Nebraska Form and Rate Filing Guideline for Student Health Plans – 12/21/2018

The purpose of this notice is to provide issuers of College Student Health Plans (SHP) in Nebraska, with guidance for the filing of rates and forms. Forms must be filed and approved in SERFF.

Rates and forms are not to be filed together – each requires a separate SERFF filing.

FORMS

- Include certification that the health benefit plan's prescription drug benefit complies with 45 CFR § 156.122.
- SHP issuers should include an appeal process and external review.
- Include Nebraska mandated benefits.
- No pre-existing condition limitations.
- No lifetime or annual dollar limits on EHBs.
- Include Summary of Benefits and Coverage (SBC) forms. Provide a uniform glossary containing standardized definitions of specified health coverage and medical terms.
- Regarding mental health parity, (MHPAEA), all plans must comply with federal regulation.
- Submit benefit schedules with little or no variability.
- Preventive health services must be covered without any cost sharing requirements.
- All cost sharing must follow the current Plan year HHS guidance for maximums defined for Individual ACA plans.
- SHPs must satisfy all EHB categories that individual ACA compliant plans have. Issuers should review the Nebraska Benchmark Plan.
- An SHP issuer does not need to make a Child Only individual plan available for the dependent of a student if that student (the parent) is not also covered.
- Issuers that offer coverage in the state must accept every individual in the state that applies for coverage, subject to the following exceptions: are not required to accept individuals who are not students or dependents of students in such coverage, and, is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis.

- Issuers must renew or continue in force coverage at the option of the individual with the following exceptions: nonpayment of premiums, fraud, violation of participation or contribution rules, termination of product, enrollees' movement outside services area, or association membership ceases.
  An issuer also is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students.

- Issuers may not: (1) deny a qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) discriminate against the individual on the basis of the individual's participation in the trial.

- Prohibition on rescissions: cancelling or discontinuing coverage with retroactive effect.

- Issuers may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.
  If a plan requires or provides for the designation of a participating primary care provider for a child, the enrollee shall be permitted to designate a physician who specializes in pediatrics (allopathic or osteopathic) as a child's primary care provider, if such provider participates in the network of the plan or issuer and is available to accept the child.

- An issuer that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

- An issuer that provides medical and surgical benefits with respect to a mastectomy must provide, in a case of a participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

- Issuers may not:
  - establish rules for eligibility of an individual based on genetic information;
  - adjust premium or contribution amounts based on genetic information;
  - request or require an individual or family member to undergo a genetic test; or
  - request, require or purchase genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

- If emergency services benefits in the emergency department of a hospital are covered or provided for by the issuer, then emergency services shall be covered:
  - Without the need for a prior authorization determination;
  - Without regard to whether the health care provider furnishing such services is a participating provider with respect to such services; and

  - If such services are provided by an out of network (OON) provider, without imposing administrative requirements or coverage limitations that are more restrictive than or cost sharing requirements that exceed those that would apply if such services were provided in-network.

RATES

(1) SHPs are considered to be Individual insurance under the ACA, but are not included as part of the issuer's Individual single risk pool in the state. Premium rating requirements of the ACA section 2701 must be followed; however, since issuers may have separate risk pools for each school, the premium may be different for each school.

SHPs do fall under CMS effective rate review requirements. Insurers are required to submit an explanation of how they comply with the provisions relating to the rating of student health insurance coverage found in the federal ACA Health Insurance Market rules issued in the federal register on February 27, 2013 (also known as CMS-9972-F).

(2) In accordance with PHS Act § 2701 (42 U.S.C. § 300gg) with respect to the premium rate charged for a particular plan or coverage, the only rating factors allowed are:

1. Family (generally per-member build-up; 3- covered child cap under age 21).
2. Geography, using the state's standard Individual ACA set of area definitions.
3. Age (Standardized 3:1 range).
4. Tobacco use (maximum 1.5:1 range).

Spouse rates must be set equal to student rates, gender rating is not allowed.
Separate rating risk pools can be created within a particular school provided it is not discriminatory or based on health status. For example, separate rates may be charged for the following classes of members:

Undergraduate students,
Graduate students,
International students,
Professional students

(3) Issuers may submit SHP rate filings in Nebraska as Blanket Accident/Sickness Insurance filings using typical LG experience rating methods to set base rates separately for each school based on their own experience. Alternatively, schools may be pooled together with a common base rate set for all schools in the pool, and a common set of rates for all plans sold to schools in the pool.

(a) Rate Quotes to New Schools: The experience rating methodology that an issuer will use to

rate new schools not currently enrolled with the carrier must be filed and approved in SERFF prior to issuing quotes to any potential new school in the market.

- Once an issuer has filed the experience rating method to be used to rate schools for a school year it may proceed to work with any schools on the rating process while it awaits Department approval of the rate filing, though rates for any potential new school may not be finalized until a rating method is approved.
- An issuer with an approved experience rating method rate filing may submit final rate quotes to schools based on the approved methodology rate filing.
- Rates to be charged specific to each school for a school year must be filed and approved prior to implementation and premium collection. Issuers should file all final school rates in SERFF for a new school year at least 60 days prior to the proposed implementation date or use of the new rates. A single rate filing may include all schools rated for the year, or rate filings for a specific school may be made.

(b) Rate Quotes to Currently Enrolled Schools: A carrier may submit a rate filing for specific schools for a new rating period (i.e. a new school year) if it already has an approved rating methodology on file which it is not modifying.

If the carrier is modifying their rating methodology from the current rating period to the new rating period, then a rate methodology filing should be submitted with the revised methodology.

- Once an issuer has filed the revised experience rating method to be used to rate schools for a school year it may proceed to work with any schools on the rating process while it awaits Department approval of the rate filing, though rates for any potential new school may not be finalized until a rating method is approved.
- An issuer with an approved revised experience rating method rate filing may then submit final rate quotes to schools based on the approved methodology rate filing.
- Rates to be charged specific to each school for a school year must be filed and approved prior to implementation and premium collection. Issuers should file all final school rates in SERFF for a new school year at least 60 days prior to the proposed implementation date or use of the new rates. A single rate filing may include all schools rated for the year, or rate filings for a specific school may be made.

(c) For renewal rate filings the rate change for each school must be indicated in the rate filing. The rate filing must state the rate change from the prior school year, or the change from the prior approved rate filing. The rate change for each school must be filed and reported in SERFF whether the school is remaining on the same benefit form or being moved to a new benefit form.

(d) Per CMS revised guidelines in 2018, issuers are no longer required to file each school's rate increase in excess of 10% in HIOS, through the RRJ module. The CMS URRT and HIOS URR are NOT applicable for SHPs and do not need to be submitted in a rate filing.

(e) If an issuer is pooling schools together and setting a pooled set of rates then the rate change for all benefit plans sold to the pool must be indicated in the rate filing. The rate filing must state the rate changes from the prior school year, or the changes from the prior approved rate filing.

The rate change for each plan in the pool must be filed and reported in SERFF whether the schools are remaining on the same benefit form or being moved to a new benefit form.

(4) All benefit plan designs offered to a school must offer an actuarial value of at least 60%. For rate filings, an issuer must provide an actuarial certification that the Actuarial Value (AV) was determined by the use of the CMS AV calculator, or by using an accepted alternative method, for unique benefit designs. Issuers may not negotiate benefit plan designs with a school that do not satisfy this AV requirement.

(a) An issuer's Federal MLR rebate calculation is based on all national SHP business in all states, and is not specific to Nebraska business. However, an issuer's projected Federal MLR should still be considered in the rate review process as indicated in 45 CFR §154.205 (b)(1). The issuer should also submit a projected Federal MLR calculation on a Nebraska specific SHP basis. Student Health Plans must maintain a minimum loss ratio of 80%, and may be required to pay rebates when the actual MLR result in a year falls below 80%.