INDUSTRIA

Preguntas y Respuestas Sobre los Seguros de Salud y la Implementación del Affordable Care Act (ACA) También Conocida como OBAMACARE.

1. Filings are by base plan or group?

2. Will there be a transitional law addressing the new guidelines on the 5 year age band to 1 year age band taking effect in 2014?

3. Associations now acting as a larger group for buying power(i.e. associations with more than 2,000 members vis a vis associations with less than 2,000 members) – are there any differences for this market group under the new rules?.

4. How is defined a full-time employee for small group?

5. Are employers allowed to charge smokers for their increase?

6. Can an insurer take all family rates and average them and issue that premium to everyone in small groups?.

7. Are there publications for state mandates? Concern is that carriers are interpreted additional benefits outside of EHB to be the same mandated benefits.

8. When is the first date for carriers to submit their rate filings for 1/1/14?

9. When is the last date for carriers to submit their rate filings for 1/1/14?

10. Effective 4/1/13, the federal rate review process has changed. How does this impact PR's rate filing process? E.g. Part I is replaced with URRT, and Part II and III stayed the same (synonymous with PR's part II)

11. Will there be guidance about formatting for rate filing? Is this going to be different for PPO vs. HMO products?

12. Do Risk adjusters, Risk Corridors, Reinsurance apply to Puerto Rico?

13. Is Puerto Rico expected to pay the ACA fee (Reinsurer Fee, Federal Insurer Annual Fee, and Comparative Effectiveness Fee that become effective 1/1/2014 or do these depend on if there is going to be an Exchange?

14. Is Puerto Rico included in the same regulation that all plans must be at a 60%, 70%, 80%, or 90% actuarial value plus or minus a 2% range?

15. Benefits in Puerto Rico are very rich compared to benefits in the US making the AV of current plans mostly range from Gold to Platinum. Is there a different AV calculator to be used by carriers in Puerto Rico?

16. **What will the rating regions look like for Puerto Rico?**

17. **Is Puerto Rico going to deviate from the Federal Age-Rating curve? Does the 3:1 ratio apply here as well?**

18. **Small Group is expected to continue for 2014 to be 2-50?**

19. **Will small group definition be based on ATNE (Average Total Number of Employees), eligible (30+), or full-time equivalence?**

20. **What is the benchmark plan used for PPO and HMO products?**

21. **Is it necessary to detail the Rx and Pediatric Dental in the benchmark?**

22. **What is your decision about the age to which Pediatric Dental and Vision has to be covered, age 19 or 21?**

23. **Can we offer Pediatric benefits (vision, dental) through a medical endorsement or rider or do they need to be included in the basic medical plan?**

24. **Is transplant coverage offered under the basic medical plan or can it be offered in a major medical plan?**

25. **The Dental Medical Equipment Benefit has a annual lime of $5,000, is this acceptable under the Essential Health Benefit requirements?**

26. **If the carriers are introducing new ACA compliant plans for 2014 and discontinuing the existing plans for new sales beginning in 2014, there is no official 'rate increase' being filed.**

There is no need to complete for Part II or any additional supporting information?

27. If a carrier were to develop a new plan to offer after 1/1/14 rates have been filed, what would be the best way to get the new plan filed?

28. Is it required that a new filing must be submitted for the introduction of a new plan?

29. Products available outside the Exchange are required to file different binder vs. the Qualified Health Plan File?

30. Will carriers be required to collect reinsurance contributions for Puerto Rico commercial major medical business?

31. Does the insurer or HMO may charge to the insured or include in the rate the PCORI Fee and the 1090A fee?

32. Would it be discriminatory, pursuant to ACA, if the insurer offers only the EHB plans in all of the metallic coverage, or if it has to offer also, all the riders and endorsements available for any insured?

33. Are there any specific OCI instructions with regard to filing policies and rates through SERFF in Puerto Rico? This is in terms of several optional data fields allowed in SERFF which may be required according to the state or jurisdiction?.

34. Specifically with regard to filings affected by Ruling Letter CN-2013-155, dated July 29, 2013, does the OCI have any preference with regard to a policy or a rate filing? In other words, can a rate filing be done along with the form filing?.

35. **What do the members of the insurance industry have to do when they confront problems with the System for Electronic Rate and Form Filing (SERFF) or the Health Insurance Oversight System (HIOS)?.**

36. **Section 2716 of ACA has been delayed (Prohibition on Discrimination in Favor of Highly Compensated Individuals) until the federal regulations to put it in effect are issued. Paragraph (L) of Article 2.050 of the Health Insurance Code ("HIC") regulates the discrimination in favor of highly compensated individuals. The Office of the Commissioner of Insurance will require compliance with Article 2.050 (L) of the HIC even though its federal counterpart provision was delayed?..**

37. **What is the uniform glossary and which terms must be included in it?.**

38. **Are waiting periods allowed?.**

[BACK]

1. **Q: ¿Filings are by base plan or group?**

A: Filings are for both but OCI is approving only base rates.

2. **Q: Will there be a transitional law addressing the new guidelines on the 5 year age band to 1 year age band taking effect in 2014?**

A: There will not be a transition law or referendum.

3. **Q: Associations now acting as a larger group for buying power (i.e. associations with more than 2,000 members vis a vis associations with less than 2,000 members) – are there any differences for this market group under the new rules.**

   A: The size of the association is not a determining factor. Rather, who the plans are sold to is the key factor. If the plans sold to Association membership are sold to individuals or small employers, then they are individual market and small employer market plans and therefore part of the individual and small employer risk pools and must be rated and sold accordingly.

   In a "mixed" association where different members have coverage that is subject to the individual market, small group market, and/or large group market rules, as determined by each member's circumstances, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer. For example, it is not permissible for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members.

4. **Q: How is a full-time employee defined for small group?**

A: Chapter 8 of the Health Insurance Code of Puerto Rico addresses the definition of part time versus full time employee status.

[BACK]

5. **Q: Are employers allowed to charge smokers for their increase?**

   A: Yes a portion – Please note that the entire cost can be charged to respective employees, only to employer who then distributes cost to employees based on tier; individual, family, etc., HIPPA Rules prohibit the use of health status when determining the employee contribution, which limits the amount of this charge that can be allocated to the employee.

6. **Q: Can an insurer take all family rates and average them and issue that premium to everyone in small groups?**

   A: Yes, but the average will have to be change if there is a change in the census.

7. **Q: Are there publications for state mandates? Concern is that carriers are interpreting additional benefits outside of EHB to be the same mandated benefits.**

A: Yes, there are published guidelines

8. **Q: When is the first date for carriers to submit their rate filings for 1/1/14?**

   A: They can be submitted any time now, but we strongly recommend the submission of 1/1/14 rates as soon as possible.

9. **Q: When is the last date for carriers to submit their rate filings for 1/1/14?**

   A: The latest date is the end of October, but earlier will be appreciated.

[BACK]

10. Q: Effective 4/1/13, the federal rate review process has changed. How does this impact PR's rate filing process? E.g. Part I is replaced with URRT, and Part II and III stayed the same (synonymous with PR's part II)

A: The new Parts I, II and II will be required according to the federal requirements and Puerto Rico timing.

11. Q: Will there be guidance about formatting for rate filing? Is this going to be different for PPO vs. HMO products?

A: The formatting will be primarily the federal requirements with a few additions in Puerto Rico. The filings will be the same.

12. Q: Do Risk adjusters, Risk Corridors, Reinsurance apply to Puerto Rico?

A: No

13. Q: Is Puerto Rico expected to pay the ACA fee (Reinsurer Fee, Federal Insurer Annual Fee, and Comparative Effectiveness Fee that become effective 1/1/2014 or do these depend on if there is going to be an Exchange?

A: Reinsurance fees and exchange fees do not applies in Puerto Rico. However, the Annual Fee on Health Insurance Provider apply to Puerto Rico

14. Q: Is Puerto Rico included in the same regulation that all plans must be at a 60%, 70%, 80%, or 90% actuarial value plus or minus a 2% range?

A: Yes

[BACK]

15. Q: Benefits in Puerto Rico are very rich compared to benefits in the US making the AV of current plans mostly range from Gold to Platinum. Is there a different AV calculator to be used by carriers in Puerto Rico?

A: The federal AV calculator must be used.

16. Q: What will the rating regions look like for Puerto Rico?

A: There will only be one region in Puerto Rico.

17. Q: Is Puerto Rico going to deviate from the Federal Age-Rating curve? Does the 3:1 ratio apply here as well?

A: No, Puerto Rico is using the Federal Age Rating Curve.

18. Q: Small Group is expected to continue for 2014 to be 2-50?

A: Yes

19. Q: Will small group definition be based on ATNE (Average Total Number of Employees), eligible (30+), or full-time equivalence?

A: Chapter 8 should be followed unless the yet to be released federal guidance is different.

20. Q: What is the benchmark plan used for PPO and HMO products?

A: Benchmark is the same for PPO and HMO plans. The benchmark for Puerto Rico is Triple- S Optimo.

[BACK]

21. Q: Is it necessary to detail the Rx and Pediatric Dental in the benchmark?

A: Yes

22. Q: What is your decision about the age to which Pediatric Dental and Vision has to be covered, age 19 or 21?

A: Age 21

23. Q: Can we offer Pediatric benefits (vision, dental) through a medical endorsement or rider or do they need to be included in the basic medical plan?

A: The Pediatric benefits are to be part of the basic medical plan.

24. Q: Is transplant coverage offered under the basic medical plan or can it be offered in a major medical plan?

A: Yes, Transplant Services are covered under the basic medical plan.

25. Q: The Dental Medical Equipment Benefit has a annual lime of $5,000, is this acceptable under the Essential Health Benefit requirements?

A: No, the Essential Health Benefit cannot have dollar limits.

26. Q: If the carriers are introducing new ACA compliant plans for 2014 and discontinuing the existing plans for new sales beginning in 2014, there is no official 'rate increase' being filed. There is no need to complete for Part II or any additional supporting information?

A: In this specific case, the carriers have to file Part I and III.

[BACK]

27. Q: If a carrier were to develop a new plan to offer after 1/1/14 rates have been filed, what would be the best way to get the new plan filed?

A: The carrier should follow the instructions of Part I of the federal template.

28. Q: Is it required that a new filing must be submitted for the introduction of a new plan?

A: Yes

29. Q: Products available outside the Exchange are required to file different binder vs. the Qualified Health Plan File.

A: The Qualified Health Plan Certification requirement applies for products offered through the Exchange. Therefore, the products are subject to the OCI's requirements.

30. Q: Will carriers be required to collect reinsurance contributions for Puerto Rico commercial major medical business?

A: The reinsurance program does not apply to Puerto Rico.

31. Q: May the insurer or HMO charge to the insured or include in the rate the PCORI Fee and the 1090A fee?

A: There is nothing in the law that prohibits insurers from doing this. State regulators may address during rate review whether amounts included in proposed rates are reasonable.

32. Q: Would it be discriminatory, pursuant to ACA, if the insurer offers only the EHB plans in all of the metallic coverage, or if it has to offer also, all the riders and endorsements available for any insured?

A: If a plan includes benefits in addition to EHB, those benefits must be made available to everyone who wants to purchase that plan.

Sometimes riders and endorsements are optional, in which case a consumer must be allowed to purchase them (unless they are excepted benefits). If they are built into the plan, then they of course would need to be made available to anyone who wants to purchase the plan.

33. Q: Are there any specific OCI instructions with regard to filing policies and rates through SERFF in Puerto Rico? This is in terms of several optional data fields allowed in SERFF which may be required according to the state or jurisdiction?

A: There are no specific instructions regarding filings of forms and/or rates in the SERFF system. However, we recommend that all fields for which the insurer or health services organization has information be completed.

34. Q: Specifically with regard to filings affected by Ruling Letter CN-2013-155, dated July 29, 2013, does the OCI have any preference with regard to a policy or a rate filing? In other words, can a rate filing be done along with the form filing?

A: It is left to the discretion of the insurer or health services organization to file rates along with the form filing.

35. Q: What do the members of the insurance industry have to do when they confront problems with the System for Electronic Rate and Form Filing (SERFF) or the Health Insurance Oversight System (HIOS)?

A: The SERFF system is a program designed by the National Association of Insurance Commissioners (NAIC) that allows the filing of forms and rates electronically. Since SERFF is a program that is created and operated by NAIC; and the OCI only participates in the program as a user; any problem that is confronted by the industry that is related with SERFF must be addressed to SERFF through the Help Desk of the program.

On the other hand, the HIOS system is a program created by the Centers for Medicaid and Medicare (CMS), which purpose is to assist in the implementation of ACA. HIOS is a database that includes information that is related with the rates of the insurance companies and health services organizations. Since HIOS is a program created and operated by CMS, any problem or difficulty that is confronted with the program must be addressed to CMS.

36. Q: Section 2716 of ACA has been delayed (Prohibition on Discrimination in Favor of Highly Compensated Individuals) until the federal regulations to put it in effect are issued. Paragraph (L) of Article 2.050 of the Health Insurance Code ("HIC") regulates the discrimination in favor of highly compensated individuals. The Office of the Commissioner of Insurance will require compliance with Article 2.050 (L) of the HIC even though its federal counterpart provision was delayed?

A: In light of the fact that Section 2716 of ACA has been delayed until the federal regulations to put it in effect are issued, the Office of the Commissioner of Insurance has determined that compliance with Article 2.050(L) of the HIC will also be delayed until the federal regulations for Section 2716 are issued.

37. Q: What is the uniform glossary and which terms must be included in it?.

A: As part of the Summary of Benefits and Coverage (SBC), the uniform glossary must provide uniform
definitions of standard insurance terms and medical terms, specified by the Secretary of the U.S.
Department of Health and Human Services, so that consumers may compare health coverage and
understand the terms of, or exceptions to, their coverage. The uniform glossary must provide uniform
definitions for the following terms:

"Allowed amount; appeal; balance billing; co-insurance; complications of pregnancy; co-payment; deductible; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitative services; health insurance; home health care; hospice services; hospitalization; hospital out-patient care; in-network co-insurance; in-network co-payment; medically necessary; network; non-preferred provider; out-of-network co-insurance; out-of-network co-payment; out-of-pocket limit; physician services; plan; preauthorization; preferred provider; premium; prescription drug coverage; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; rehabilitation services; skilled nursing care; specialist; usual customary and reasonable (UCR); and urgent care"

38. Q: Are waiting periods allowed?.

A: Health plans offered outside the open enrollment period and outside a special enrollment period may contain a waiting period that will not exceed ninety (90) days. This 90-day limitation is applicable to group plans and individual plans.
Health plans offered during open enrollment periods or under special enrollment periods (which include but are not limited to the following events: the birth of a person without regard to the insurance status of the parents, marriage, loss of eligibility for Mi Salud or an employment plan, or a dependent reaching 26 years of age) are prohibited to contain waiting periods. Waiting periods cannot be imposed in a discriminatory manner.

[BACK]