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BULLETIN NUMBER 2013-04

TO: All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina and All South Carolina Licensed Health Maintenance Organizations (collectively "Health Insurance Issuers" or "Issuers")

FROM: Raymond G. Farmer *R.G.F.*
Director of Insurance

SUBJECT: Process for Filing Amendments to Forms to Comply with the 2014 Market Reform Requirements of the Patient Protection and Affordable Care Act (ACA)

DATE: April 29, 2013

I. BACKGROUND AND PURPOSE

The purpose of this Bulletin is to inform all licensed Issuers of the procedures for filing amendments to existing policy forms, including grandfathered coverage, or new policy forms to comply with the 2014 Market Reforms and any additional filing requirements related to the Patient Protection and Affordable Care Act (ACA) requirements. South Carolina Department of Insurance (Department) Bulletin 2010-04 informed all licensed Issuers of the procedures for filing amendments to comply with the Immediate Market Reforms. This Bulletin supplements the filing requirements set forth in Bulletin 2010-04.

THIS BULLETIN REFLECTS REGULATORY AND FILING REQUIREMENTS BASED UPON THE FEDERAL GUIDANCE THAT HAS BEEN ISSUED FOR COMPLIANCE WITH THE ACA TO DATE. THIS BULLETIN MAY BE SUPPLEMENTED OR MODIFIED IN THE FUTURE TO REFLECT ADDITIONAL REQUIREMENTS OR GUIDANCE AS IT BECOMES AVAILABLE.

II. ACA REQUIREMENTS

Listed below are the market reforms with which issuers must comply.

A. Immediate Market Reforms

The following health insurance market reforms became effective six months after the enactment of ACA and are often referred to as the “Immediate Market Reforms:”

1. No lifetime benefit limits on dollar value of benefits (PHSA §2711);
2. Restricted annual limits on certain benefits as determined by United States Department of Health and Human Services (HHS) (PHSA §2711);
3. Rescissions prohibited (except for fraud or intentional misrepresentation) (PHSA §2712);
4. Benefits for preventive services required, with no cost-sharing (PHSA §2713);
5. Coverage of dependent children up to age 26 (PHSA §2714);
6. Pre-existing condition exclusions prohibited for children up to age 19 (PHSA §2704);
7. Prohibition of discrimination based upon salary (PHSA §2716) ;
8. Internal and external appeals process for enrollees (PHSA §2719);
9. Access to primary care provider, including pediatricians (PHSA §2719A);
10. Access to OB/GYNs (PHSA §2719A); and
11. Coverage for emergency services at in-network cost-sharing level; no prior authorization requirements (PHSA §2719A).

B. 2014 Market Reforms

The following health insurance market reforms become effective January 1, 2014, and are often referred to as the “2014 Market Reforms.”

- 1) No preexisting condition exclusions (PHSA §2704);
- 2) Fair health insurance premiums (premiums may only vary by age, tobacco use, geographic rating area, and whether coverage is individual or family) (PHSA §2701);
- 3) Guaranteed availability of coverage (PHSA §2702);
- 4) Guaranteed renewability of coverage (with certain exceptions) (PHSA §2703);
- 5) Prohibitions on discrimination against individual participants and beneficiaries based on health status (PHSA §2705);
- 6) Prohibitions on discrimination against providers operating within the scope of their practice and individuals or employers based upon receipt of subsidy or providing information to investigators (PHSA §2706);
- 7) Inclusion of Essential Health Benefits (EHB), including compliance with cost-sharing limitations, deductibles, and actuarial value standards (PHSA §2707) (PPACA §1302) ;
- 8) Prohibition on imposing annual limits on the dollar value of EHBs (PHSA §2711);
- 9) Prohibition on excessive waiting periods (PHSA §2708); and
- 10) Coverage for individuals participating in approved clinical trials for certain conditions (PHSA §2709).

C. Other ACA requirements

1) Summary of benefits and coverage (PHSA §2715)

The ACA creates a separate summary benefit disclosure requirement. PHSA 2715 requires group health plans and insurers to provide each enrollee with a 4-page double-sided Summary of Benefits and Coverage (EBC) and a uniform glossary of terms. The filing requirements for the SBC are set forth in Section III below.

2) Provision of Additional Information (PHSA§2715A)

All plans must submit to the Secretary of HHS and the Department and make available to the public the following information in plain language:

- Claims payment policies and practices;
- Periodic financial disclosures;
- Data on enrollment;
- Data on disenrollment; and
- Data on the number of claims that are denied.

Filing requirements for this information are set forth below.

D. Grandfathered Coverage

1. Overview

Grandfathered plans are those group health plans or health insurance coverage that do not need to comply with certain ACA coverage mandates if the plan had at least one individual enrolled as of March 23, 2010. In order to maintain status as a grandfathered health plan, a plan must: a) include a statement in any plan material that the plan is a grandfathered plan within the meaning of Section 1251 of the ACA and b) maintain records necessary to substantiate the terms of the plan if effective as of March 23, 2010, and verify its status as a grandfathered plan for as long as the plan maintains that it is entitled to grandfathered status. Grandfathered status extends to new enrollees. Accordingly, additional family members may be enrolled in group and individual policies and new employees and their families may enroll in group health plans. Group health plans that are maintained pursuant to a collective bargaining agreement will remain grandfathered until the last of the agreements governing the plan terminates.

In 2014, when insurers will be required to maintain a single risk pool for all of their individual market policies in a state and a single risk pool for all of their small group market policies in a state, grandfathered plans will not be required to be included in those single risk pools. Any state law that attempts to require them to be included would be invalid. In addition, grandfathered plans will not be included in the risk adjustment mechanism or the temporary risk corridor program. While grandfathered plans will be required to make payments into the transitional reinsurance program for the individual market that the bill establishes, they will not be eligible to collect payments under the program.

2. Coverage Mandates for Grandfathered Plans

The ACA does specifically apply a number of provisions to grandfathered plans from which they would otherwise be exempt. These provisions include:

- Relating to excessive waiting periods (PHSA §2708);
- Provisions of section PHSA §2711 relating to lifetime limits (but not those dealing with annual limits);
- Relating to rescissions (PHSA §2712);
- Relating to extension of dependent coverage (PHSA §2714);
- Uniform summary of benefits and coverage and standardized definitions (PHSA §2715); and
- Bringing down the cost of health care coverage (PHSA §2718).

Other provisions are applied only to group plans that are grandfathered. These provisions are:

- Provisions of PHSA §2711 relating to annual limits;
- Relating to pre-existing condition exclusions (PHSA §2704); and
- Relating to coverage of adult children only if the adult child is not eligible for their own employer-sponsored coverage (PHSA §2714).

3. Specific Coverage Exemptions for Grandfathered Plans

Grandfathered plans are exempt from all other provisions of subtitles A (immediate reforms) and C (market reforms) for as long as they are able to maintain their grandfathered status. These provisions include the following reforms that go into effect prior to 2014 including:

- First-dollar coverage of preventive health benefits (PHSA §2713);
- Provision of additional information (PHSA §2715A);
- Prohibition of discrimination based upon salary (PHSA §2716);
- Ensuring the quality of care (PHSA §2717);
- Internal and external appeals (PHSA §2719);
- Patient protections (PHSA §2719A);
- Health insurance consumer information (PHSA §2793); and
- Ensuring that patients get value for their dollars (PHSA §2794).

Grandfathered plans are also exempt from the market reforms that go into effect on January 1, 2014. These provisions include:

- Fair health insurance premiums (PHSA §2701);
- Guaranteed availability of coverage (PHSA §2702);
- Guaranteed renewability of coverage (PHSA §2703);
- Prohibition on discrimination based upon health status (PHSA §2705); and
- Nondiscrimination in health care (PHSA §2706).

4. Ways to Lose Grandfathered Status

A plan can lose its grandfathered status. There are a number of ways a grandfathered health plan may lose its grandfathered status:

- Through business restructuring (i.e., merger, acquisition, or similar restructuring to cover new individuals under the plan); or
- If the grandfathered plan:
 - Eliminates all or substantially all benefits to diagnose or a condition;
 - Increases the cost-sharing percentage (e.g., coinsurance) from what it was on March 23, 2010;
 - Increases the deductible or out-of-pocket limit (based on a certain formula);
 - Decreases the employer's contribution by more than 5% over what it was on March 23, 2010; and
 - Adopts an annual dollar limit that is lower than the annual dollar limit in effect on March 23, 2010, based on certain rules.

Insurers must be able to document and justify any claim to grandfathered status. Questions about grandfathered status may be directed to the contact person referenced *infra*. The filings requirements for grandfathered plans and non-grandfathered plans are detailed in the sections that follow.

III. REQUIREMENTS APPLICABLE TO FILINGS

All filings made to comply with the 2014 Market Reforms must also comply with the requirements of Bulletin 2003-13. Pursuant to Bulletin 2011-09, all filing must be made via the System for Electronic Rate and Form Filings (SERFF). South Carolina is using SERFF Plan Management for inside and outside health insurance exchange plans. All templates submitted should include all plans in the market, regardless of context inside or outside of the health insurance exchange. No more than one binder should be submitted per market - one individual and one Small Business Health Insurance Options Program (SHOP). Qualified Health Plans (QHP) must submit applications in HIOS as well as SERFF.

In addition, the following information must be included with the filing:

A. Grandfathered Policy Forms

Health Insurance Issuers may file amendments to grandfathered policy forms solely to incorporate the required 2014 market reforms. The following additional information should be provided:

- 1) Filing Description;
- 2) ACA Uniform Compliance Summary (*See Appendix A*);
- 3) ACA Certification of Compliance, which indicates that the only amendments that have been made are amendments necessary to incorporate the 2014 market reforms (*See Appendix B-1*);

- 4) If rates are impacted, rates must be submitted for prior approval in accordance with Bulletin 2013-01, which may be accessed at:

<http://doi.sc.gov/Documents/Bulletins/2013/Rate%20Filing%20Procedures.pdf>; and

- 5) A copy of the SBC required by PHSA §2715, a certification that the document complies with the requirements of PHSA §2715, and any related regulatory guidance must be provided within 30 days of the submission of the filing. The filing must also include a certification that the SBC has been provided to all policyholders and enrollees as required PHSA §2715 and any related regulatory guidance. The certification must be submitted annually by July 1st of each year thereafter.

B. Non-Grandfathered Policy Forms Amendments

Health Insurance Issuers may file amendments to existing policy forms solely to incorporate the required 2014 market reforms. The following additional information should be provided:

- 1) Filing Description;
- 2) ACA Uniform Compliance Summary (See Appendix A);
- 3) ACA Certification of Compliance, which indicates that the only amendments that have been made are amendments necessary to incorporate the 2014 market reforms (See Appendix B-1);
- 4) If rates are impacted, rates must be submitted for prior approval in accordance with Bulletin 2013-01, which may be accessed at:

<http://doi.sc.gov/Documents/Bulletins/2013/Rate%20Filing%20Procedures.pdf>; and

- 5) A copy of the SBC required by PHSA §2715, a certification that the document complies with the requirements of PHSA §2715, and any related regulatory guidance must be provided within 30 days of the submission of the filing. The filing must also include a certification that the SBC has been provided to all policyholders and enrollees as required PHSA §2715 and any related regulatory guidance. The certification must be submitted annually by July 1st of each year thereafter.

C. New Policy Forms

Health Insurance Issuers may submit new policy forms to comply with the 2014 market reforms. The policy forms must incorporate the Immediate Market Reforms and the 2014 Market Reforms and any additional South Carolina requirements. The following additional information should be provided:

- 1) Filing Description;
- 2) ACA Uniform Compliance Summary (See Appendix A);
- 3) ACA Certification of Compliance, which indicates that the policy form complies with applicable requirements of the ACA (See Appendix B-2);

- 4) Rates for new policy forms must be submitted for prior approval in accordance with Bulletin 2013-01, which may be accessed at:

<http://doi.sc.gov/Documents/Bulletins/2013/Rate%20Filing%20Procedures.pdf>; and

- 5) A copy of the SBC required by PHSA §2715, a certification that the document complies with the requirements of PHSA §2715, and any related regulatory guidance must be provided within 30 days of the submission of the filing. The filing must also include an initial certification that the SBC will be provided to all policyholders and enrollees as required. The certification must be submitted annually by July 1st of each year thereafter indicating that the SBC has been provided to all policyholders and enrollees as required PHSA §2715 and any related regulatory guidance.

D. Additional Filing Requirements Applicable to All Filings

- 1) The Issuer must include a certification that the information required by PHSA §2715A has been made available to the public and a method for the Department to access the information or a copy of the information.
- 2) For any network plan that either requires enrollees to use or creates incentives, including financial incentives, for enrollees to use the plan's participating provider network, the issuer must include a certification that it has reviewed our Network Adequacy Procedures found in Appendix C and that the network for the plan meets these standards.
- 3) Health Insurance Issuers must clearly indicate the method for supplementing habilitative services and the benefits provided in the filings submitted.
- 4) If actuarial substitutions are included in the filing, the information described in Appendix D must be submitted to the Department as part of filing.
- 5) Each filing must include a demonstration of the calculation of the actuarial value (AV), together with a certification from a credentialed actuary that the plan has been accurately entered into the AV calculator and that the metal level assigned accurately reflects the results of the AV calculator.
- 6) To the extent that an Issuer has not complied with a South Carolina law or regulation due to a conflict with the ACA and a belief that the South Carolina requirement prevents the application of the federal law and is therefore preempted, the Issuer must clearly document the provision that has not been complied with and the reason the Issuer believes the requirement to be preempted in making the certification required in Appendix B.

IV. ADDITIONAL REGULATORY GUIDANCE

Additional regulatory guidance related to EHBs, AV, EHB Substitutions, Cost Sharing Reductions, Fair Premiums, Pediatric and Adult Dental and Vision Plans is found in Appendix D.

V. QUESTIONS

Any questions about the contents of this Bulletin should be directed to the attention of: Loraine Ingram, Compliance Analyst, at 803-737-6097, or Tina Brown, Supervisor, Life, Accident and Health Forms & Rates, Program Area, at 803-737-6162.

ACA Uniform Compliance Summary

(Revised to include all reforms)

Please select the appropriate check box below to indicate which product is amended by this filing.

INDIVIDUAL HEALTH BENEFIT PLANS *(Complete SECTION A only)*

SMALL / LARGE GROUP HEALTH BENEFIT PLANS *(Complete SECTION B only)*

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the market reform requirements of the Affordable Care Act (ACA). These ACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				O Yes O No

ACA Uniform Compliance Summary

SECTION A Individual Health Benefit Plans

Category	Description	Reference	Grandfathered	Non -Grandfathered
Pre Existing Conditions	Eliminate Pre-existing Condition Exclusions	§ 2704	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Annual Limits	Eliminate Annual Dollar Limits on Essential Health Benefits	§ 2711	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Lifetime Limits	Eliminate Lifetime Dollar Limits on Essential Health Benefits	§ 2711	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Rescissions	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	§ 2712	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION A Individual Health Benefit Plans

Category	Description	Reference	Grandfathered	Non -Grandfathered
Preventive Care	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	§ 2712	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Dependent Coverage	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	§ 2714	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Internal Appeals	Internal Appeals Process –Must offer an internal claims and appeals process that complies with law in effect on March 23, 2010, meet the requirements of Section 2719(a)(1) of the Public Health Service Act as added by Title I, Subtitle A, Section 1001(4) of the Patient Protection and Affordable Care Act, and must update the claims and appeals processes in accordance with standards established by the Secretary of Health and Human Services.	§ 2719	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
External Review	External Review – Must comply with state law if state external review procedures at a minimum include the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (“NAIC Uniform Model Act”). If the state has not established an external review process that at a minimum includes the consumer protections set forth in the NAIC Uniform Model Act, then must comply with the minimum standards established by the Secretary of Health and Human Services.	§ 2719	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION A Individual Health Benefit Plans

Category	Description	Reference	Grandfathered	Non -Grandfathered
Emergency Services	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	§ 2719A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Primary Care Providers	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.	§ 2719A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Gynecological and Obstetric Services	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	§ 2719A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION A Individual Health Benefit Plans

Category	Description	Reference	Grandfathered	Non -Grandfathered
Excessive Waiting Periods	Relating to Excessive Waiting Periods	§ 2708	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Summary of Benefits and Coverage	Summary of Benefits and Coverage and Uniform Glossary of terms/standardized definitions	§ 2715	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Restrictions on Health Insurance Premiums	Restrictions on Health Insurance Premiums - premiums may only vary by age, tobacco, geographic rating area and whether coverage is individual or family)	§ 2701	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Guaranteed Availability of Coverage	Guaranteed availability of coverage	§ 2702	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION A Individual Health Benefit Plans

Category	Description	Reference	Grandfathered	Non -Grandfathered
Guaranteed Renewability of Coverage	Guaranteed renewability of coverage (with certain exceptions)	§ 2703	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Prohibitions on Discrimination against individuals and beneficiaries	Prohibitions on discrimination against individual participants and beneficiaries based on health status	§ 2705	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Prohibitions on Discrimination against providers	Prohibitions on discrimination against providers operating within scope of practice and individuals or employers based upon receipt of subsidy or providing information to investigators	§ 2705	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Essential Health Benefits	Inclusion of Essential Health Benefits (EHB), including compliance with cost-sharing limitations, deductibles and actuarial value standards	§ 2707 (PPACA §1302)	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION A Individual Health Benefit Plans

Category	Description	Reference	Grandfathered	Non -Grandfathered
Clinical Trials	Coverage for individuals participating in approved clinical trials for certain conditions	§ 2709	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Provision for Additional Information	Provision of Additional Information	§ 2715A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION B Group Health Benefit Plans (Small and Large)

Category	Description	Reference	Grandfathered	Non -Grandfathered
Pre Existing Conditions	Eliminate Pre-existing Condition Exclusions	§ 2704	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Annual Limits	Eliminate Annual Dollar Limits on Essential Health Benefits	§ 2711	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Lifetime Limits	Eliminate Lifetime Dollar Limits on Essential Health Benefits	§ 2711	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Recissions	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	§ 2712	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION B Group Health Benefit Plans (Small and Large)

Category	Description	Reference	Grandfathered	Non -Grandfathered
Preventive Care	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	§ 2712	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Dependent Coverage	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	§ 2714	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Internal Appeals	Internal Appeals Process –Must offer an internal claims and appeals process that complies with law in effect on March 23, 2010, meet the requirements of Section 2719(a)(1) of the Pubic Health Service Act as added by Title I, Subtitle A, Section 1001(4) of the Patient Protection and Affordable Care Act, and must update the claims and appeals processes in accordance with standards established by the	§ 2719	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Extenal Review	External Review – Must comply with state law if state external review procedures at a minimum include the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (“NAIC Uniform Model Act”). If the state has not established an external review process that at a minimum includes the consumer protections set forth in	§ 2719	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

ACA Uniform Compliance Summary

SECTION B Group Health Benefit Plans (Small and Large)

Category	Description	Reference	Grandfathered	Non -Grandfathered
Emergency Services	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	§ 2719A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Primary Care Providers	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.	§ 2719A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Gynecological and Obstetric Services	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	§ 2719A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Excessive Waiting Periods	Relating to Excessive Waiting Periods	§ 2708	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION B Group Health Benefit Plans (Small and Large)

Category	Description	Reference	Grandfathered	Non -Grandfathered
Excessive Waiting Periods	Relating to Excessive Waiting Periods	§ 2708	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Summary of Benefits and Coverage	Summary of Benefits and Coverage and Uniform Glossary of terms/standardized definitions	§ 2715	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Restrictions on Health Insurance Premiums	Restrictions on Health Insurance Premiums - premiums may only vary by age, tobacco, geographic rating area and whether coverage is individual or family)	§ 2701	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Guaranteed Availability of Coverage	Guaranteed availability of coverage	§ 2702	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION B Group Health Benefit Plans (Small and Large)

Category	Description	Reference	Grandfathered	Non -Grandfathered
Guaranteed Renewability of Coverage	Guaranteed renewability of coverage (with certain exceptions)	§ 2703	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Prohibitions on Discrimination against individuals and beneficiaries	Prohibitions on discrimination against individual participants and beneficiaries based on health status	§ 2705	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Prohibitions on Discrimination against providers	Prohibitions on discrimination against providers operating within scope of practice and individuals or employers based upon receipt of subsidy or providing information to investigators	§ 2705	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Essential Health Benefits	Inclusion of Essential Health Benefits (EHB), including compliance with cost-sharing limitations, deductibles and actuarial value standards	§ 2707 (PPACA §1302)	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

ACA Uniform Compliance Summary

SECTION B Group Health Benefit Plans (Small and Large)

Category	Description	Reference	Grandfathered	Non -Grandfathered
Clinical Trials	Coverage for individuals participating in approved clinical trials for certain conditions	§ 2709	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			
Provision for Additional Information	Provision of Additional Information	§ 2715A	N/A	<input type="radio"/> Yes <input type="radio"/> No If no, please explain.
	Explanation:			
	Page Number:			

Appendix B-1

ACA CERTIFICATION – AMENDMENTS TO POLICY
CERTIFICATION OF COMPLIANCE WITH ACA

I, THE UNDERSIGNED OFFICER OF _____
(Name of Entity)

HAVE REVIEWED OR SUPERVISED THE REVIEW OF THE POLICY FORMS, ENDORSEMENTS, OR AMENDMENTS CONTAINED IN THIS FILING AND HEREBY CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THEY ARE IN COMPLIANCE WITH THE PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, INCLUDING ANY INTERIM OR FINAL RULES, AS APPLICABLE, AND ANY APPLICABLE STATUTES, REGULATIONS, AND BULLETINS OF THE STATE OF SOUTH CAROLINA. I FURTHER CERTIFY THAT THE ONLY AMENDMENTS MADE TO THE POLICY ARE THOSE NECESSARY TO INCORPORATE THE 2014 MARKET REFORMS AND THE FORMS WILL BE REVISED AND/OR DISCONTINUED AS APPROPRIATE IN THE EVENT OF FUTURE CHANGES IN APPLICABLE STATE OR FEDERAL STATUTES, REGULATIONS, OR BULLETINS.

(Signature of Officer*)

(Title of Officer*)

(Printed Name of Officer*)

(Date)

** If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, General Counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors.*

Appendix B-2

ACA CERTIFICATION – NEW POLICY FORMS

CERTIFICATION OF COMPLIANCE WITH ACA

I, THE UNDERSIGNED OFFICER OF _____
(Name of Entity)

HAVE REVIEWED OR SUPERVISED THE REVIEW OF THE POLICY FORMS, ENDORSEMENTS, OR AMENDMENTS CONTAINED IN THIS FILING AND HEREBY CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THEY ARE IN COMPLIANCE WITH THE PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, INCLUDING ANY INTERIM OR FINAL RULES, AS APPLICABLE, AND ANY APPLICABLE STATUTES, REGULATIONS, AND BULLETINS OF THE STATE OF SOUTH CAROLINA. I FURTHER CERTIFY THAT THE FORMS WILL BE REVISED AND/OR DISCONTINUED AS APPROPRIATE IN THE EVENT OF FUTURE CHANGES IN APPLICABLE STATE OR FEDERAL STATUTES, REGULATIONS, OR BULLETINS.

(Signature of Officer*)

(Title of Officer*)

(Printed Name of Officer*)

(Date)

** If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, General Counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors.*

Appendix C
NETWORK ADEQUACY STANDARDS

General:

This section sets out the general requirements for developing and maintaining an adequate network of providers to ensure access to appropriate care. The requirements are developed pursuant to authority set forth in S.C. Code Ann. § 38-3-110(1), §38-33-40 (B), 38-71-1750 and 25A S.C. Code Ann. Reg. 69-22.

Health insurance coverage, health insurance issuer (“issuer”), health maintenance organization (HMO) and network plan are as defined in 38-71-840. For avoidance of doubt, a network plan includes any plan that either requires enrollees to use or creates incentives, including financial incentives, for enrollees to use the plan’s participating provider network.

1. The issuer must have a network of providers, including primary care physicians, hospitals and specialists. The network of providers must meet any additional standards set forth in § 1311 (c)(1) of the ACA as further defined in 45 CFR Section 156.230.
2. There must be a network within a reasonable distance of each geographical area to be served. An area is a county. The issuer of a network plan shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business and personal residence of enrollees.
3. Where the rural nature of a county makes it impossible to build an adequate network, the issuer must contract with a sufficient number of providers to represent the general health care access patterns within that county.
4. Out of network providers may be used to supplement the network but not ordinarily to meet the minimum requirements, unless providers are unavailable (rural area).
5. Issuers must maintain a complete file on each provider, including members of a practice group (may be kept at a PPO or similar group administrator). The file must include an original, signed hold harmless agreement, an original provider agreement (may refer to master contract between group and HMO), and the original or copies of all credentialing material, even where credentialing is delegated. Group administrators may sign for the group as permitted by law, including hold harmless and participation agreement.
6. A network plan must disclose in writing, using the plain and ordinary meaning of words so as reasonably to ensure comprehension by the insured or member, and make available to an insured or a member at the time of enrollment:
 - services or benefits under the plan, including limitations on services;
 - rules regarding copayments, prior authorization, and review requirements that apply to the benefits plan of the insured or member;

- potential financial liability for the insured or member to pay for a portion of services received from an out-of-network provider;
 - financial obligations of the insured or member for items and services both in and out of the network;
 - the number, mix, and distribution of network providers and a current list of network providers upon request from an insured or a member;
 - the rights and responsibilities of an insured or a member, including an explanation of any appeals process for the denial of care or services under the plan; and
 - the existence of any limitations on the choice of providers by an insured or a member.
7. The burden of network sufficiency shall lie with the Issuer. The Issuer shall demonstrate the adequacy of the providers in its network plan by providing supporting documentation and a certification as described in Appendix A upon initial approval of the network plan and annually thereafter.
8. Specific guidelines as set forth below:

PROVIDER NETWORK ADEQUACY GUIDELINES

1. The Department will continue to license HMO and review the adequacy of networks for network plans by county.
2. The Department will continue to approve HMOs for initial marketing and actual enrollment after reviewing the completed provider networks (executed contracts) by county.
3. Networks may include providers outside the area to be served.
4. Issuers shall contract with providers in each county to be served, and not rely solely on radius standards.
5. The Department reserves the right to withdraw approval of any network plan if based on actual practice, it becomes apparent that a network does not meet community standards of care.
6. The Department reserves the right to determine a network to be inadequate where the standards have been met at a minimum, but the network does not appear to be reasonable based on community practices, or the complaints are sufficient in number and severity to warrant an adverse determination.
7. Issuers should document good faith efforts to contract with providers where they feel there are unreasonable barriers to entry.

8. Issuers should document why certain providers do not meet its own standards for quality, including lack of accreditation, inability to meet National Committee for Quality Assurance standards, etc.
9. Each Issuer must file an access plan with the filing for initial approval of the network plan, showing the provider network, and by February 1st of each year thereafter, that shows how it was determined that provider network meets the network adequacy requirements set forth in this Network Adequacy Standard. These guidelines and the "Managed Care Plan Network Adequacy Model Act" should also be used for reference. The access plan should include a description of the network, referral procedures, ongoing monitoring, and any reasonable criteria used by the Issuer to determine network adequacy. The access plan should be stamped, "CONFIDENTIAL." Radius maps must be included in the access plan. Use of "GeoAccess" or something similar is encouraged. The initial access plan should be accompanied by a certification by an officer of the Issuer that the requirements set forth in this Network Adequacy Standard have been met. After the first submission, the Issuer may certify annually that there have been no substantive changes in the network, and attach a current provider directory (in lieu of a complete description analysis). This letter must come from an officer of the company and specify the addition or loss of any hospital providers.
10. Approval of a provider network will not, in and of itself, constitute proof of actual provider network adequacy in the event of a complaint.
11. There should be at least one primary care physician (PCP) per 2000 members accessible within a 30-mile radius for 95% of the population of the area to be served. If a radius map cannot demonstrate this, the Issuer may state that it generally meets this requirement, and how this was determined. An exception may be made for an Issuer serving only the Medicaid program, HHS allows a standard of one PCP per 2500 members.
12. There should be a contracted hospital within the county, or within a 30-mile radius of 95% of the population of the area to be served where none exists in the county. The Issuer must have a contractual arrangement with a tertiary care facility within a reasonable travel distance.
13. The Issuer must contract with an adequate number and type of specialists within a 50-mile radius of 95% of the population in the area to be served. The mileage standards do not apply to subspecialists. For subspecialists, the HMO should describe how it will assure access to subspecialists, as necessary.
14. There should be at least one OB-GYN within a 30-mile radius for 95% of the population of the area to be served.
15. There should be at least one pharmacy within a 20-mile radius of all enrollees.

NETWORK ADEQUACY CERTIFICATION

CERTIFICATION OF COMPLIANCE WITH NETWORK ADEQUACY

I, THE UNDERSIGNED OFFICER OF _____
(Name of Entity)

CERTIFY THAT I HAVE REVIEWED THE NETWORK ADEQUACY PROCEDURES FOUND IN APPENDIX C AS OUTLINED IN SC BULLETIN 2013-04 AND THAT OUR NETWORK FOR THE PLAN MEETS THESE STANDARDS.

(Signature of Officer*)

(Title of Officer*)

(Printed Name of Officer*)

(Date)

** If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, General Counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors.*

Appendix D

Regulatory Guidance for Filing Products to Comply with Essential Health Benefits (EHBs)

The ACA requires that all carriers offering coverage for non-grandfathered, individual and small group plans, both inside and outside a Health Insurance Exchange (Exchange), provide coverage for EHBs. Carriers must include items and services within the following 10 benefit categories as part of their plan design to comply with the EHB requirement:

- Ambulatory Patient Services;
- Emergency Services;
- Hospitalization;
- Maternity and Newborn Care;
- Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment;
- Prescription Drugs;
- Rehabilitative and Habilitative Services and Devices;
- Laboratory Services;
- Preventive and Wellness Services and Chronic Disease Management; and
- Pediatric Services, including Oral and Vision Care.

The default benchmark plan is the largest small group plan by enrollment in the state. The plan will constitute the EHBs for the non-grandfathered, individual, and small group market for calendar years 2014 and 2015. The default benchmark plan for South Carolina is Blue Cross and Blue Shield of South Carolina Business Blue Complete PPO. Pediatric oral and vision have been supplemented by the Federal Employee Dental and Vision Insurance Program (FEDVIP). Habilitative services were not included in the benchmark and must be supplemented in accordance with the procedures outlined in the final market rules, 45 CFR 156.115 (a) (5). Health Insurance Issuers must clearly indicate the method for supplementing habilitative services and the benefits provided in the filings submitted.

Actuarial Guidelines

The following provides actuarial guidelines related to EHB Substitutions, AV, Cost Sharing Reductions, and Fair Premiums:

I) EHB Substitutions

Certain provisions may be adopted by the Department to allow carriers to make actuarially equivalent substitutions for their plans within each of the 10 EHB categories specified except for prescription drug benefits. At this time, the Department has elected to allow for actuarial substitutions. If actuarial substitutions are included in the filing, the following data must be submitted to the Department as part of filing requirements to review substitution options:

- Attach a demonstration/explanation of equivalent value in each category to the Actuarial Memorandum in SERFF and include the following:
 - Provide an explanation of actuarial methodology following Actuarial Standards of Practice (ASOP);
 - Use a standardized plan population; and
 - Determine equivalence regardless of cost-sharing.
- Provide AV both before and after substitution including how benefits were defined and entered into the AV calculator.
- Include attestation certifying data used to derive substitution is accurate and follows ASOP.

II) Actuarial Value

Carriers must supply AV for plans both inside and outside the Federally-Facilitated Exchange (FFE) for consumer plan comparison purposes and to properly evaluate plans as part of the actuarial review.

The ACA requires non-grandfathered individual and small group health insurance plans, except for catastrophic plans, to fall within one of four “metal tiers” as defined by the AV of the benefits offered by the plan, relative to the full cost of the EHBs:

- Platinum: 90% AV;
- Gold: 80% AV;
- Silver: 70% AV; and
- Bronze: 60% AV.

Plans would be allowed a margin of +/- 2% of the required AV for each metal tier. At a minimum, all Issuers selling coverage through the FFE must make available at least one plan in the silver level and one plan in the gold level.

The ACA defines a catastrophic plan as a permissible benefit design offered to certain qualified individuals. Catastrophic plans do not have to meet a specific AV, but must comply with the maximum out-of-pocket limits.

The metallic levels of coverage that plans will be categorized by the ACA are not defined by deductibles, copayments, or coinsurance. Instead, AV is used. For example, a plan with an AV of 60% (bronze plan) means that for a standard population, the plan will pay 60% of their EHBs, while the enrollees in it will pay 40% of the cost through some combination of deductibles, copayments, and coinsurance. With a higher AV, the plan will have less patient cost-sharing resulting in a higher premium amount on average for the insured. The percentage a plan pays for any given enrollee will generally be different from the AV, which is an aggregated average in terms of spending.

Section 1302(c)(2)(C) of the ACA directs that the limit on deductibles described in section 1302(c)(2)(A) for a health plan offered in the small group market be applied so as to not affect

the actuarial value of any health plan. Thus, a Health Insurance Issuer may make adjustments to its deductible to maintain the specified AV for the applicable level of coverage. In so doing, a plan may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without doing so.

Each filing must include a demonstration of the calculation of the AV, together with a certification from a credentialed actuary that the plan has been accurately entered into the AV calculator and that the metal level assigned accurately reflects the results of the AV calculator.

III) Cost-Sharing Reductions

- Ensure that the following cost sharing limits are maintained:
 - High-Deductible Health Plans (HDHP) for 2013- \$6,250 Individual/ \$12,500 Family.

The ACA outlines requirements for QHPs to provide reduced cost-sharing for individuals purchasing coverage through the FFE with a household income below 250% of Federal Poverty Level (FPL). Each silver level plan submitted to the FFE must be accompanied by three variants providing AVs of 73%, 87% and 94%. These AVs would be provided in the same way that AVs for the metal tiers will be provided.

Cost-sharing must first be reduced by lowering the out-of-pocket limit to levels specified in annual guidance that will be provided by HHS, and then by applying adjustments to other cost-sharing factors. Cost-sharing reductions exclude reductions in premiums, balance billing amounts for non-network providers, and spending for non-covered services. The design of reduced cost-sharing variants cannot violate prohibitions on discriminatory benefit design.

The ACA provides that QHPs covering an American Indian/Alaskan Native whose family income is less than 300% of the FPL shall not be subject to any cost-sharing under the plan.

IV) Fair Premiums

The ACA requires non-grandfathered individual and small group health insurance plans to only vary the rate charged for a particular plan or coverage by the following:

- Age Rating Factors (Rate cannot vary by more than 3:1.);
- Geographic Rating Areas;
- Tobacco Rating (Rate cannot vary by more than 1.5:1.); and
- Family Composition.

At this time, the Department is not electing to narrow the bands and ratios required by the ACA nor merge the individual and small group markets. Geographic rating areas are specified by county.

Section 1304 of ACA defines the small group market to include employers with 1-100 employees. Until 2016, states may elect to define it as employers with 1-50 employees. South Carolina law currently defines small employers as employers with 1-50 employees. Thus, for 2014, “small employer” in South Carolina is defined as an employer with 1-50 employees.

Regulatory Guidance for Filing Pediatric/Adult Dental Products

It is anticipated that South Carolina may have five stand-alone dental plans offered on the FFE. Since pediatric dental is one of the ten EHB categories, the Department assumes that the five stand-alone dental plans will be offering pediatric dental coverage. As a result, if a carrier is offering major medical products on the FFE, then they are not required to also offer pediatric dental coverage. It is the carrier’s choice if they still want to offer pediatric dental and also adult dental on the FFE.

Carriers that are not participating on the FFE must offer pediatric dental coverage with their major medical plan since pediatric dental is an EHB. Carriers that offer major medical, non-grandfathered health insurance products in the individual and/or small group market must meet EHB requirements whether or not participating on the FFE. Stand-alone adult dental plans will continue to be offered off the FFE as a current option in the market and is not considered part of the EHB requirements. However, an issuer may carve out pediatric dental from a plan if they have assurance that the individual has purchased an FFE certified dental plan.

Grandfathered stand-alone pediatric and/or stand-alone adult (family) plans are excepted benefits under HIPAA and are exempt from ACA market insurance reforms. However, the ACA requires carriers offering dental coverage for the non-grandfathered, individual, and small group plans inside the FFE to meet the same requirements as QHPs, as relevant. Further guidance is anticipated as related to filing for dental plans.

When filing for a pediatric and/or adult dental product whether on or off the FFE, please consider that parts of the new filing instructions, checklists and/or requirements may not be applicable and can be bypassed or noted as N/A.

Regulatory Guidance for Filing Pediatric/Adult Vision Products

Pediatric vision is one of the ten EHB categories. As stated above, carriers that offer major medical, non-grandfathered health insurance products in the individual and/or small group market must meet EHB requirements whether or not participating on the FFE. As a result, carriers must include pediatric vision coverage as part of their major medical plan for both on and off the FFE. Stand-alone pediatric vision plans will not be available on the FFE. Stand-alone adult vision plans may be offered on the FFE. Stand-alone adult vision plans will continue to be offered off the FFE as a current option in the market and is not considered part of the EHB requirements.

When filing for a pediatric and/or adult vision product whether on or off the FFE, please consider that parts of the new filing instructions, checklists and/or requirements may not be

applicable and can be bypassed or noted as N/A. Pediatric dental and/or vision plans provide coverage for individuals under the age of 19.