

**North Carolina Department of Insurance**  
**ACA Market Reform and Plan Management Questions and Answers**  
**March 24, 2015**

**Disclaimer: The following responses are based on current federal guidance and interpretations and are subject to change.**

**I. General Rate and Form Filing Questions**

**1. **UPDATED** - When are filings due to NCDOI?**

Insurers should generally plan for a 90-day review process. For insurers applying to offer any plans on the Federally Facilitated Marketplace (FFM) or Federally Facilitated SHOP (FF-SHOP), insurers should be mindful of federal deadlines, and should submit NCDOI regulatory submissions concurrent with or soon after submissions to the federal exchange. Insurers offering plans only outside the Exchange should be mindful of federal deadlines established around rates and the federally mandated open enrollment periods. Additional review time may be needed in cases where filings are not complete, the filing includes an excessive number of plans, the filing includes any Essential Health Benefit (EHB) substitutions, or the filing includes unique cost-sharing designs that cannot be accommodated by the federal actuarial value calculator. Insurers should also review the Division's Advisory Memorandum for additional information.

**2. **UPDATED** - Is the expectation that we will be submitting Exchange only products in April or do the off Exchange plans need to be submitted as well?**

As noted above, for insurers planning to apply to offer any plans on the federal exchange in a given market, all non-grandfathered ACA compliant plans for that market, both on and off the Exchange, should be submitted to NCDOI at the same time for consideration in conjunction with the single-risk pool rate filing. Also note that insurers must submit a single rate filing for each market (individual and small group) for all non-grandfathered ACA compliant plans offered on and off the Exchange.

**3. UPDATED - What is the form and rate submission process for grandfathered and transitional plans?**

NCDOI highly recommends insurers split grandfathered and transitional business from non-grandfathered business for purposes of forms and products. This will help streamline reviews. There are no changes to the submission requirements for grandfathered plans from those requirements currently in effect. However, NCDOI requests that insurers consider their timelines for grandfathered or transitional business and try to time submission of those filings outside of the traditional ACA review period of April to October, if possible.

**4. Will NCDOI require submission of SERFF Binders as part of the form filing process?**

Yes, NCDOI is requiring submission of SERFF Binders to include information on all non-grandfathered ACA compliant plans, including those intended to be offered only outside the Exchange. Please see the instructions in SERFF and the Division's Advisory Memorandum for more information about what is required as part of the plan binder.

NCDOI will review the SERFF Binders for compliance with the federal Essential Health Benefits and Actuarial Value requirements; as well as other applicable state and federal laws.

**5. Given the SERFF Binder Functionality, will NCDOI still require submission and approval of form and rate filings through SERFF before they are used in North Carolina?**

Yes, the Commissioner's prior approval authority for insurance forms and rates is still in effect and the SERFF Binder functionality does not take the place of any form or rate filing processes or requirements.

**6. Are insurers required to split Exchange and non-Exchange insurance forms?**

No, insurers are not required to split Exchange and non-Exchange insurance forms. However, if the insurer uses a single form (or set of forms) for both, then the insurer should use variable language in the form(s) to accommodate exchange specific requirements. The related Explanation of Variability must clearly explain this variability.

**II. QHP Certification**

**1. UPDATED - Will North Carolina certify plans as QHPs for use on the Federally Facilitated Marketplace (FFM)?**

As a state with a FFM, the FFM will make QHP certification decisions. NCDOI will review forms, rates and SERFF Binders for compliance with applicable state and federal laws, but will not review Exchange-specific certification criteria such as Essential Community Provider standards, Meaningful Difference, or non-discriminatory cost sharing.

**2. UPDATED - Where can insurers find out information about submission of the QHP Application to the FFM?**

The Federal Technical Assistance Portal containing training opportunities relating to various federal requirements can be found at <https://www.regtap.info/> .

The federal exchange has also set up a helpdesk for insurers which can be accessed by phone at: 855-CMS-1515 or by email at: [CMS\\_FEPS@CMS.HHS.GOV](mailto:CMS_FEPS@CMS.HHS.GOV).

The Center for Consumer Information and Insurance Oversight (CCIIO) has also issued a letter to issuers on Federally-facilitated marketplaces. The letter is available at:

[http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016\\_Letter\\_to\\_Issuers\\_2\\_20\\_2015.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf).

CCIIO also issued information relating to the 2016 Plan Year QHP application and templates at: <http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>

**III. Geographic Rating**

**1. UPDATED - What geographic rating areas will apply in North Carolina?**

CCIIO accepted a set of 16 geographic rating areas based on county lines to meet the requirements for presumptive approval by CCIIO. These areas are available at [http://www.ncdoi.com/HealthCareReform/HCR\\_Rate\\_Filing.aspx](http://www.ncdoi.com/HealthCareReform/HCR_Rate_Filing.aspx) .

**2. How should geographic rating factors be developed?**

Geographic rating factors should be based on unit cost analysis or otherwise adjusted for morbidity differences across geographic regions.

**3. UPDATED - How will geographic rating factors apply in the small group market?**

Geographic area for a small employer group should be based upon the main location of the employer.

**IV. Age Rating**

**1. Has North Carolina requested an alternative age curve?**

No, North Carolina has not requested use of an alternative age curve. The federal age curve will apply.

## V. Tobacco Rating

1. **UPDATED** - Will North Carolina limit tobacco rating to less than the 1.5:1.0 ratio allowed in the federal law?

Per G.S. §58-50-130(b1)(1)d., tobacco use factors in the small group market shall not vary by more than the ratio of 1.2:1.

## VI. Essential Health Benefits

1. **Where can I find information about the Essential Health Benefits in North Carolina?**

Information about Essential Health Benefits in North Carolina is available at:  
[http://www.ncdoi.com/LH/LH\\_HCR\\_EHBAV.aspx](http://www.ncdoi.com/LH/LH_HCR_EHBAV.aspx)

2. **UPDATED** - Does North Carolina have a specific definition for habilitative benefits?

At this time, North Carolina has not defined habilitative benefits for purposes of Essential Health Benefits. Therefore, the federal definition found in 45 CFR 156.115(a)(5)(i) shall apply.

3. **Will NCDOI allow for substitutions of Essential Health Benefits?**

At this time, NCDOI plans to allow for actuarially equivalent substitutions of Essential Health Benefits, but asks that insurers engage NCDOI as soon as possible if substitutions will be requested. If insurers do not engage NCDOI early, review times may be longer and insurers may need to plan for more than 90-days. When an insurer utilizes actuarial equivalent substitutions in any plan, the insurer must submit the federal supporting documentation “EHB – Substituted Benefit (Actuarial Equivalent) Justification”.

## VII. Rate Filing Questions

1. **UPDATED** - Should insurers file rates separately for grandfathered and transitional business and non-grandfathered ACA-compliant plans?

Yes, non-grandfathered ACA-compliant plan rates must be submitted in a single filing for each market (individual vs. small group), and grandfathered and transitional rates must be submitted separately consistent with pre-2014 requirements, standards, and processes.

2. **Should insurers file rates separately for Exchange and non-Exchange plans?**

No, rates for all non-grandfathered ACA-compliant plans (inside and outside the Exchange) must be submitted in a single-risk pool filing for each market (individual vs. small group).

3. **UPDATED** - Can insurers submit quarterly trend increases in their annual small group single-risk rate filings to be pre-approved to apply in the small group market for effective dates later than January?

Yes, insurers can submit quarterly trend increases annual small group single-risk pool rate filings to apply to groups with renewal or effective dates later in the calendar year. Information and data to support these quarterly increases must be included in the rate filings, including the NC-specific rating template.

4. **UPDATED** - Can insurers submit rate changes to apply to small groups with renewal or effective dates after January?

Yes, and all requirements associated with the annual filing apply to quarterly rate changes, including the NC Rate Data template and the federal URRT.

5. **What are the submission requirements for non-grandfathered ACA-compliant rate filings?**

Please refer to the rate filing checklists available at:  
[http://www.ncdoi.com/LH/LH\\_HCR\\_Rate\\_Filing.aspx](http://www.ncdoi.com/LH/LH_HCR_Rate_Filing.aspx).

6. **Are insurers required to submit the completed checklist with their rate filings?**

Submission of the completed checklist is strongly recommended to help facilitate review.

7. **Are insurers still required to submit the information required in NCDOI's Small Group Advisory Memorandum released in January 2012 for non-grandfathered plans?**

For non-grandfathered rate filings, applicable requirements from the Small Group Advisory Memorandum have been incorporated into the Actuarial Memorandum instructions. Refer to the applicable checklist for information on rate filing requirements.

For grandfathered and transitional plan rate filings, insurers should continue to submit the information required in the Small Group Advisory Memorandum.

## VIII. **SERFF Plan Binder and Federal Plan Management Templates**

1. **UPDATED** - Where can insurers find the Federal Plan Management Templates?

The Federal Plan Management Templates are available on HIOS or at  
[http://www.serff.com/plan\\_management\\_data\\_templates\\_2016.htm](http://www.serff.com/plan_management_data_templates_2016.htm).

**2. UPDATED - Will NCDI require that the Federal Plan Management Data Templates be submitted with Off-Exchange Plans? With On-Exchange Plans?**

**For On-Exchange AND Off-Exchange:** Yes, NCDI will require the following Federal Plan Management Data Templates be submitted via a SERFF Plan Binder for each market (individual and small group) for both on-exchange and off-exchange plans. Insurers may submit separate binders for on-exchange plans than off-exchange plans. Collectively all binders for a market should reflect ALL the plans the insurer will market in the plan year.

Plan/Benefits Template

- Prescription Drug Template
- Network Template
- Service Area Template
- Rate Data Template
- Business Rule Template
- Unified Rate Review (Required in the single-risk pool rate filing. DO NOT submit with the Plan Binder)

Insurers should also submit Federal Plan Management supporting documentation as necessary to address possible deficiencies such as the Formulary – Inadequate Category/Class Count Supporting Documentation and Justification when an insurers formulary does not meet the category/class count requirements of the regulation and there is an appropriate explanation for the deficiency.

## **IX. Plan Information**

- 1. UPDATED - For small group plans sold in 2014 or later, can a carrier file a flexible benefit plan and premium rate structure that does not include fixed benefit plans, or must the benefit plans all be pre-defined packages prior to filing?**

No, each combination of benefits and cost sharing, including different combinations of medical and drug plans, must be reported as a separate plan that meets the actuarial value/metal level requirements (or the requirements of a catastrophic plan). This is the case for all non-grandfathered ACA-compliant plans both inside and outside the Exchange. Further, when NCDI approves the forms and rates associated with a plan identified in the associated Plan Binder, the Department is accepting the plan as presented in the Plans and Benefits template along with the associated formulary. No deviations from those plans' benefits, cost-sharing, or limitations are permitted, even if an approved insurance policy form permits variability in those areas. This does not apply to the cost-sharing reduction variations of exchange plans as required by federal regulation.

Insurers should review the renewability and uniform plan modification provisions found in federal regulation as they consider their plan portfolio for the upcoming plan year. All previously accepted plans must be accounted for in the Binder, either as a plan continuing to be made available, or identified (by Standard Component ID) in supporting documentation as a plan that the insurer will cease to market as of January 1, 2016.

## **X. Dental and Vision Information**

- 1. UPDATED - Is NCDI aware of any stand-alone dentals plans that are intending to participate on the Exchange?**

A number of stand-alone dental plan insurers have participated on the FFM and FF-SHOP in 2014 and 2015, and NCDI expects that to be the case again in 2016.

- 2. Are Separate Forms Required for Small Groups (50 or less) and Large Groups (51 or more) for Stand-alone Dental plans?**

No, insurers are not required to submit different forms for stand-alone dental for small group versus large group.

- 3. Where can insurers find information relating to the Largest FEDVIP dental or vision plans by national enrollment in order to find the benefits that must be provided for the pediatric dental and vision part of the Essential Health Benefits?**

Vision Plan: <http://archive.opm.gov/insure/health/planinfo/2012/brochures/FEPBlueVi.pdf>

Dental Plan: <http://archive.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf>

- 4. Which FEDVIP plan should be used for defining the pediatric vision benefit for purposes of determining the Essential Health Benefits for NC, the Standard or High Option?**

Based upon the EHB final regulation, the vision benefit should be based upon the High Option (see chart at end of the regulation). Note that the chart also indicates that the referenced FEDVIP plans are as of March 31, 2012 and appear subject to change.

**XI. NEW – Uniform Modifications For Existing Plans**

- 1. May an insurer make an adjustment to the Out-of-Pocket limit on a previously accepted plan under the federal uniform modification of coverage rules, thereby avoiding creation of a new “plan”?**

To the degree an insurer wishes to change the Maximum Out-of-Pocket limits (MOOPs) on a plan and the change is due to a modification in federal or state requirements, then the change would be considered a uniform modification of coverage. Note however that MOOPs for plans in general (\$6850 for self-only coverage and \$13700 for other than self-only coverage for plan year 2016) or those for High Deductible Health Plans (HDHPs) (2016 limits not yet defined by IRS) are MAXIMUMS and therefore an insurers’ 2015 MOOPs would still comply with 2016 plan year limits.

- 2. If an insurer has previously accepted plans that have a certain AV for 2015 plan year but do meet that AV using the 2016 AV calculator, may the insurer modify cost sharing under the plans without the need to create new “plans”?**

45 CFR 147.106(e)(3)(iv) would appear to provide that changes to a plan’s cost sharing to maintain the metal level are considered uniform modifications as long as the applicable criteria in 45 CFR 147.106(e)(3)(i) through (v) are also met. If any of the applicable criteria is not met, then this is NOT a uniform modification and the insurer must create new plans.



- 3. If an insurer is required under the guaranteed renewability/uniform modification provisions to create a new plan or otherwise chooses to cease offering a certain plan, must the insurer give the impacted policyholders covered by the discontinued plan a 90-day notice of discontinuation?**

If an insurer has to create new plans for 2016 (or chooses to) and the insurer is not offering a previously accepted plan any longer and all the plans (new and discontinued) are under the same PRODUCT (as defined in 45 CFR 144.103 – refer to PRODUCT IDS from HIOS and what plans are under each product) , then the insurer should follow the notification requirements set out in 45 CFR 147.106(f). Insurers should also refer to the bulletin issued by CMS on September 2, 2014 relating to “Form and Manner of Notices When Discontinuing or Renewing a Product in The Group or Individual Market”. That bulletin can be accessed here:

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.PDF> .

- 4. If an insurer is required under the guaranteed renewability/uniform modification provisions to create a new plan or otherwise chooses to cease offering a certain plan, must the insurer give the impacted policyholders covered by the discontinued plan a 90-day notice of discontinuation?**

If an insurer has to create new plans for 2016 (or chooses to) and the insurer is not offering a previously accepted plan any longer and all the plans (new and discontinued) are under the same PRODUCT (as defined in 45 CFR 144.103 – refer to PRODUCT IDS from HIOS and what plans are under each product) , then the insurer should follow the notification requirements set out in 45 CFR 147.106(f). Insurers should also refer to the bulletin issued by CMS on September 2, 2014 relating to “Form and Manner of Notices When Discontinuing or Renewing a Product in The Group or Individual Market”. That bulletin can be accessed here:

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## **XII. NEW - King vs Burwell Information**

- 1. What contingency plans has NCDOI developed in light of the King vs Burwell case pending in the Supreme Court?**

The North Carolina Department of Insurance has not developed any contingency plans related to the case because the situation has too many unknowns. NCDOI expects insurers to submit the annual single-risk pool rate filings pursuant to and in accordance with current requirements.

Should the case result in a need for insurers to adjust their rate filings as submitted to NCDI, then NCDI will work with insurers to accommodate such changes.

- 2. Will NCDI accept/permit insurers to submit more than one single-risk pool filing (one representing rates if the status quo is maintained and one should the plaintiffs prevail) or submit two sets of rates in a single rate filing to facilitate changes if the plaintiffs prevail?**

No. NCDI does not have the resources or the time under the federally defined rate filing timelines to review multiple rate filings/scenarios per insurer. Insurers are encouraged to make contingent plans themselves in order that requests to make changes to submitted rate filings can be done efficiently, particularly if the insurer intends to participate on the exchange/SHOP.

- 3. If an insurer participates on the FFM or FF-SHOP, and following a ruling in favor of the plaintiffs, the insurer decides to not participate on the FFM or FF-SHOP in 2016, would that decision trigger a market withdrawal as contemplated under NC or federal laws?**

As long as the insurer does not intend to terminate ALL coverage in the applicable market (individual, small group) and the insurer intends to continue to market health benefit plans outside/off the exchange/SHOP, then the answer is no. In such cases the insurer should review renewability and uniform modification provisions found in the federal regulations, including discontinuation of a product and offer of replacement coverage requirements.

On the other hand, if the insurer intends to cease marketing in the respective market and to terminate ALL plans, then that is a market withdrawal which requires a 180-day notice to the Commissioner and the impacted policyholders and participants.

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Questions about this FAQ should be directed to [lhinbox@ncdoi.gov](mailto:lhinbox@ncdoi.gov) or (919) 807-6055.