Government of the District of Columbia
Department of Insurance Securities and Banking

Gennet Purcell
Commissioner

Bulletin
10-IB-02-08/10

TO: All Insurers, Health Maintenance Organizations and Other Entities Licensed To Do Business In The District of Columbia

FROM: Gennet Purcell, Commissioner

RE: Compliance Procedures for Federal Health Care Reform Requirements Effective September 23, 2010.

DATE: August 16, 2010

In March 2010, the President signed into law the Patient Protection and Affordable Care Act , Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (collectively, "PPACA Reform"). The PPACA Reform, among other changes, establishes a number of requirements pertaining to individual and group health insurance plans. Several provisions of the PPACA Reform become applicable six months after the effective date, which will be September 23, 2010.

The changes that will become effective September 23, 2010 include:

- Elimination of lifetime dollar limits on essential benefits;
- Elimination of annual lifetime dollar limits on essential benefits except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014;
- Elimination of pre-existing condition exclusions for enrollees under age 19;
- Prohibition of rescissions except in the case of fraud or intentional misrepresentation of material fact;
- Extension of dependent coverage for most adult children up to age 26 (this is already required under DC Law 18-499);
- Requirement that non-grandfathered plans provide out-of-network emergency services coverage if the policy otherwise covers emergency services;
- Requirement that non -grandfathered plans have an internal and external appeals process;

- Requirement of coverage of preventive health services and prohibition of cost-sharing for specified preventive services ;
- Requirement that non-grandfathered plans allow enrollees to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider; and
- Prohibition of non-grandfathered plans requiring authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider.

Form and Rate Filings

PPACA Reform forms and rates should be filed now to ensure compliance with the September 23, 2010 deadline and prevent a backlog in processing forms and rate filings. The District of Columbia mandates the use of the System for Electronic Rate and Form Filing (SERFF). Thus, all policies, riders, endorsements, applications, and other required insurance form filings and rates shall be filed through SERFF.

The Department's review process in health insurance filings submitted with changes solely to comply with PPACA can be expedited if there is no deviation from PPACA Reform standards required for:

- Limited annual and lifetime dollar limits
- Restrictions on rescissions
- First-dollar coverage for preventive services
- Extension of coverage to dependents
- Internal and external claims appeal rights
- Coverage for emergency care without prior approval
- Direct access to obstetricians and gynecologist
- Selection of a primary care provider for children
- Limitations on pre-existing conditions and exclusions

Language that is considered to be in compliance to PPACA Reform standards is included in Appendix A, B, and C. Each filing will be required to have a signature from an officer of the company that will certify that the filing is in compliance with District of Columbia law and PPACA Reform requirements

Disclosures

The District of Columbia also will require that a written disclosure be sent to each insured (new or existing) which informs the insured whether he or she has a grandfathered plan, and which changes could impact the status of such plan. Also, prior to issuing new coverage to any group or individual purchaser, the group or purchaser must be notified that the plan is not grandfathered under PPACA Reform.

Further, the Commissioner must be provided notice of a pending rescission of coverage along with an explanation of the basis for the rescission at least fifteen (15) days prior to the effective date of the rescission. This notice will provide the Commissioner the opportunity to review the proposed rescission and, if needed, investigate the proposed rescission prior to it taking effect. Rescission notices should be sent by e-mail to the Associate Commissioner for Insurance, Philip Barlow, at philip.barlow@dc.gov.

For assistance with, or questions regarding, form filings please contact the Insurance Examiner Manager, Jamai Fontaine, at 202-442-7782. For assistance with, or questions regarding, rate filings, please contact the Supervisory Actuary, Robert Nkojo, for rate finings and questions at 202-442-7757.

APPENDICIES TO BULLETIN:

Item 1 - APPENDIX A ..... Grandfathered Plans

Item 2 - APPENDIX B ..... Non-Grandfathered Plans

Item 3 - APPENDIX C ..... Certificate of Compliance

Please follow the PPACA Reform requirements to make a filing with The District of Columbia Department of Insurance, Securities and Banking under Bulletin 10-IB-02-08/10:

APPENDIX A

GRANDFATHERED PLANS:

Definition changes and model language for Essential Health Benefits, Policy Year, Lifetime Dollar Limits, Annual Dollar Limits, Recessions, Prohibition on Pre-Existing Conditions for Children and Extension of Adult Dependent Coverage. Conforming amendments can be filed as a rider, endorsement or new policy.

Definitions

The following definitions have the following meanings:

"Essential health benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes 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.

"Policy year" means the 12-month period that is designated as the policy year in the contract. If there is no designation of a policy year in the contract, then the policy year is the deductible or limit year used under the contract. If deductibles or other limits are not imposed on a yearly basis under the contract, the policy year is the calendar year.

Lifetime Dollar Limits **(Individual & Group Health Plans)**
Any lifetime dollar limit on any essential health benefits in the contract is deleted.
The contract is amended to provide that if an individual's coverage under the contract had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a policy year that begins on or after September 23, 2010, and coverage will begin on the first day of the policy year that begins on or after September 23, 2010.

Annual Dollar Limits (Small & Large Group Health Plans Only)
Any annual dollar limit on any essential health benefits in the group contract or certificate is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the group contract or certificate.

Rescissions **(Individual & Group Health Plans)**
Any provision of the contract that describes the right of [*insert company name*] to rescind or void the contract is amended to permit [*insert company name*] to rescind or void the coverage

of an individual only if (1) the individual performs an act, practice, or omission that constitutes fraud; or (2) the individual makes an intentional misrepresentation of material fact.
Any provision of the contract that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

This amendment shall be effective [*insert effective date of amendment rider*].

Prohibition on Pre-Existing Conditions for Children (Small & Large Group Health Plans Only)
The following provisions of the group contract or certificate shall not apply to any child who is under the age of 19:
(1) Any provision that describes a pre-existing condition exclusion or limitation;
(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the individual is covered under the group contract or certificate; and
(4) Any provision of the group contract or certificate that describes possible denial or rejection of coverage due to underwriting.

This amendment shall be effective [*insert effective date of amendment]*.

Extension of Adult Dependent Coverage (Individual & Group Health Plans)
DC Law 18-203 requires coverage for dependent children until age 26. PPACA Reform requires the expansion of dependent coverage up to age 26. Any provision or definition for eligibility should be amended for compliance.

This amendment shall be effective [insert effective date of amendment].

APPENDIX B

Non-Grandfathered Plans:

Definition changes and model language for Emergency Services, Emergency Medical Condition, Essential Health Benefits, Non-Participating Provider, Participating Provider, Policy Year, Lifetime Dollar Limits, Annual Dollar Limits, Recessions, Preventive Services, Prohibition on Pre-Existing Condition for Children and Extension of Adult Dependent Coverage. Conforming amendments can be filed as a rider, endorsement or new policy.

"Emergency services" means, with respect to an emergency medical condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

"Essential health benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes 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.

"Non-participating provider" means a health care practitioner or health care facility that has not contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees.

"Participating provider" means a health care practitioner or health care facility that has contracted directly with [*insert company name*] or an entity contracting on behalf of [*insert company name*] to provide health care services to [*insert company name*]'s enrollees.

"Policy year" means the 12-month period that is designated as the policy year in the contract. If there is no designation of a policy year in the contract, then the policy year is the deductible or limit year used under the contract. If deductibles or other limits are not imposed on a yearly basis under the contract, the policy year is the calendar year.

***Lifetime Dollar Limits (*Individual & Group Health Plans)**
Any lifetime dollar limit on any essential health benefits in the contract is deleted.
The contract is amended to provide that if an individual's coverage under the contract had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a policy year that begins on or after September 23, 2010, and coverage will begin on the first day of the policy year that begins on or after September 23, 2010.

***Annual Dollar Limits* (Individual & Group Health Plans)**
Any annual dollar limit on any essential health benefits in the contract is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the contract.

***Rescissions* (Individual & Group Health Plans)**
Any provision of the contract that describes the right of [*insert company name*] to rescind or void the contract is amended to permit [*insert company name*] to rescind or void the coverage of an individual only if (1) the individual performs an act, practice, or omission that constitutes fraud; or (2) the individual makes an intentional misrepresentation of material fact.
Any provision of the contract that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

***Preventive Services* (Individual & Group Health Plans)**
In addition to any other preventive benefits described in the contract, [*insert company name*] shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits [*for PPO, EPO or HMO plans, insert "for services received from participating providers"*]:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, such additional preventive care and screenings not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

[*for individual PPO contracts, insert "For services received from non-participating providers, the preventive service benefits described above shall be covered at 80% of the amount covered for services received from participating providers."*]

[*Insert company name*] shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Prohibition on Pre-Existing Conditions for Children **(Individual & Group Health Plans)**
The following provisions of the contract shall not apply to any child who is under the age of 19:
(1) Any provision that describes a pre-existing condition exclusion or limitation;
(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the contract; and
(4) Any provision of the contract that describes possible denial or rejection of coverage due to underwriting.

Choice of Provider *[do not include this provision if the contract does <u>not require</u> the selection of a primary care provider by an individual]* **(Individual & Group Health Plans)**

Any provision of the contract that indicates that an individual is required to designate or provide for the designation of a primary care provider is amended to permit the individual to select any participating primary care provider who is available to accept the individual.
Any provision of the contract that indicates that a primary care provider is required to be designated for a child, is amended to permit the designation of any participating physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider, if the provider is available to accept the child.

Any provision of the contract that requires a woman to receive a referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating

provider who specializes in obstetrics or gynecological care is deleted. The contract is also amended to provide that the obstetrical and gynecological care received from a participating provider who specializes in obstetrics or gynecological care without the referral or authorization from the primary care provider includes the ordering of related obstetrical and gynecological items and services that are covered under the contract.

***Emergency Services* (Individual & Group Health Plans)**
Any provision of the contract that provides benefits with respect to services in an emergency department of a hospital is amended to provide emergency services:

1. Without the need for any prior authorization determination, even if the emergency services are provided by a non-participating provider;
2. Without regard to whether the health care provider furnishing the emergency services is a participating provider with respect to the services; and
3. If the emergency services are provided by a non-participating provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers.

***Cost-Sharing Requirements for Emergency Services* (Individual & Group Health Plans)**
If any copayment amount or coinsurance percentage described in the contract for emergency services is different for a service received from a participating provider than a non-participating provider, the copayment amount and coinsurance percentage for emergency services provided by a non-participating provider is amended to be identical to the copayment amount and coinsurance percentage listed in the contract for emergency services provided by a participating provider.

[*Insert company name*] shall pay the greater of the following amounts for emergency services received from non-participating providers:

1. The amount set forth in the contract to which this amendment rider is attached;
2. The amount negotiated with participating providers for the emergency service provided, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider. If there is more than one amount negotiated with participating providers for the emergency service provided, the amount paid shall be the median of these negotiated amounts, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.
3. The amount for the emergency service calculated using the same method [*insert company name*] generally used to determine payments for services provided by a non-participating provider (such as usual, customary and reasonable amount), excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider; or
4. The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*) for the emergency service, excluding any copayment or

coinsurance that would be imposed if the service had been received from a participating provider.

Any other provision of the contract that describes cost-sharing for services received from non-participating providers, other than copayment amounts or coinsurance responsibilities, continue to apply to emergency services received from non-participating providers. Examples of these cost-sharing requirements include deductibles and out-of-pocket limits. Any out-of-pocket limit described in the contract that generally applies to services received from non-participating providers is applicable to emergency services received from non-participating providers.

This amendment rider shall be effective [*insert effective date of amendment rider*].

Extension of Adult Dependent Coverage (Individual & Group Health Plans)
DC Law 18-203 requires coverage for dependent children until age 26. PPACA Reform requires the expansion of dependent coverage up to age 26. Any provision or definition of eligibility should be amended for compliance.

This amendment shall be effective [insert effective date of amendment]

Appeal Process (Individual & Group Health Plans)
Revise language for Appeal Process and add the contact information below:

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:

District of Columbia Department of Health Care Finance, Office of the Health Care Ombudsman And Bill of Rights, 825 North Capital Street, 6th floor, NE, Washington, DC 20002 (1-877-685-6391 or fax 202-478-1397)

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity cases:

District of Columbia Department of Insurance, Securities and Banking, Consumer Services Division , 810 First Street NE, Suite 701, Washington, DC 20002 (202-727-8000 or fax 202-535-1197, 202-354-1085).

This amendment shall be effective [insert effective date of amendment]

APPENDIX C

CERTIFICATE OF COMPLIANCE

If you wish to use the expedited process provided by Bulletin 10-IB-02-08/10 and your company is certain that it is in full compliance with DC Law 18-499 and PPACA Reform, you can attach this document which requires a signature from an Officer of your company.

Title:

_____

Signature:

_____

Date:

_____