will not be required to submit any information in addition to the attestation regarding network adequacy as ODI currently reviews HIC networks. On the other hand, ODI intends on reviewing network adequacy for non-HIC issuers by accepting an issuer's NCQA or URAC accreditation. If an issuer is not accredited, ODI will require issuers to submit an access plan as part of their QHP application. The access plan must demonstrate that the issuer has standards and procedures in place to maintain an adequate network. Instructions for completing the required access plan information can be found at:

[http://www.serff.com/documents/plan\\_management\\_data\\_instructions\\_ch6.pdf](http://www.serff.com/documents/plan_management_data_instructions_ch6.pdf). *updated 4/05/13*

48. Contracts that will be filed for products seeking QHP certification will include new language that reflects ACA related regulatory changes (federal grace period requirements, terminations, etc.). Will ODI review only look at this new language, or will your review also look at language that has been previously approved and is currently in place?

- o No, the substantive nature of the regulatory changes will require ODI to review **all** language within a filing to ensure compliance with all applicable laws and regulation. *updated 1/25/13*

49. Does a QHP have to offer all "actuarial value" plans or can it just offer one?

- o As required under the Final Exchange Regulation, QHP issuers must offer at a minimum a silver level plan and a gold level plan, but may elect to offer additional levels as well. The final regulation can be found here <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf> *updated 3/1/13*

50. Pursuant to the requirements for issuers to be considered a Qualified Health Plan, the issuer must be accredited by NCQA or URAC. If the issuer currently is meeting the CMS requirements as a Medicare

Advantage (MA) Plan, will the contract between CMS and the MA Plan fulfill the accreditation requirement?

- If an issuer has an existing commercial or Medicaid plan that has been accredited by either NCQA or URAC and is comparable to the QHP the issuer intends on selling, the issuer will have complied with the QHP-Accreditation certification requirement until the end of calendar year 2015. Beginning in 2016, all QHPs sold on the Exchange will need to be accredited. ODI is not aware of written guidance specific to MA plans. *updated 3/27/13*

51. Is there a listing or directory that you can provide of Essential Community Providers (ECP) who offer dental and/or vision services?

- HHS is expected to release an updated non-exhaustive list of federally recognized Essential Community Providers. At this time, we do not have information regarding whether dental or vision providers will be included.

Generally, in order to satisfy the QHP-ECP requirement, issuers will need to either contract with HRSA 340B ECPs (HRSA 340B is a federal funding program that is used to recruit and retain providers in rural areas that otherwise would not be an ideal location to set-up shop) or comply with requirements related to the ECP write-in option. However, acceptance of ECP write-ins are not guaranteed. *updated 3/27/13*

52. For Essential Community Providers (ECP), will Ohio use the Safe Harbor and Simplified Requirements that CMS has developed? Will ODI accept facility names (and not require individuals)? Are there other sets of standards that issuers can use?

- Issuers are expected to ensure that QHP and Stand Alone Dental Plan networks include a sufficient number and types of ECPs. As part of this review, ODI will approve the ECP certification requirements so long as one of the following standards is satisfied: the safe-harbor standard; the minimum expectation standard; or the alternate standard for integrated issuers. Proposed ECPs will be cross-referenced with the ECP List published by CMS. The ECP List includes providers at the facility-name level – not the individual provider level. The ECP List can be found at the following: <https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Providers/ibqy-mswq>

If an ECP an issuer has contracted with is not on the list, issuers will have the opportunity to write-in additional ECPs. Those write-ins will then be reviewed and either accepted or denied. Please see the following HHS issued letter for more information: [http://cciio.cms.gov/resources/regulations/Files/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf). *updated 4/26/13*

53. For the service area portion of the QHP, will ODI consider service areas that include only partial counties? (For FFE, CMS will consider issuer's service areas including only partial counties but as a rule expect full county service areas.)

- As part of the service area review, ODI expects the service area of a QHP to be, at a minimum, an entire county or group of counties. ODI will be conducting an automated check to identify partial-county requests. If a partial county request is identified, ODI will then conduct a case-by-case manual review to determine whether the partial county service area is justified. *updated 4/26/13*

54. Should a QHP's on-line directory and paper directory automatically denote which providers are ECP and Tribal providers?

- No, written guidance has been released that would require an issuer to automatically denote whether a provider is an ECP or Tribal provider. *updated 3/27/13*

55. When reviewing a HIC's network for plan year 2014, will ODI rely on the HIC's current accreditations?

- Yes, we will accept evidence of network accreditation by URAC or NCQA. An Ohio licensed HIC's network, quality assurance and utilization review processes were reviewed/approved at the time the certificate of authority was issued or the last evaluation of a service area expansion or major modification adding a line of business. ODI will also collect and review applicable federal templates and attestations. *updated 5/30/13*

56. How will ODI review network adequacy for HIC applicants seeking licensure changes such as certificate of authorities, service area expansion, and major modifications?

- ODI will utilize normal review processes for licensure as outlined in Chapter 1751 of the Ohio Revised Code. ODI will also collect and review applicable federal templates and attestations. *updated 5/30/13*

57. How will ODI conduct network adequacy review of PPO/Indemnity QHPs?

- For PPO Indemnity QHPs, the Department will accept as evidence of network adequacy an existing NCQA or URAC accreditation of the issuers' commercial major medical or Medicaid plans. If the PPO/Indemnity Issuer is not accredited, ODI will require issuers to submit an access plan as part of the QHP application. The access plan must demonstrate that the issuer has standards and procedures in place to maintain an adequate network. Instructions for completing the required access plan information can be found at: [http://www.serff.com/documents/plan\\_management\\_data\\_instructions\\_ch6.pdf](http://www.serff.com/documents/plan_management_data_instructions_ch6.pdf) updated 4/05/13. Finally, ODI will review QHP application issuer attestations that relate to network adequacy and collect the Network ID template and review for compliance with federal law. *updated 5/30/13*

58. Will Letters of Intent with Facilities and Providers at the time of the QHP filing be sufficient?

- A QHP will not be rejected/denied/disapproved solely on the basis that an issuer has submitted letters of intent as a means of complying with the network adequacy and ECP QHP certification requirements. However, QHPs that are submitted with letters of intent will be disapproved if an issuer/provider contract is not in effect by July 31, 2013. *updated 5/30/13*

59. Should a QHP issuer's provider directory denote which providers are ECPs?

- QHP issuers are required to make its provider directory for a QHP available for publication online and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are accepting new patients. Aside from those requirements, QHP issuers are free to provide additional information, including whether the provider is recognized as an ECP.

*updated 5/30/13*

60. In Ohio, are QHPs required to contract with Indian Health Care providers and offer limited cost sharing products for Native Americans?

- No. The federal database does not include Ohio as having any federally recognized tribes nor does the HHS "List of Indian Providers" include any Ohio-based providers. Accordingly, QHPs will not be required to contract with Indian Health Care providers or file the Model QHP Addendum for Indian Health Care Providers with QHP binder submissions. *updated 5/30/13*

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## ***Essential Health Benefits***

61. Are all products required to comply with mental health parity? Which mental health parity law? Federal or state? On exchange? Off exchange? QHP and non-QHP?

- As required in the Essential Health Benefits Regulation, it is our understanding that all products required to include EHB will also be required to meet federal mental health parity law. The final rule can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf>. *updated 3/22/13*

62. When will ODI release the definition of essential health benefits for Ohio?

- EHB information can be found below. *updated 1/25/13*

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| <b>Essential Health Benefits Documents</b> |
|  |

**[Ohio Essential Health Benefits Benchmark Plan Template](#)**

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63. Will ODI follow the process outlined in the proposed EHB regulation that allows actuarial equivalent substitutions within a benefit category?
- o Yes; however, complex filings and/or filings that include actuarial substitutions may take longer to review and insurers should plan accordingly. *updated 1/25/13*
64. What habilitative services must be offered within Ohio's Essential Health Benefits package?
- o At a minimum, issuers must include the benefits as outlined in the governor's letter dated December 26, 2012 which can be found at <http://insurance.ohio.gov/Company/Documents/Habilitative%20Services%20Letter.pdf>. In addition, issuers must ensure that products are otherwise compliant with all other EHB requirements, as required in the Essential Health Benefits Regulation; the regulation can be found at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf>. *updated 3/22/13*
65. Is non-emergency care when traveling outside of the U.S. a required Essential Health Benefit under the Ohio Benchmark Plan?
- o No. Non-emergency care when traveling outside of the U.S. is not a required benefit under the Ohio Benchmark Plan. Issuers have the ability to cover non-emergency care when traveling outside of the U.S. by including those types of providers in their network. *updated 5/30/13*

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***Certificate of Authority Questions***

66. Do HICs need to wait on the Department's review pursuant to 1751.03 and 1751.13 (Major Modification) prior to negotiating new contractual amendments with participating providers? The stated concern is that 3963.04 requires insurers to provide material amendments to participating providers 90 days prior to the effective date of the amendments effective date.

- The Department is not aware of any insurance law requirement prohibiting the negotiation of amendments prior to the Department's review as long as all parties are aware that the proposed amendment may need to change based upon the Department's review. *updated 3/27/13*

67. If a plan is not currently in the individual market – except for purposes of open enrollment or conversion, is ODI going to require a Major Modification filing?

- This is unique to each company. Without any additional information, it would appear from the facts provided in the question that a plan that is only being sold in the individual market for open enrollment/conversion that will now be available to all in the individual market would require a Major Modification.

To be specific, Major Modification filings are governed by 1751.03(B), and are required if a HIC has any Major Modification to its operations which affects: the solvency of the HIC, the continued provision of services that it has contracted with its providers, or the manner in which the HIC conducts its business. As a result, carriers should discuss with legal counsel and other advisors regarding whether new plans represent a major change to their operations that would necessitate a Major Modification filing. *updated 3/27/13*

68. Is there any consideration being given to relaxing the required review timeframes (i.e. for Major Modification filing – 60 day review period; service extension – 75 day review period)?

- While the Department strives to process complete filings as quickly as possible, these timeframes are statutory requirements. However, the actual timeframe for ODI staff to review and approve a particular filing varies and is heavily dependent on the type, completeness and complexity of the filing. The Department staff stands ready to assist companies as they make changes and to efficiently move the filings through review. *updated 3/27/13*

69. To meet quickly approaching federally set deadlines for participating in the exchange; may a HIC submit required components of its Major Modification separately as the HIC completes each component? For example, the HIC would submit the Major Modification with one or two required components completed and then amend its filing as other components are completed and available for submission. Would ODI review each component when submitted by the HIC rather than waiting until all components of the Major Modification are received?

- By statute, ODI's review period for Major Modification filings is limited to 60 days (other time limits apply to other types of filings). It is ODI's view that this review period does not commence until the filing is substantially complete. When a company makes a Major Modification filing, within a few days of receipt, ODI assigned staff conducts an initial, cursory review of the filing for completeness. If the filing is determined to be substantially complete, then ODI assigned staff begins its in-depth review of the filing. Otherwise, the company is notified of any missing items.

Due to the unique circumstances and timelines of the new market rules, ODI intends to make every effort to ensure a complete and thorough review in a short timeframe. Therefore, ODI assigned staff is able to begin its review of an otherwise incomplete filing, provided that staff has a "substantially complete" component with which to begin its review. If companies plan to take advantage of this option, please contact your assigned risk assessment analyst or call (614) 728-1753. *updated 3/27/13*

70. Can new companies that do not have an NAIC number file products for review in SERFF at the same time the COA application is pending?

- Yes, once an insurance company files an application for a COA, ODI can ensure product review is not held up as the COA application is being reviewed by allowing SERFF to accept a filing without an NAIC number. If your company plans to take advantage of this option, you must talk to your risk assessment assigned analyst. *updated 3/27/13*

For more information, please see our [HIC filing requirements for an Ohio Certificate of Authority](#).

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## ***Miscellaneous***

71. Will individual and small group be merged into a single pool after 2014?

- As permitted in the Health Insurance Market and Rate Review Rules, Ohio does not plan to merge its individual and small group market pools at this time. The regulation can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf>. *updated 3/22/13*

72. Does the Department intend to keep filings confidential until the deadline for the submission of filings?

- No, filings will become public in accordance with current Ohio statutory requirements. *updated 1/25/13*

73. Can enrollees change plan designs once they are already enrolled in an Exchange plan outside of their renewal date?

- As finalized in the Exchange Regulation and the Proposed Medicaid/Exchange Regulation, individuals will be allowed to enroll during special enrollment periods. The final regulation can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>. The proposed regulation can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf> . *updated 1/25/13*

74. Will the High Risk Pool cease to exist once the Exchange is established or will they be integrated into the products?

- The Ohio PCIP will cease providing coverage to its enrollees as of 1/1/2014. During the open enrollment period the Ohio administrator will work with the PCIP enrollees to transition them to other products both on and off exchange, depending on their particular circumstances. *updated 3/27/13*

75. Will there be any additional fees or costs imposed on business written through the exchange?

- As mandated in the HHS Payment and Benefit Parameters Notice, the federal exchange will levy a monthly user fee rate that equals 3.5% of the monthly premium for exchange QHP plans. Ohio is not levying any additional fees over and above those mandated by the federal exchange. *updated 3/27/13*

76. Are there specific criteria for the tobacco cessation wellness programs under the ACA?

- HHS has issued final regulations regarding non-discriminatory wellness programs in group health coverage. This regulation contains clarification on requirements and reward/incentive limitations for participatory wellness programs and health-contingent well programs. Specific criteria can be found in the final wellness regulation at <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28361.pdf>. *updated 4/26/13*

77. In reference to Ohio Revised Code 1751.141 - Please provide clarification of the applicability of this regulation to require coverage of dependent children living outside of the service area of the HIC, where the subscriber under the HIC is court ordered to provide healthcare to dependent children. Must a HIC cover the dependent child, or is this the responsibility of the subscriber to provide independent coverage to the dependent child, outside of the subscriber's contract with the HIC?

- Under Ohio law, if a subscriber of a HIC is court-ordered to provide health care coverage for a dependent child living outside the HICs approved service area, it is the responsibility of the HIC to provide coverage to the dependent child. Please see <http://codes.ohio.gov/orc/1751.141>. *updated 4/26/13*

78. Is Ohio electing to increase the small group market definition to 100 employees in 2014? Will groups with 51 - 100 employees be community rated in 2014 and 2015?

- Generally speaking, health insurance market reforms, including community rating, enacted under the ACA apply to the individual and small group market. Until 2016, Ohio's small group market will be defined as a group with 50 or less employees. In 2016, the definition for small group will change, as required under the ACA, to a group with 100 or less employees. *updated 4/26/13*

79. Will the exchange user fee be applied only to QHPs or all plans?

- As ODI understands this issue, the user fee will be based on the premiums for exchange QHPs, but carriers are required to make a market-wide adjustment to the index rate to account for the exchange user fee. *updated 3/27/13*

80. Are issuers required to develop a schedule of benefits that is similar to or more detailed than the Benchmark Plan schedule of benefits?

- Issuers are not required to develop a schedule of benefits. However, if an issuer does include a schedule of benefits in their policy, then it will be required to be filed with the Department. Please note that the schedule of benefits is different than the Summary of Benefits and Coverage (SBC), a federal requirement. *updated 5/30/13*

81. Are issuers required to file an SBC and Uniform Glossary with the Department?

- Issuers are expected to comply with federal guidelines regarding the SBC and uniform glossary. PPO/Indemnity Issuers are not required to file the SBC and uniform glossary. HICs, on the other hand, will be required to file their SBCs as it is part of the HIC solicitation review. For more information on the SBC requirements, please see the final SBC regulation at <http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf#page=2> . For more information on the SBC and Uniform Glossary Templates, please see <http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3230.pdf#page=1>. *updated 5/30/13*

82. Does the Department expect to see language that separately reflects state cancer clinical trial coverage requirements and federal clinical trial coverage requirements in form filing submissions?

- Generally, ORC §3923.80 requires coverage for costs of routine patient care for participants in eligible cancer clinical trials. The federal mandate contained in PHSA §2709 with respect to coverage for individuals participating in approved clinical trials is more expansive than and encompasses the state requirement with one exception. Unlike the federal mandate, Ohio law does

not specifically require an individual to have the reference of a participating health professional or to provide appropriate medical and scientific information in order to qualify for coverage. Therefore, filings should contain separate language to reflect this difference between the state and federal laws. *updated 5/30/13*

83. For plans being submitted solely off-Exchange, are issuers required to file using the SERFF Binder functionality?

- o No, solely off-exchange filings will not need to use the Binder functionality in SERFF. Carriers will be required to submit the Uniform Rate Review Template (URRT) as well as the Rate Data Template as a part of the off-exchange rate filing. Carriers will also need to follow the Ohio ACA Compliant Form Filing Guidance and submit all required information, including a completed EHB worksheet for each plan variation as a part of the off-exchange form filing. Finally, carriers must also provide a document that outlines the benefit features (including cost sharing) for each plan design. This document must be attached to both the rate and form filings, must also include plan IDs, the metal tier, and all cost sharing features for each plan.

Carriers that have already submitted solely off-exchange binders may withdraw the binder filing and attach the required documentation to the appropriate rate and form filing. *updated 8/22/13*

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## ACA Compliant Filing Guidance

[QHP Compliance Review Checklist](#)

[Filing Guidance Document](#)

[Rate Filing Guidance Checklist](#)

[Sample Guidance and Checklist](#)

## Other Resources

[April 5, 2013 Final Annual Letter to Issuers](#)

[Rating Areas Map](#)

[Ohio ECP List](#)

[Ohio Dental ECP List](#)

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This information is provided as general guidance and is subject to change. Though reasonable efforts have been taken in compiling this information, the Department does not warrant the completeness or accuracy of the information, nor accept responsibility for errors, omissions or advice given or for any losses arising directly or indirectly from reliance upon information contained in this publication.

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