Form Filing Review Checklist
HEALTH SERVICES PLANS
(INDIVIDUAL AND SMALL GROUP)

NOTICE: This checklist must be completed in its entirety and submitted with each health services plan. The failure to submit a completed checklist will result in a delay of the review of the submission, and may result in the rejection of the filing.

This checklist was developed as a resource for carriers for product design purposes. This checklist is offered to assist carriers but may be subject to change; accordingly, it is not binding on the Bureau or the federal Department of Health and Human Services. This checklist should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state and federal insurance laws and associated rules and regulations. <u>It is the responsibility of the carriers to verify that their products comply with all relevant statutory and regulatory requirements.</u>

Company Name:			
Product Name:		SERFF Tracking Number:	
Plan:		Submission Includes Plans Intended for:	
☐	60% AV (Bronze)	☐	Inside the Exchange
☐	70% AV (Silver)	☐	Outside the Exchange
☐	80% (Gold)	☐	Inside and Outside the Exchange
☐	90% (Platinum)		
☐	Child-Only		
☐	Catastrophic Plan: - Only available to individuals under age 30 or those with hardship/affordability exemption; - Must not meet bronze, silver, gold or platinum AV requirement; - All Essential Health Benefits (EHBs) must be subject to the in-network deductible and no EHB may have any other cost-sharing in-network, EXCEPT a deductible must not apply to preventive services and at least the first 3 primary care physician visits per year; - Cost-sharing must not apply to preventive services; - The in-network deductible must mirror the highest allowed maximum out-of-pocket amount.		

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General Filing Requirements			
	14 VAC 5-100-40 1	Each form submitted must have a number which may consist of digits, letters or a combination of both. The number must distinguish the form from all other forms used by the insurer.	
	14 VAC 5-100-40 3	Certificate of Compliance signed by General Counsel or officer of company, or attorney or actuary representing company is required.	
	14 VAC 5-100-40 5	Description of market for which the forms are intended.	
Form Number	14 VAC 5-100-50 1 § 38.2-3500 A 5	Form number must appear in lower left-hand corner of **first page** of each form.	
Company Name & Address	14 VAC 5-100-50 2	Full and proper corporate name (including "Inc." or "The") and address must prominently appear on **cover sheet** of all policies and other forms required to be submitted.	
Final form	14 VAC 5-100-50 3	Form must be submitted in the form in which it will be issued and completed in "John Doe" fashion to indicate its intended use.	
Application	14 VAC 5-100-50 4	Any form, to be issued with an attached application, must be filed with a copy of the application completed in "John Doe" fashion to indicate its intended use. (If an application was previously approved, provide SERFF tracking number or copy with approval date.)	
Type Size	14 VAC 5-100-50 5	Individual Accident and Sickness forms must be printed with type size of at least ten-point type. All other forms must be printed with type size of at least eight-point.	
Table of Contents	14 VAC 5-110-50	Required for a policy with more than three (3) pages for groups with ten (10) or fewer members.	
Readability	14 VAC 5-110-60	Disclose the score, number of words, sentences, and syllables for each form for groups with ten (10) or fewer members.	
Rate Filing	14 VAC 5-130-60	Rate schedule must be updated and certified actuarial memorandum and unified rate review template (URRT) must be provided.	
Additional SERFF Filing Requirements	*Administrative Letter 2012-03*	*Additional SERFF filing requirements must be met as specified below for life and health forms and rate filings. Failure to provide the applicable information may result in a **"REJECTED"** filing.*	
General Information – Filing Description		(i) Description of each form by name, title, edition date, and intended use.	
		(ii) Identification of changes in benefits and premiums (previously approved or filed forms). [Place changed contract provisions (red-lined or highlighted) in Supporting Documentation].	
		(iii) Identification of SERFF or state tracking number for the previously approved or filed form for which the new form revises, replaces, or is intended to be used.	

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		(iv) A statement as to whether any other regulatory body has withdrawn approval of the form because the form contains one or more provisions that were deemed to be misleading, deceptive or contrary to public policy.	
MCHIP Requirements			
		Regarding the plan submitted with this filing, is the provider network consistent with the information previously filed and approved under Section 38.2-5802? ☐ Yes ☐ No If no, this filing must include the following: 1. A detailed description of the criteria used to determine how a provider is included in the network or allocated to a tier within the network. 2. An explanation of whether or not the network changed or tiered network will result in any material change in the method of operation that is currently on file with the Financial Regulation Division. Pursuant to Administrative Letter 1998-11, any change that increases or decreases, or is likely to increase or decrease a health carrier's revenues, expenses, or net worth in an amount that exceeds 5% of the health carrier's current net worth qualifies as a material change that must receive prior approval from the Financial Regulation Division. 3. A response as to whether or not the Virginia Department of Health (VDH) has determined that the network is adequate.	
Provider Lists/Service Area	§ 38.2-5803 A 1	List of providers and their locations shall be available to the enrollee. If an electronic version is made available, the coverage document must include a direct workable URL so that the insured can access the specific provider directory applicable to that particular plan. The insured must not be required to log in to access this information, and must be provided all information necessary to determine the applicable provider network.	
Service Area	§ 38.2-5803 A 2	Description of service area or areas shall be described in the policy.	
Complaints	§ 38.2-5803 A 3	Description of method of resolving complaints.	
Bureau of Insurance & Department of Health Notice	§ 38.2-5803 A 4	Each EOC shall contain a notice: "This Company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1."	
Ombudsman Notice	§ 38.2-5803 A 5	A prominent notice in the EOC stating: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice must also include the toll free telephone number, mailing address and electronic mailing address of the Office of the Managed Care Ombudsman.	
General Provisions			
Contents of Policies/Important Notice	§ 38.2-305 A & B	Each policy shall specify: (1) names of parties to contract, (2) subject of insurance, (3) risk insured against, (4) time the insurance takes effect and period during which insurance is to continue, (5) a statement of premium, except in the case of group insurance, (6) conditions	

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		pertaining to insurance. Policy must also contain an important notice regarding who to contact with questions.	
Insurance Fraud Notice Not Applicable	§ 38.2-316 D 1	Any notice citing Code of Virginia § 52-40 defining insurance fraud and penalties associated with this section must be removed. This section does not apply to accident and sickness insurance.	
Misrepresentation	§ 38.2-316 D 3	No form shall contain any provision that encourages misrepresentation or is misleading, deceptive or contrary to the public policy.	
Medicaid Eligibility/Status Prohibited	§ 38.2-508.3	When considering eligibility, Medicaid eligibility cannot be a factor, and when determining a claim, Medicaid status cannot be a factor.	
Subrogation	§ 38.2-3405 A	Policy cannot allow subrogation of any person's right to recovery for personal injuries from a third party.	
COB/Liability Coverage Prohibited	§ 38.2-3405 B	No plan shall require beneficiary to pay back any benefits from the proceeds of a recovery by such beneficiary from any other source. This provision shall not prohibit an exclusion of benefits paid under worker comp laws or govt. programs nor shall it prohibit coordination of benefits between insurance contracts.	
Worker's Compensation Exclusion	§ 38.2-3405 D	Under specified circumstances, issuers shall not exclude coverage for any medical condition whenever benefits payable under workers compensation are excluded from coverage.	
Denial of Certain Prescription Drugs Prohibited	§ 38.2-3407.5	Each EOC must contain language indicating benefits will not be denied for any USFDA approved drug to treat cancer because the drug has not been approved by the FDA for that specific type of cancer for which the drug has been prescribed, if the drug is recognized as safe and effective for treatment of that specific type of cancer in standard reference compendia.	
Denial of Benefits for Certain Prescription Drugs Prohibited	§ 38.2-3407.6:1	Each EOC must contain language indicating benefits will not be denied for any FDA approved drug to treat cancer pain because the dosage is in excess of recommended dosage, if prescribed for a patient with intractable cancer pain.	
Ambulance Services	§ 38.2-3407.9	For ambulance services, any such person shall receive reimbursement for such services directly from the issuer of the policy, when the issuer is presented with an assignment of benefits by the person providing such services.	
Prescription Drug Formularies	§ 38.2-3407.9:01 B 1, 2, 3	For plans using closed formularies, plan must have a process to allow medically necessary non-formulary prescription drug if the formulary drug is determined by the health services plan and physician to be inappropriate therapy. Requests must be acted on within one business day of receipt. See specific subsections of the Code.	
Exclusion of Prescription Drug Coverage Prohibited	§ 38.2-3407.9:02	Prescription drugs shall not be excluded from coverage solely on the basis of the length of time since the drug obtained FDA approval.	
Provider Continuation – Active Treatment	§ 38.2-3407.10 F 1	Terminated provider may continue to treat enrollee for 90 days, if enrollee is under active course of treatment with provider, enrollee requests such continuing care, and provider has not been terminated for cause.	
Provider Continuation –	§ 38.2-3407.10 F 2	Terminated provider may continue to treat enrollee, who has entered 2nd trimester of pregnancy at	

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Pregnancy		the time of provider's termination, except when provider is terminated for cause. Treatment may continue through postpartum care.	
Provider Continuation – Terminal Illness	§ 38.2-3407.10 F 3	Terminated provider may continue to treat enrollee who is determined to be terminally ill at the time of provider's termination, except when the provider is terminated for cause. Treatment may continue for duration of enrollee's life for care of terminal illness.	
Reduction of Benefits	§ 38.2-3407.10 M	Carriers shall provide group policyholders written notice of any benefit reductions. Policyholders shall provide employees written notice of benefit reductions.	
Access to Specialists-Standing Referrals	§ 38.2-3407.11:1	The plan must permit any enrollee a standing referral as provided in subsection B of this statute.	
Standing Referrals for Cancer Patients	§ 38.2-3407.11:2	The plan must place a procedure in place to permit an enrollee diagnosed with cancer to have a standing referral to a board-certified physician in pain management oncologist.	
Claims Paid to Insureds for Services from Nonpar. Provider	§ 38.2-3407.13:2	The certificate and explanation of benefit must include notice for the enrollees, for services performed by a non-participating provider, informing the enrollee of his or her responsibility to apply the plan payment to the claim from such non-participating provider.	
Orally Administered Cancer Chemotherapy Drugs	§ 38.2-3407.18	Carriers shall include coverage for cancer chemotherapy drugs administered orally and intravenously or by injection and shall provide that the durational limits, deductibles, coinsurance factors and copayments for orally administered cancer chemotherapy drugs shall have consistently applied criteria within the same plan as those for cancer chemotherapy drugs that are administered intravenously or by injection.	
Exclusion or Reduction of Benefits	§ 38.2-3415	No plan shall reduce or exclude any benefits because benefits have been payable under any individual policy.	
Waiting Period	§ 38.2-3452	Waiting period for group enrollee shall be no longer than 90 days before being eligible for coverage (Small Group).	
Pharmacy Freedom Choice	§ 38.2-4209.1	If plan has outpatient prescription drug benefits, plan must allow for freedom of choice of pharmacies, if non-participating pharmacies agree in writing to accept reimbursement, including copayment, at the same rates as participating pharmacies.	
Dependent Coverage	PHSA §2714 (45 CFR §147.120) § 38.2-3409 § 38.2-3411 § 38.2-3411.2 § 38.2-3439	Dependent children who are incapable of self-sustaining employment by reason of intellectual disability or physical handicap shall be covered beyond the specified age. Plan shall provide newborn coverage from the moment of birth. Coverage must be same as for the insured including congenital defects and birth abnormalities. Must notify Insurer within 31 days of birth for coverage to continue. Any insurance benefits applicable for children under the policy shall be payable with respect to adopted children or children placed in foster care. If a policy offers dependent coverage, it must include dependent coverage to age 26 without restriction to financial dependency, residency, marital, student or employment status, or eligibility for other coverage.	
Annual and Lifetime	PHSA §2711	This limits the ability for companies to impose annual and lifetime dollar limits on essential health	

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Limits	(45 CFR §147.126) § 38.2-3440	benefits in and out-of-network. Note: The prohibition of annual and lifetime limits applies only to **dollar limits on EHBs.** Routine adult dental and cosmetic orthodontia may include annual and lifetime dollar limits; however, medically necessary orthodontia for children under age 19 may not include annual or lifetime dollar limits.	
Rescissions	PHSA §2712 (45 CFR §147.128) § 38.2-3441	Rescissions are prohibited except for an act, practice, or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact in the application. The insurer must provide at least 30 days advance written or electronic notice to each participant who would be affected before coverage may be rescinded.	
Preventive Services	PHSA §2713 (45 CFR §147.130) § 38.2-3442	This requires non-grandfathered plans to cover in network preventive health and wellness services without out-of-pocket cost-sharing (co-insurance, co-payment or deductible). **See EHB checklist**	
Access to OB/GYN	PHSA §2719A (45 CFR §147.138) § 38.2-3443	The plan must not require prior authorization or referral requirements for obstetrical or gynecological care if care is provided by in-network providers specializing in obstetrics or gynecology. A health carrier shall provide notice to a covered person of the terms and conditions of the plan related to the designation of a participating healthcare professional.	
No Pre-existing Condition Exclusions	PHSA §2704 and §1255 (45 CFR §147.108) § 38.2-3444	Issuers may not impose pre-existing condition exclusions.	
Emergency Services	PHSA §2719A (45 CFR §147.138) § 38.2-3445	Plans must cover in and out-of-area emergency services, including ambulance services available 24 hours a day, 7 days a week. Plans must cover emergency services. Such coverage must be without requirements for prior authorization or requirement that service be provided by a participating provider. Cost sharing (copay and coinsurance amounts) must not differ from the in-network level. Deductibles and out-of-pocket maximums that apply generally to out-of-network benefits may be imposed on out-of-network emergency services. Plans must pay for out of network emergency services the greatest of: (1) the median in-network rate; (2) the usual and customary rate (or similar rate determined using the issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	
Emergency Services Definitions	PHSA §2719A (45 CFR §147.138) § 38.2-3438	"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	

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		attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus." "Emergency services means with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department to evaluate the condition; and within the capabilities of the staff/facilities available at the hospital, examination/ treatment required to stabilize the patient." "Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta."	
Primary Care Providers	PHSA §2713 (45 CFR §147.130) § 38.2-3443	Network plans requiring or providing for a primary care health professional to be designated must: 1. allow each enrollee to designate any participating primary healthcare professional who is available to accept such individual. 2. a participating healthcare professional specializing in pediatrics and available to accept children may be designated as primary healthcare provider. 3. Notice of these is required when carrier provides primary subscriber with a policy, certificate, or contract of health insurance.	
Provider Nondiscrimination	PHSA §2706 § 38.2-4221	Providers operating within their scope of practice, license or certification cannot be discriminated against.	
Nondiscriminatory Benefit Design	45 CFR §156.200(e) and 45 CFR §156.225 § 38.2-326	QHPs shall not use benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. QHPs shall not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.	
"Michelle's Law"	PHSA §2728 (45 CFR §147.145) § 38.2-3525 E (Small Group)	**Coverage for dependent student on <u>medically necessary leave of absence</u> ("Michelle's Law")** ☐ Issuer cannot terminate coverage due to a medically necessary leave of absence before: • The date that is 1 year after the first day of the leave; or • The date on which coverage would otherwise terminate under the terms of the coverage. ☐ Change in benefits prohibited – child on medically necessary leave of absence is entitled to the same benefits as if the child continued to be a covered student who was not on a medically necessary leave of absence; however, if there is a change in the manner in which	

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		the beneficiary/parent is covered and continues to cover the dependent, the changed coverage will apply for the remainder of the period of the medically necessary leave of absence. ☐ Eligibility for protections: a dependent child under the terms of the coverage of the beneficiary, enrolled in the coverage on the basis of being a student immediately before the first day of the medically necessary leave of absence involved. ☐ Medically necessary leave of absence means: a leave of absence or change of enrollment of a dependent child from a postsecondary education institution that: 1. Commences while the child is suffering from a serious illness or injury; 2. Is medically necessary; and 3. Causes the child to lose student status for purposes of coverage under the terms of coverage. ☐ Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the terms for continued coverage during medically necessary leaves of absence.	
Cost Sharing Limits	42 USC §18022 26 USC §223(c)(2) (A)(ii) 2016 Notice of Benefit and Payment Parameters § 38.2-3451	Cost-sharing in-network limited to maximum out-of-pocket for high deductible health plans in 2014 (adjusted by IRS), increased by this amount multiplied by the premium adjustment percentage set by HHS ($6,850 individual/$13,700 family for 2016). Cost-sharing includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense for EHB covered under the plan. Non EHB cost-sharing may contribute to cost-sharing limit. Qualified medical expense means an expense paid by the insured person for medical care for her/himself, covered spouse, and covered dependent(s) that are not compensated for by insurance or otherwise. Plans that use separate service providers may have non-integrated maximum out-of-pocket limits as long as the total amount for the plan does not exceed the 2016 cost-sharing limit. Mental health/substance abuse benefits must not have separate limits than other services in general. The contract must clearly describe any and all out-of-pocket maximums and deductible limits. For family limits on cost sharing, the contract must not show limits or maximums for an individual unless that limit or maximum may apply.	

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Guaranteed Renewability	PHSA §2702 (45 CFR §146.152, 147.106, and 148.122) (See also § 38.2-3432.1, § 38.2-3514.2 and § 38.2-3430.7)	Coverage is guaranteed renewable at the option of the insured and may be limited to when an individual lives, works, or resides in the service area. May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or coverage is uniformly terminated. Medicare eligibility or entitlement is not a basis for non-renewal or cancellation. **NOTE: Student health plans are not subject to Guaranteed Renewability and Guaranteed Availability.**	
Renewability (Group Only)	§ 38.2-3432.1 2015 Letter to Issuers in the Federally-facilitated Marketplace	Each insurer shall renew or continue in force coverage with respect to all insureds at the option of the employer with specific exceptions listed in this section of the Code. On the SHOP, carrier must renew a group even if it does not meet Exchange participation requirements if that group renews during the open enrollment period.	
Renewability of Individual Health Insurance Coverage	§ 38.2-3514.2 § 38.2-3430.7	Renewal is at the option of the individual, except for specific reasons expressed in the statutes.	
Cancellation by Insured (Individual Only)	§ 38.2-3503.13	The enrollee may cancel this policy at any time by written notice to the company. In the event of cancellation, the company shall promptly return the unearned portion of any premium; the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.	
Termination Notice Employer	§ 38.2-3542	Notice must be given to employer at least 15 days prior to terminating contract due to non-payment of premiums.	
Continuation (Group Only)	§ 38.2-3541	Each policy shall contain a provision that sets forth a provision for continuation of coverage.	
Explanation of Internal Appeals Process	45 CFR §147.136 29 CFR §2560.503-1 § 38.2-305 § 38.2-3570 § 38.2-5803 14 VAC 5-216-30	**Specific requirements to be included in or attached to policy:** 1. The procedure must identify timeframes to submit internal appeals on a standard, concurrent or urgent care basis, and timeframes for the issuer to respond to these appeals in accordance with federal and state law; 2. No fee can be charged for appeals process; 3. The procedures must not unduly inhibit initiation or processing of claims; 4. Plans must include contact information for enrollee to submit an appeal, including name, address, and phone number; 5. Issuer must allow an authorized representative of the claimant to act on behalf of the claimant in pursuing a benefit claim or appeal of an adverse benefit determination. In an urgent care appeal, the issuer must recognize a health care professional with knowledge of the person's medical condition as an authorized representative. 6. Plans must include required contact information for the Bureau; and 7. (For MCHIPs) Plans must include the required statement in VA Code § 38.2-5803 A 5 to include contact information for the Office of the Managed Care Ombudsman, indicating the mailing address, email address and local and toll-free phone number.	

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Explanation of Right to External Review	45 CFR §147.136 29 CFR §2560.503-1 § 38.2-3570	**Specific requirements to be included in or attached to policy:** 1. An explanation of the right to file a request for external review of adverse determinations or final adverse determinations with the Bureau, including an explanation of those determinations eligible for external review: determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination that a service is experimental/investigational; 2. Notification that the enrollee will be required to authorize the release of medical records required for the external review.	
Claims Procedures	45 CFR §147.136 29 CFR §2560.503-1	**The following rules relate to requirements for initial adverse benefit determinations. These processes fall under the jurisdiction of the Virginia Department of Health (VDH), Office of Licensure and Certification, and are included in this checklist for informational purposes only. <u>The Bureau does not speak for VDH, and any VDH requirements or guidelines take precedence over this information.</u>** **General requirements for Claims Procedures:** 1. required to include a description of: a. claims procedures, b. procedures for obtaining prior approval, c. preauthorization procedures, d. utilization review procedures, and e. applicable time frames 2. The claims procedure cannot unduly inhibit the initiation or processing of claims. A <u>claim for benefits</u> is a request for benefits made by a claimant in accordance with an issuer's reasonable procedure for filing benefit claims, including pre-service and post-service claims. **Time and process for urgent care (pre-service, post-service):** 1. Determination for urgent care must be made within 72 hours. 2. Notice of the determination within 72 hours of receipt of the claim. 3. Notice of urgent care decisions must include a description of the expedited review process applicable to such claim. 4. No extension of the determination time-frame is permitted. 5. If the claimant fails to provide sufficient information, issuer must notify the claimant within 24 hours and must include specific information necessary to complete the claim. 6. The claimant must have at least 48 hours to provide the specified information. 7. A determination must be made within 48 hours of receiving specified information or expiration of time afforded to the claimant to provide the specified information (whichever is earlier).	

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		Time and process for concurrent urgent care (at the request of the claimant): 1. Claim for concurrent urgent care: Refers to a claimant requesting to extend the course of treatment beyond time/number of treatments. 2. Claim for concurrent urgent care: if a claimant requests to extend the course of treatment beyond time/number of treatments. 3. Claim must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. 4. Determination must be made within 24 hours. 5. Notification is required within 24 hours of the claimant's request. **Time and process for pre-service claim:** 1. Determination and notification for a pre-service claim must be made within 15 days of the request of the claim. 2. Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. 3. Notice required of the extension prior to the expiration of the initial 15-day period. 4. The issuer must identify for the claimant the circumstances requiring the extension and date by which the issuer expects to render a decision. 5. If the claimant fails to provide sufficient information, the issuer must notify the claimant and specifically describe the required information needed to render a decision. 6. Claimant has 45 days from receipt of notice of insufficient information to provide specified information. **Time and process for on-going services/treatment (concurrent care decisions):** 1. Reduction/termination of benefits of ongoing courses of treatment (concurrent care) before the end of the time/treatments is considered an adverse benefit determination. 2. Determination and notice of determination for concurrent care must be made sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. **Time and process for post-service claim:** 1. Determination for post-service claim must be made within 30 days of receipt of claim. 2. Notice of the determination must be made within 30 days of receipt of the claim. 3. Determination extension up to 15 days is allowed if necessary due to matters beyond the control of the issuer. Notice of the extension must be provided to the claimant prior to expiration of the initial 30-day period. The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision. 4. If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information necessary to render a decision. The claimant has at	

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	§ 38.2-3559 § 38.2-3562 § 38.2-3563 § 38.2-5803 14 VAC 5-216-30 14 VAC 5-216-40 14 VAC 5-216-70 Administrative Letter 2011-05	least 45 days from the receipt of notice to provide the specified information. **Standards for all required notices: (This information is not required to be in the policy, but nothing in the policy may conflict.)** 1. Issuer must provide the claimant with written or electronic notification of any adverse benefit determination for pre-service, post-service, and concurrent treatment claims. 2. All notices of adverse benefit determination (including final internal adverse benefit determinations) must be provided in a culturally and linguistically appropriate manner and must include: a. In the English version, a statement prominently displayed in any applicable non-English language indicating how to access the issuer's language services; b. Information sufficient to identify the claim involved including date of service, health care provider, claim amount, and, upon request, diagnosis/treatment codes and their meanings; c. Specific reason for the adverse benefit determination, including the denial code and its corresponding meaning and a description of the issuer's standard that was used in denying the claim; d. Diagnosis/treatment codes and meanings must be provided as soon as practicable. Requests for this information cannot be considered a request for an internal appeal or external review; e. Statement indicating that the claimant has access to all documents related to claim; f. applicable expedited review process; g. a description of available internal appeals and external review processes (to include applicable timeframes for enrollee submission and issuer response – standard and expedited or urgent care); h. contact information to submit appeal or complaint – name, address, telephone number; i. claimant's right to bring civil action under §502(a) of ERISA if applicable; j. availability of and contact information for health insurance consumer assistance or, if MCHIP, ombudsman; and k. claimant's right to request an external review if he or she has not received a final benefit determination within the required timeframes, unless the claimant agreed to the delay. 3. An **adverse determination** must describe: a. all of the information in an adverse benefit determination; b. required language of VA Code § 38.2-3559; c. process in which an external review may be requested if issuer does not meet review timeframes; d. website and phone number to assist claimant in requesting an external review in the above circumstance; and	

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		e. notice that an expedited review: (i) is available if medically needed or for experimental/investigational treatments; and (ii) can be requested at the same time as an expedited internal appeal.	
Internal Appeals	PHSA §2719 (45 CFR §147.136) 14 VAC 5-216-40	***Procedures described in the policy should reflect these timeframes and not contradict this process.*** **Internal appeals of adverse benefit determinations - processes, rights and required notices:** 1. Enrollees have a right to one internal appeal of an adverse benefit determination. 2. Enrollees may review the claim file and present evidence and testimony as part of the internal appeals process. 3. Enrollees have at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal. 4. Enrollees must have access to an expedited review process. Requests for expedited review must be allowed to be submitted orally or in writing. 5. A clinical peer reviewer must review appeals involving medical judgment. 6. Appeal reviewer must not be involved with previous claim. 7. Issuer must identify person rendering any expert advice. ***Procedures described in the policy should reflect these timeframes and not contradict this process.*** **In addition to adverse benefit determination and adverse determination requirements, a final adverse determination notification must include:** 1. A statement that the communication represents a final adverse determination; 2. Forms necessary to request an external review; and 3. Notice of expedited external review available if the decision involves emergency care, and patient has not been discharged from facility. <u>Pre-service claim</u>: Determination and notification must be made within 30 days after receipt of the claimant's request. <u>Post-service claim</u>: Determination and notification must be made within 60 days after receipt of the claimant's request.	
	14 VAC 5-216-50	<u>Urgent claim</u>: 1. Determination and notification must be made within 72 hours after receipt of the claimant's request. a. If claimant fails to provide sufficient information to determine covered/payable benefits for an urgent claim, the issuer must: i. Notify the claimant within 24 hours of the information necessary to complete the claim.	

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	§ 38.2-3560 14 VAC 5-216-20 14 VAC 5-216-30 14 VAC 5-216-45	ii. Give the claimant at least 48 hours to provide the specified information. iii. Provide notice of the determination within 48 hours of the earlier of receiving the specified information and the end of the time period provided to return the specified information. Notice must be provided in the most expeditious method available. The issuer must provide the claimant with written or electronic notice of the determination in a culturally and linguistically appropriate manner. An <u>adverse benefit determination</u> means a denial, reductions, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage or any decision to deny individual coverage in an initial eligibility determination must be treated as an adverse benefit determination. An <u>adverse determination</u> means a determination by a health carrier or utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested service of payment is denied, reduced, or terminated. If an issuer fails to adhere to all of the requirements listed with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate an external review or any remedies available under State law. *The following does not need to be stated as part of the process, but must not be contradicted in the policy:* 1. The internal claims and appeals process will not be deemed exhausted if the violation did not cause harm to the claimant so long as the issuer demonstrates that the violation was for good cause or due to matters beyond the control of the issuer, and 2. That the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the claimant. 3. Violations that are part of a pattern by the issuer will not be deemed de minimis. <u>Ongoing (concurrent care) decisions</u>:	

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	14 VAC 5-216-60	1. Issuer is required to provide continued coverage pending the outcome of an appeal; 2. Issuer must notify enrollee of decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow enrollee to file an internal appeal and receive a determination prior to the reduction or termination.	
External Review	PHSA §2719 (45 CFR §147.136) § 38.2-3556 § 38.2-3559 § 38.2-3560 § 38.2-3563 § 38.2-3564 § 38.2-3569 14 VAC 5-216-45	**External review processes rights and required notices:** External review of an adverse determination for: 1. medical necessity; 2. appropriateness; 3. health care setting; 4. level of care; or 5. effectiveness of a covered benefit. External review of adverse determinations for experimental or investigational treatments or services. *Process should reflect the following:* 1. Have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. 2. Issuers must provide effective written notice to claimants of external review rights in plan materials, and in each notice of adverse benefit determination. 3. Exhaustion of internal appeals is required prior to external review. The process shall be deemed exhausted: a. if issuer did not meet internal appeal process timelines (with limited exceptions) or otherwise violated the provisions of the appeal process; or b. in cases of an urgent care appeal. 4. Cost of an external review must be borne by the issuer. 5. Claimant cannot be charged a filing fee. 6. Restriction on the minimum dollar amount of a claim is not allowed. 7. Claimant has 120 days to file for external review after the receipt of the right to an external review of an adverse determination (including final internal adverse determination). 8. IRO decision is binding on the issuer. 9. For standard reviews (not urgent), the IRO must inform the issuer and the claimant in writing of its decision within 45 days from the Independent Review Entity's receipt of the request for review. Urgent care: 1. The process must provide for expedited external review of urgent care claims. 2. The IRO must inform the issuer, the claimant, and the Bureau of an urgent care decision within 72 hours from receipt of an eligible request for review.	

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		If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification.	
Enrollment Periods for Qualified Individuals	45 CFR §155.725 45 CFR §155.420 § 38.2-3432.3 § 38.2-3448 45 CFR §146.117 § 38.2-3432.3 § 38.2-3448 45 CFR §155.410 45 CFR §155.420 § 38.2-3448 45 CFR §147.104 45 CFR §155.420 § 38.2-3448	**Provide and disclose enrollment periods for qualified individuals:** **SHOP** – Special enrollment periods available for 30 days from the date of the following: Loss of minimum essential coverage; marriage, birth, adoption, placement for adoption, placement in foster care; unintentional enrollment or non-enrollment in a QHP; violation by QHP of material contract provision; permanent move; Native American; other exceptional circumstances; misconduct in enrollment assistance. Special enrollment for Medicaid/FAMIS – 60 days **Small Group** – 30 days from the date of the following: Employee or dependent loss of coverage; termination of employer contributions; exhaustion of COBRA continuation coverage; marriage, birth, adoption or placement for adoption. **Individual Market** special enrollment – **On Exchange** – 60 days from the date of the following: Loss of minimum essential coverage; marriage, birth, adoption, placement for adoption, placement in foster care; individual gains citizenship, national, or lawfully present; unintentional enrollment or non-enrollment in a QHP; violation by QHP of material contract provision; newly eligible for premium tax credit; permanent move; Native American; other exceptional circumstances; misconduct in enrollment assistance. **Individual Market – Off Exchange** – 60 days from the date of the following: Loss of minimum essential coverage; marriage, birth adoption, placement for adoption, placement in foster care; unintentional enrollment or non-enrollment in a QHP; violation by QHP of material contract provision; newly eligible for premium tax credit; permanent move; misconduct in enrollment assistance.	