



## Miscellaneous – Frequently Asked Questions 2013

<b>Question</b>	<b>Answer</b>
1. 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: <a href="http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf">http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf</a> . updated 3/22/13
2. 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
3. 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: <a href="http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf">http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf</a> . The proposed regulation can be found at: <a href="http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf">http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf</a> . updated 1/25/13
4. 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

<p>5. Will there be any additional fees or costs imposed on business written through the exchange?</p>	<p>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. <i>Updated 3/27/13</i></p>
<p>6. Are there specific criteria for the tobacco cessation wellness programs under the ACA?</p>	<p>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 <a href="http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28361.pdf">http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28361.pdf</a>. <i>updated 4/26/13</i></p>
<p>7. 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?</p>	<p>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 <a href="http://codes.ohio.gov/orc/1751.141">http://codes.ohio.gov/orc/1751.141</a>. <i>updated 4/26/13</i></p>
<p>8. 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?</p>	<p>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. <i>updated 4/26/13</i></p>
<p>9. Will the exchange user fee be applied only to QHPs or all plans?</p>	<p>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. <i>updated 3/27/13</i></p>
<p>10. Are issuers required to develop a schedule of benefits that is similar to or more detailed than the Benchmark Plan schedule of benefits?</p>	<p>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. <i>updated 5/30/13</i></p>

<p>11. Are issuers required to file an SBC and Uniform Glossary with the Department?</p>	<p>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 <a href="http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf#page=2">http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf#page=2</a> . For more information on the SBC and Uniform Glossary Templates, please see <a href="http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3230.pdf#page=1">http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3230.pdf#page=1</a>. <i>updated 5/30/13</i></p>
<p>12. 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?</p>	<p>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. <i>updated 5/30/13</i></p>
<p>13. For plans being submitted solely off-Exchange, are issuers required to file using the SERFF Binder functionality?</p>	<p>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. <i>updated 8/22/13</i></p>