FILED

JAN 17, 2014

Hearings Unit, OIC
Patricia D. Petersen
Chief Hearing Officer

STATE OF WASHINGTON
BEFORE THE WASHINGTON STATE
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of: **Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings.**	**Docket No. 13-0293** **SEATTLE CHILDREN'S HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT**

I. RELIEF REQUESTED

Plaintiff Seattle Children's Hospital (SCH) asks for partial summary judgment, ruling as a matter of law that the OIC, in its review and approval of the Exchange plan rate request filings for Coordinated Care Corporation (CCC), BridgeSpan Health Company, and Premera Blue Cross: (1) failed to consider or apply controlling federal law under the Affordable Care Act, which requires that Exchange plans include pediatric hospital services within their networks unless certain conditions are shown to exist; (2) failed to give required consideration to the unique pediatric services available in this state only at SCH; and (3) failed to consider the consequences of allowing these plans to exclude SCH from their exchange networks.

II. BACKGROUND

The OIC approved the following individual market Exchange rate request filings on the following dates:

Carrier	Date of OIC Decision	Request ID #
Coordinated Care Corporation	September 5, 2013	259755
Premera Blue Cross	July 31, 2013	254695
Bridgespan Health Company	July 31, 2013	254781

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The OIC initially rejected each plan's filings, based in part on lack of network adequacy, but reversed itself, for unknown reasons, with respect to Premera and Bridgespan. CCC requested adjudication, in which it prevailed on the question whether RCW 48.46.030 or WAC 284-43-200 require pediatric specialty hospitals to be included in exchange plan networks. According to the Chief Hearing Officer's decision, the OIC staff took inconsistent positions on the question and could not identify a single pediatric service that CCC's current network could not provide, except for NICU services. Declaration of Michael Madden Ex. D at p. 7. The decision also indicated that "spot contracting" can cure defects in network adequacy. *Id.* at pp. 11-12.

SCH timely appealed all three approvals pursuant to RCW 48.04.010(1)(b) because it adversely impacted them in numerous ways. None of these OIC-approved Exchange plans has contracted with SCH to provide services to plan participants. SCH is the only pediatric hospital in King County and the preeminent provider of pediatric specialty services in the Northwest. Declaration of Eileen O'Connor, at ¶¶ 4-7. Many of these services are not available elsewhere in the Northwest. *Id.* There is no reason to believe that the care needs of children covered by Exchange plans will be significantly different than those of SCH's other patient populations. Inevitably, children covered by the challenged Exchange plans will require services available only at SCH, but they will be able to access those services only on an out-of-network basis, which generally carries with it the obligation to pay a higher percentage of "co-insurance." As a result, children covered by these plans who are in need of SCH's care are more likely to experience delay, meaning that when they present for care they will be more acutely ill and require additional or more complex services. These patients will consume more resources, thereby reducing resources available for other SCH patients and impairing the ability of SCH to serve the pediatric healthcare needs of the region.

SCH anticipates financial loss or injury will arise primarily from the anticipated use of SCH services, due to lack of availability elsewhere, by numerous enrollees in these Exchange plans despite the exclusion of SCH from the plan's networks, resulting in payment for those

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services either at out-of-network rates, or under arrangements made by spot-contracting, which will result in financial loss to SCH due to inadequate payment rates and the administrative burden of the spot-contracting arrangements. Spot-contracting also, by definition, involves out-of-network care, and should not be taken into consideration when determining network adequacy.

III. SUMMARY OF ARGUMENT

The Affordable Care Act ("ACA") and accompanying regulations expressly require that qualified health plans offering their products through state-operated exchanges must include pediatric services, including pediatric hospital services, within their networks.[1] Although these requirements apply to the OIC's approval process,[2] it is apparent from the CCC record that the OIC staff did not recognize their importance and therefore failed to ask or answer the relevant questions under the ACA. Under these circumstances, SCH is entitled to partial summary judgment, vacating the prior approvals and directing the staff to review the applications under the proper ACA standards. *See Children's Hosp. & Med. Ctr. v. Washington State Dep't of Health*, 95 Wn. App. 858, 871, 975 P.2d 567 (1999) (no deference owed to agency actions based on erroneous interpretation of law).

Additionally, it appears that the OIC was misinformed or uninformed as to (a) the nature and extent of pediatric services that are available only through Seattle Children's, particularly in King County and north; (b) the consequences of allowing spot contracting as a substitute for network inclusion in these circumstances; and (c) inclusion of SCH in Premera's exchange plan network. On each of these questions, the undisputed facts are contrary to the assumptions upon

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[1] *See* 42 U.S.C. § 18022(b)(1) (requiring regulations defining "essential health benefits" to include pediatric services); 42 U.S.C. § 18031(c)(1)(requiring regulations for certification of qualified health plans to include, "at a minimum," certain "essential community providers," including children's hospitals, "within their health plan networks"); 45 CFR § 156.110 (establishing exchange plan benchmark standards that include "pediatric services"); 45 CFR 156.230-.235 (requiring QHP's to include essential community providers in their networks).

[2] 42 U.S.C. § 18031(b); RCW 48.43.715.

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which OIC apparently based its decision. For these reasons also, the OIC's approvals should be vacated with a direction to re-review based on an adequate record.

ISSUES PRESENTED

In the OIC's review and approval of the Exchange plans from BridgeSpan, Premera, and CCC:

1. Was the OIC required to consider and comply with federal law, including 42 U.S.C. § 18022(b)(1), and 42 U.S.C. § 18031(c)(1)(C), as well as 45 C.F.R. § 156.020, § 156.110, § 156.115, § 156.200, § 156.230, and § 156.235?

2. Did the OIC fail to consider and comply with 42 U.S.C. § 18022(b)(1), and 42 U.S.C. § 18031(c)(1)(C), as well as 45 C.F.R. § 156.020, § 156.110, § 156.115, § 156.200, § 156.230, and § 156.235?

3. Did the OIC fail to give required consideration to the unique services provided at SCH?

4. Did the OIC fail to take into consideration the fact that SCH is not an "in-network" provider?

IV. EVIDENCE RELIED UPON

SCH relies upon the accompanying Declaration of Michael Madden, together with the exhibits thereto, the accompanying Declaration of Eileen O'Connor, together with the exhibits thereto, and the records and files herein.

V. ANALYSIS

Under CR 56, summary judgment is appropriate where "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Id., see also, e.g., Eugster v. State,* 171 Wn.2d 839, 843, 259 P.3d 146 (2011).

A. Federal, and enabling state law, requires Exchange plans to include SCH, a pediatric hospital and essential community provider providing essential health benefits.

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Congress requires state Exchange plans to cover ten "essential health benefits." 42 U.S.C. § 18022(b)(1). One of those ten essentials is "pediatric services, including oral and vision care." *Id.* The HHS regulations require "that each QHP complies with benefit design standards," 45 C.F.R. § 156.200, which are defined to include "[t]he essential health benefits as described in section 1302(b) [42 U.S.C. § 18022(b)]". 45.C.F.R. § 156.20. The HHS regulations further require that a state's "benchmark" Exchange plan must include these ten essential health benefits. 45 C.F.R. § 156.110.

Congress further provided, in 42 U.S.C. § 18031(c)(1), that "essential community providers" must be included in qualified health plans' networks:

> The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, **to be certified, a plan shall, at a minimum—**
>
> ***
>
> (C) **include within health insurance plan networks those essential community providers,** where available, that serve predominately low-income, medically-underserved individuals, **such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. § 256b(a)(4)]** .... [Emphasis added.]

42 U.S.C. § 256b(a)(4)(M) refers to "A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act [42 U.S.C. § 1395ww (d)(1)(B)(iii)]," which in turn references hospitals, "whose inpatients are predominantly individuals under 18 years of age." The relevant HHS regulations similarly provide that carriers must ensure that their Exchange plans "include[] essential community providers," 45 C.F.R. § 156.230, which are defined to include children's hospitals:

> **Essential community providers are** providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section...:
> (1) **Health care providers defined in section 340B(a)(4) of the PHS Act [42 USC § 256(b)(a)(4)];**.... [Emphasis added.]

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45 C.F.R. § 156.235(c), SCH is listed in CMS's database of Essential Community Providers.[3] The OIC has admitted that SCH is an Essential Community Provider. Madden Decl. Ex. A, at p. 3.

States have an obligation to ensure compliance with these two federal requirements. As to compliance with the essential health benefits requirement, a state Exchange must certify that any plan listed on its Exchange is a "qualified health plan," which requires that the plan offer the essential health benefits described in 42 U.S.C. § 18022. 42 U.S.C. § 18021. State law also specifically requires the Commissioner to ensure compliance with the essential health benefits requirement. RCW 48.43.715 provides:

> (3) A health plan required to offer the essential health benefits ... under P.L. 111-148 of 2010, as amended [42 U.S.C. §§ 18022], may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, **the commissioner**:
>
> (a) **Must ensure that the plan covers the ten essential health benefits** categories specified in section 1302 of P.L. 111-148 of 2010, as amended; [Emphasis added.]

The same requirement is found in the OIC's recently adopted Exchange plan rule, WAC 284-43-849, which provides:

> For plan years beginning on or after January 1, 2014, **each** nongrandfathered **health benefit plan offered,** issued, or renewed to small employers or individuals, both **inside** and outside **the Washington health benefit exchange, must provide coverage for a package of essential health benefits,** pursuant to RCW 48.43.715. [Emphasis added.]

As to compliance with the essential community providers requirement, 42 U.S.C. § 18031(b)(1) requires each state to "facilitate[] the purchase of qualified health plans" on its Exchange, with "qualified health plan" defined as a health plan that "complies with the regulations developed by the Secretary." 42 U.S.C. § 18021(a)(1).

Both federal and state law therefore impose two requirements on Exchange plans: (1) that they include essential health benefits, and (2) that they include essential community providers in

[3] *See* https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq (last accessed January 17, 2014).

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their networks. Plans can be excused from the latter requirement only if a "provider refuses to accept the generally applicable payment rates of such plan." 42 USC §180310(c)(2); *also see* WAC 284-43-200 (as part of Commissioner's consideration of network adequacy, he must consider the "relative availability of providers, which "includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions").

B. The OIC failed to consider these mandatory requirements.

There is no dispute here that SCH is an essential community provider; the OIC has admitted this. Madden Decl. Ex. A at p.3. There also can be no dispute here that SCH, the only pediatric hospital in King County, providing multiple services that are unique in the state and Northwest, is providing essential health benefits. O'Connor Decl. ¶¶ 4-7 and Ex. B. The OIC appears to dispute, however, its own obligation to ensure compliance with the above two federal requirements. *See* Madden Decl. Ex. A at p. 3. SCH is entitled as a matter of law to a ruling that the OIC was affirmatively required to comply with and consider these two federal requirements in its review and approval of the Bridgespan, Premera, and CCC Exchange plan rate request filings and has failed to do so. Madden Decl. Ex. D at p. 7.

C. The OIC failed to give required consideration to the unique services provided at SCH.

SCH offers many pediatric services that are unique in Washington state. O'Connor Decl. at ¶¶ 4-7 and Ex. B. As just one example, SCH provided 100% of the kidney and liver transplants in Washington state in 2012. *Id.* at ¶ 5. The extensive list of unique services (O'Connor Decl. Ex. B) is undisputed. The OIC has effectively admitted that it had no information regarding SCH's unique services when it approved these Exchange plans without SCH as an in-network provider. Madden Decl. Ex. A at pp. 5-6; Ex. B at pp. 7-8.[4] SCH is entitled to a ruling that, as a matter of law, the OIC failed to take into consideration SCH's unique services. Given the OIC's obligation to ensure that

[4] Because the OIC did not seek any input or participation from SCH, CCC presented testimony at its hearing, "uncontroverted by the OIC," asserting that CCC could provide "99% of covered pediatric ... services" without SCH or other pediatric specialty hospitals. *See* Madden Decl. Ex. D at p. 7.

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Exchange plans provide essential health benefits, including pediatric hospital services, this ruling is highly relevant to the issues in this action.

D. The OIC failed to give required consideration to the fact that SCH is not an in-network provider with these Exchange plans.

SCH also asks for a ruling as a matter of law that the OIC failed to give required consideration to the fact that SCH is not an in-network provider with these Exchange plans. In particular, SCH asks for a ruling that the OIC failed to consider that SCH is not an in-network provider with the Premera Exchange plans.

In response to SCH's request for admission, the OIC admitted that, as to BridgeSpan and CCC, SCH was an "out-of-network" provider, but denied that SCH was an "out-of-network" provider as to Premera. Madden Decl. Ex. A at p. 3. The undisputed facts establish that SCH is out-of-network as to each of these three providers. O'Connor Decl. ¶¶ 2-3.

Premera notified SCH, by letter dated September 30, 2013, that SCH was a "Tier 3" provider with Premera. O'Connor Decl. Ex. A at SCH000092. Premera further stated that "Claims from Tier 3 ... hospitals ... will be processed at the out-of-network benefit levels." *Id.* Premera has informed the OIC that SCH is not in Premera's "Heritage Signature Network." *Id.* at SCH000104. Premera also advised SCH that it was using its "Heritage Signature network for the Exchange products." *Id.* at SCH000090. Premera provided SCH with a list of the hospitals included in Premera's "Heritage Signature Network." SCH was not included on the list. *Id.* at SCH000094-95. The fact that SCH is out-of-network as to Premera's Exchange plans is relevant to the Hearing Unit's determination regarding whether the OIC fulfilled its statutory obligations in reviewing and approving Premera's Exchange plans.

Any argument that the exclusion of SCH as an in-network provider in these Exchange plans is not relevant here is without merit. The OIC, in this action, asserts that an Exchange plan may satisfy its network obligations with out-of-network providers. However, the OIC took the opposite position in the recent CCC proceedings. Madden Decl. Ex. C at p. 12 (OIC motion asserting that the argument that a plan can "satisfy its obligations to provide essential health

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benefits through non-networked providers" is "an express violation of RCW 48.46.030"). The OIC failed to give consideration to the undisputed facts as to how the use of "spot-contracting" to obtain SCH's services as an out-of-network provider causes harm to SCH's patients, and to SCH's ability to provide needed services. O'Connor Decl. ¶¶ 8-12. SCH is entitled to a ruling that, as a matter of law, SCH is not an in-network provider with these plans, and that the OIC may not take into consideration out-of-network providers in its review and determination of network adequacy.

VI. PROPOSED ORDER

A proposed order is attached to the Hearing Unit's copy of this pleading.

VII. CONCLUSION

SCH asks the Hearings Unit for partial summary judgment to determine as a matter of law that the OIC: (1) failed to follow controlling law requiring Exchange plans to include pediatric hospitals such as SCH; (2) failed to give required consideration to the unique pediatric services available in this state only at SCH; and (3) failed to give required consideration to the fact that SCH is not an "in-network" provider in these Exchange plans. Based on these rulings, the approvals should be vacated and remanded to the Commissioner for consideration under proper standards.

RESPECTFULLY SUBMITTED this 17th day of January, 2014.

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By _____

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APPENDIX

Federal Statutes

1. 42 U.S.C. § 18021
2. 42 U.S.C. § 18022
3. 42 U.S.C. § 18031

Federal Regulations

4. 45 C.F.R. § 156.20
5. 45 C.F.R. § 156.110
6. 45 C.F.R. § 156.115
7. 45 C.F.R. § 156.200
8. 45 C.F.R. § 156.230
9. 45 C.F.R. § 156.235

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CERTIFICATE OF SERVICE

I certify that I served a true and correct copy of this document on all parties or their counsel of record on the date below by hand delivery on today's date addressed to the following:

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I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Executed at Seattle, Washington, this 17th day of January, 2014.

Julia Crippen
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EXHIBIT 1

42 USC 18021: Qualified health plan defined
Text contains those laws in effect on January 13, 2014

From Title 42-THE PUBLIC HEALTH AND WELFARE
CHAPTER 157-QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III-AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part A-Establishment of Qualified Health Plans

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§18021. Qualified health plan defined

(a) Qualified health plan

In this title: [1]

(1) In general

The term "qualified health plan" means a health plan that-

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 18031(c) of this title issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 18022(a) of this title; and

(C) is offered by a health insurance issuer that-

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title; [1]

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 18031(d) of this title and such other requirements as an applicable Exchange may establish.

(2) Inclusion of CO–OP plans and multi-State qualified health plans

Any reference in this title [1] to a qualified health plan shall be deemed to include a qualified health plan offered through the CO–OP program under section 18042 of this title, and a multi-State plan under section 18054 of this title, unless specifically provided for otherwise.

(3) Treatment of qualified direct primary care medical home plans

The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

(4) Variation based on rating area

A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 300gg(a)(2) of this title).

(b) Terms relating to health plans

In this title: [1]

(1) Health plan

(A) In general

The term "health plan" means health insurance coverage and a group health plan.

(B) Exception for self-insured plans and MEWAs

Except to the extent specifically provided by this title,[1] the term "health plan" shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 1144 of title 29.

(2) Health insurance coverage and issuer

The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms by section 300gg–91(b) of this title.

(3) Group health plan

The term "group health plan" has the meaning given such term by section 300gg–91(a) of this title.

(Pub. L. 111–148, title I, §1301, title X, §10104(a), Mar. 23, 2010, 124 Stat. 162, 896.)

REFERENCES IN TEXT

This title, where footnoted in text, is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

AMENDMENTS

2010-Subsec. (a)(2) to (4). Pub. L. 111–148, §10104(a), added pars. (2) to (4) and struck out former par. (2). Prior to amendment, text of par. (2) read as follows: "Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 18042 of this title or a community health insurance option under section 18043 of this title, unless specifically provided for otherwise."

[1] *See References in Text note below.*

EXHIBIT 2

42 USC 18022: Essential health benefits requirements
Text contains those laws in effect on January 13, 2014

From Title 42-THE PUBLIC HEALTH AND WELFARE
CHAPTER 157-QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III-AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part A-Establishment of Qualified Health Plans

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§18022. Essential health benefits requirements

(a) Essential health benefits package

In this title,[1] the term "essential health benefits package" means, with respect to any health plan, coverage that-

(1) provides for the essential health benefits defined by the Secretary under subsection (b);
(2) limits cost-sharing for such coverage in accordance with subsection (c); and
(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential health benefits

(1) In general

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.

(2) Limitation

(A) In general

The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) Certification

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) Notice and hearing

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) Required elements for consideration

In defining the essential health benefits under paragraph (1), the Secretary shall-

(A) ensure that such essential health benefits reflect an appropriate balance among the categories

described in such subsection,[2] so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that-

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 18031(b)(2)(B)(ii) [3] of this title (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and [4]

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains-

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) Rule of construction

Nothing in this title [1] shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) Requirements relating to cost-sharing

(1) Annual limitation on cost-sharing

(A) 2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of title 26 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 and later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall-

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) Annual limitation on deductibles for employer-sponsored plans

(A) In general

In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed-

(i) $2,000 in the case of a plan covering a single individual; and

(ii) $4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of title 26 (determined without regard to any salary reduction arrangement).

(B) Indexing of limits

In the case of any plan year beginning in a calendar year after 2014-

(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(C) Actuarial value

The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) Coordination with preventive limits

Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act [42 U.S.C. 300gg–13].

(3) Cost-sharing

In this title- [1]

(A) In general

The term "cost-sharing" includes-

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of title 26) with respect to essential health benefits covered under the plan.

(B) Exceptions

Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) Premium adjustment percentage

For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) Levels of coverage

(1) Levels of coverage defined

The levels of coverage described in this subsection are as follows:

(A) Bronze level

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are

actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) Actuarial value

(A) In general

Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) Employer contributions

The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of title 26) may be taken into account in determining the level of coverage for a plan of the employer.

(C) Application

In determining under this title,[1] the Public Health Service Act [42 U.S.C. 201 et seq.], or title 26 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) Allowable variance

The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) Plan reference

In this title,[1] any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) Catastrophic plan

(1) In general

A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if-

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides-

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); [1] and

(ii) coverage for at least three primary care visits.

(2) Individuals eligible for enrollment

An individual is described in this paragraph for any plan year if the individual-

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title [1] that the individual is exempt from the requirement under section 5000A of title 26 by reason of-

(i) section 5000A(e)(1) of such title (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such title (relating to individuals with hardships).

(3) Restriction to individual market

If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) Child-only plans

If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and

such plan shall be treated as a qualified health plan.

(g) **Payments to Federally-qualified health centers**

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1396a(bb) of this title) for such item or service.

(Pub. L. 111–148, title I, §1302, title X, §10104(b), Mar. 23, 2010, 124 Stat. 163, 896.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a), (b)(5), (d)(2)(C), (4), and (e)(2)(B), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

The Public Health Service Act, referred to in subsec. (d)(2)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 2713, referred to in subsec. (e)(1)(B)(i), probably means section 2713 of act July 1, 1944, which is classified to section 300gg–13 of this title.

AMENDMENTS

2010-Subsec. (d)(2)(B). Pub. L. 111–148, §10104(b)(1), substituted "shall issue" for "may issue".

Subsec. (g). Pub. L. 111–148, §10104(b)(2), added subsec. (g).

[1] *See References in Text note below.*

[2] *So in original. Probably should be "paragraph,".*

[3] *So in original. Probably should be "18031(d)(2)(B)(ii)".*

[4] *So in original. The word "and" probably should not appear.*

EXHIBIT 3

42 USC 18031: Affordable choices of health benefit plans
Text contains those laws in effect on January 13, 2014

From Title 42-THE PUBLIC HEALTH AND WELFARE
CHAPTER 157-QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III-AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part B-Consumer Choices and Insurance Competition Through Health Benefit Exchanges

Jump To:
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References In Text
Amendments

§18031. Affordable choices of health benefit plans

(a) Assistance to States to establish American Health Benefit Exchanges

(1) Planning and establishment grants

There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after March 23, 2010, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) Amount specified

For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) Use of funds

A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) Renewability of grant

(A) In general

Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant-

(i) is making progress, as determined by the Secretary, toward-

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) Limitation

No grant shall be awarded under this subsection after January 1, 2015.

(5) Technical assistance to facilitate participation in SHOP Exchanges

The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) American Health Benefit Exchanges

(1) In general

Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title [1] as an "Exchange") for the State that-

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title [1] referred to as a "SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) Merger of individual and SHOP Exchanges

A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP

Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary

(1) In general

The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum-

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act [42 U.S.C. 300gg–1(c)]), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 U.S.C. 1396r–8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options;

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act [42 U.S.C. 280j–2], as applicable; and

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act [42 U.S.C. 1320b–9a].

(2) Rule of construction

Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) Rating system

The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) Enrollee satisfaction system

The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) Internet portals

The Secretary shall-

(A) continue to operate, maintain, and update the Internet portal developed under section 18003(a) of

this title and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 [1] of the Public Health Service Act and to a copy of the plan's written policy.

(6) Enrollment periods

The Secretary shall require an Exchange to provide for-

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of title 26 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.]; and

(D) special monthly enrollment periods for Indians (as defined in section 1603 of title 25).

(d) Requirements

(1) In general

An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) Offering of coverage

(A) In general

An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) Limitation

(i) In general

An Exchange may not make available any health plan that is not a qualified health plan.

(ii) Offering of stand-alone dental benefits

Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of title 26 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 18022(b)(1)(J) of this title).

(3) Rules relating to additional required benefits

(A) In general

Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 18022(b) of this title.

(B) States may require additional benefits

(i) In general

Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title.

(ii) State must assume cost

A State shall make payments-

(I) to an individual enrolled in a qualified health plan offered in such State; or

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).

(4) Functions

An Exchange shall, at a minimum-

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act [42 U.S.C. 300gg–15];

(F) in accordance with section 18083 of this title, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.], or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title;

(H) subject to section 18081 of this title, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of title 26, an individual is exempt from the individual requirement or from the penalty imposed by such section because-

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury-

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of title 26 because-

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such title to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 18081(b)(4) of this title that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) Funding limitations

(A) No Federal funds for continued operations

In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds

In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) Consultation

An Exchange shall consult with stakeholders relevant to carrying out the activities under this section,

including-

(A) educated health care consumers who are enrollees in qualified health plans;
(B) individuals and entities with experience in facilitating enrollment in qualified health plans;
(C) representatives of small businesses and self-employed individuals;
(D) State Medicaid offices; and
(E) advocates for enrolling hard to reach populations.

(7) Publication of costs

An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) Certification

(1) In general

An Exchange may certify a health plan as a qualified health plan if-

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan-

(i) on the basis that such plan is a fee-for-service plan;
(ii) through the imposition of premium price controls; or
(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) Premium considerations

The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) [1] of the Public Health Service Act [42 U.S.C. 300gg–94(b)(1)] (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(3) Transparency in coverage

(A) In general

The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.
(ii) Periodic financial disclosures.
(iii) Data on enrollment.
(iv) Data on disenrollment.
(v) Data on the number of claims that are denied.
(vi) Data on rating practices.
(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.
(viii) Information on enrollee and participant rights under this title.[1]
(ix) Other information as determined appropriate by the Secretary.

(B) Use of plain language

The information required to be submitted under subparagraph (A) shall be provided in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) Cost sharing transparency

The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect

to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) Group health plans

The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

(f) Flexibility

(1) Regional or other interstate exchanges

An Exchange may operate in more than one State if-

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) Subsidiary Exchanges

A State may establish one or more subsidiary Exchanges if-

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act [42 U.S.C. 300gg(a)].

(3) Authority to contract

(A) In general

A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) Eligible entity

In this paragraph, the term "eligible entity" means-

(i) a person-

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of title 26 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

(g) Rewarding quality through market-based incentives

(1) Strategy described

A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for-

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) Guidelines

The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) Requirements

The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable

Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) Quality improvement

(1) Enhancing patient safety

Beginning on January 1, 2015, a qualified health plan may contract with-

(A) a hospital with greater than 50 beds only if such hospital-

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act [42 U.S.C. 299b–21 et seq.]; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) Exceptions

The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) Adjustment

The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) Navigators

(1) In general

An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) Eligibility

(A) In general

To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) Types

Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that-

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) Duties

An entity that serves as a navigator under a grant under this subsection shall-

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act [42 U.S.C. 300gg–93], or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) Standards

(A) In general

The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of

interest. Under such standards, a navigator shall not-

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) Fair and impartial information and services

The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) Funding

Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) Applicability of mental health parity

Section 2726 of the Public Health Service Act [42 U.S.C. 300gg–26] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) Conflict

An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subchapter.

(Pub. L. 111–148, title I, §1311, title X, §§10104(e)–(h), 10203(a), Mar. 23, 2010, 124 Stat. 173, 900, 901, 927.)

REFERENCES IN TEXT

Subtitles A and C, referred to in subsec. (a)(4)(A)(i)(II), are subtitles A (§§1001–1004) and C (§§1201–1255), respectively, of title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, 154. Subtitle A enacted sections 300gg–11 to 300gg–19, 300gg–93, and 300gg–94 of this title, transferred sections 300gg–4 to 300gg–7 and 300gg–13 of this title to sections 300gg–25 to 300gg–28 and 300gg–9 of this title, respectively, amended sections 300gg–11, 300gg–12, and 300gg–21 to 300gg–23 of this title, and enacted provisions set out as a note under section 300gg–11 of this title. Subtitle C enacted subchapter II of this chapter and sections 300gg to 300gg–2 and 300gg–4 to 300gg–7 of this title, transferred section 300gg of this title to section 300gg–3 of this title, amended sections 300gg–1 and 300gg–4 of this title, and enacted provisions set out as a note under section 300gg of this title. For complete classification of subtitles A and C to the Code, see Tables.

This title, referred to in subsecs. (b)(1) and (e)(3)(A)(viii), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

Section 2716 of the Public Health Service Act, referred to in subsec. (c)(5), probably should be section 2715 of the Public Health Service Act, act July 1, 1944, which is classified to section 300gg–15 of this title and requires the Secretary to develop a uniform explanation of coverage documents and standardized definitions. Section 2716 of act July 1, 1944, which is classified to section 300gg–16 of this title, relates to prohibition on discrimination in favor of highly compensated individuals.

The Social Security Act, referred to in subsecs. (c)(6)(C), (d)(4)(F), and (f)(3)(B)(ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part D of title XVIII of the Act is classified generally to part D (§1395w–101 et seq.) of subchapter XVIII of chapter 7 of this title. Titles XIX and XXI of the Act are classified generally to subchapters XIX (§1396 et seq.) and XXI (§1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 2794 of the Public Health Service Act, referred to in subsec. (e)(2), probably means section 2794 of act July 1, 1944, as added by section 1003 of Pub. L. 111–148, which relates to premium increases for consumers and is classified to section 300gg–94 of this title. Another section 2794 of act July 1, 1944, relates to uniform fraud and abuse referral format and is classified to section 300gg–95 of this title.

The Public Health Service Act, referred to in subsec. (h)(1)(A)(i), is act July 1, 1944, ch. 373, 58 Stat. 682. Part C of title IX of the Act is classified generally to part C (§299b–21 et seq.) of

subchapter VII of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

This subchapter, referred to in subsec. (k), was in the original "this subtitle", meaning subtitle D of title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 162, which enacted this subchapter and amended sections 501, 4958, and 6033 of Title 26, Internal Revenue Code.

AMENDMENTS

2010-Subsec. (c)(1)(I). Pub. L. 111–148, §10203(a), added subpar. (I).

Subsec. (d)(3)(B)(ii). Pub. L. 111–148, §10104(e)(1), added cl. (ii) and struck out former cl. (ii). Prior to amendment, text read as follows: "A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of title 26 and section 18071(c)(4) of this title."

Subsec. (d)(6)(A). Pub. L. 111–148, §10104(e)(2), inserted "educated" before "health care".

Subsec. (e)(2). Pub. L. 111–148, §10104(f)(1), which directed substitution of "shall" for "may" in second sentence, was executed by making the substitution in third sentence before "take" to reflect the probable intent of Congress because the word "shall" already appeared in second sentence.

Subsec. (e)(3). Pub. L. 111–148, §10104(f)(2), added par. (3).

Subsec. (g)(1)(E). Pub. L. 111–148, §10104(g), added subpar. (E).

Subsec. (i)(2)(B). Pub. L. 111–148, §10104(h), substituted "resource partners of the Small Business Administration" for "small business development centers".

[1] *See References in Text note below.*

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(ix) 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(x) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(xi) 1334. Multi-State plans.

(xii) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(xiii) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(xiv) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(xv) 1413. Streamlining of procedures for enrollment through an Exchange and State, Medicaid, CHIP, and health subsidy programs.

(2) This part is based on section 1150A, Pharmacy Benefit Managers Transparency Requirements, of title I of the Act:

(b) *Scope.* This part establishes standards for QHPs under Exchanges, and addresses other health insurance issuer requirements.

§ 156.20 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Actuarial value (AV) means the percentage paid by a health plan of the percentage of the total allowed costs of benefits.

Applicant has the meaning given to the term in §155.20 of this subchapter.

Base-benchmark plan means the plan that is selected by a State from the options described in §156.100(a) of this subchapter, or a default benchmark plan, as described in §156.100(c) of this subchapter, prior to any adjustments made pursuant to the benchmark standards described in §156.110 of this subchapter.

Benefit design standards means coverage that provides for all of the following:

(1) The essential health benefits as described in section 1302(b) of the Affordable Care Act;

(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

Benefit year has the meaning given to the term in §155.20 of this subtitle.

Cost-sharing has the meaning given to the term in §155.20 of this subtitle.

Cost-sharing reductions has the meaning given to the term in §155.20 of this subtitle.

Delegated entity means any party, including an agent or broker, that enters into an agreement with a QHP issuer to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

Downstream entity means any party, including an agent or broker, that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer. The term "downstream entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

EHB-benchmark plan means the standardized set of essential health benefits that must be met by a QHP, as defined in §155.20 of this section, or other issuer as required by §147.150 of this subchapter.

Essential health benefits package or EHB package means the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the ten statutory categories of benefits, as described in §156.110(a) of this subchapter; provides the benefits in the manner described in §156.115 of this subchapter; limits cost sharing for such coverage as described in §156.130; and subject to offering catastrophic plans as described in section 1302(e) of the Affordable Care Act, provides distinct levels of coverage as described in §156.140 of this subchapter.

Federally-facilitated SHOP has the meaning given to the term in §155.20 of this subchapter.

Group health plan has the meaning given to the term in §144.103 of this subtitle.

Health insurance coverage has the meaning given to the term in §144.103 of this subtitle.

Health insurance issuer or issuer has the meaning given to the term in §144.103 of this subtitle.

Issuer group means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(1) of the Affordable Care Act of plan coverage.

Percentage of the total allowed costs of benefits means the anticipated covered medical spending for EHB coverage (as defined in §156.110(a) of this subchapter) paid by a health plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

Plan year has the meaning given to the term in §155.20 of this subchapter.

Qualified employer has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan issuer has the meaning given to the term in §155.20 of this subchapter.

Qualified individual has the meaning given to the term in §155.20 of this subchapter.

[77 FR 18468, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012; 78 FR 12865, Feb. 25, 2013; 78 FR 15535, Mar. 11, 2013; 78 FR 54142, Aug. 30, 2013]

§156.50 Financial support.

(a) *Definitions.* The following definitions apply for the purposes of this section:

Participating issuer means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in §155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in §155.1065 of this subtitle), or other issuers identified by an Exchange.

(b) *Requirement for State-based Exchange user fees.* A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under §155.160 of this subchapter.

(c) *Requirement for Federally-facilitated Exchange user fee.* To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.

(d) *Adjustment of Federally-facilitated Exchange user fee.*—(1) A participating issuer offering a plan through a Federally-facilitated Exchange may qualify for an adjustment in the Federally-facilitated Exchange user fee specified in paragraph (c) of this section to the extent that the participating issuer—

(i) Made payments for contraceptive services on behalf of a third party administrator pursuant to 26 CFR 54.9815–2713A(b)(2)(ii) or 29 CFR 2590.715–2713A(b)(2)(ii); or

(ii) Seeks an adjustment in the Federally-facilitated Exchange user fee with respect to a third party administrator that, following receipt of a copy of the self-certification referenced in 26 CFR 54.9815–2713A(a)(4) or 29 CFR 2590.715–2713A(a)(4), made or arranged for payments for contraceptive services pursuant to 26 CFR 54.9815–2713A(b)(2)(i) or (ii) or 29 CFR 2590.715–2713A(b)(2)(i) or (ii).

(2) For a participating issuer described in paragraph (d)(1) of this section to receive the Federally-facilitated Exchange user fee adjustment—

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in any of the three largest small group insurance products by enrollment, as defined in §159.110 of this subpart, in the State's small group market as defined in §155.20 of this subchapter.

(2) *State employee health benefit plan.* Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.

(3) *FEHBP plan.* Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 USC 8903.

(4) *HMO.* The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.

(b) *EHB-benchmark selection standards.* In order to become an EHB-benchmark plan as defined in §156.20 of this subchapter, a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in §156.110 of this subpart; and

(c) *Default base-benchmark plan.* If a State does not make a selection using the process defined in §156.100 of this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State's small group market. If Guam, the U.S. Virgin Islands, American Samoa, or the Northern Marianna Islands do not make a benchmark selection, the default base-benchmark plan will be the largest FEHBP plan by enrollment.

§ 156.105 Determination of EHB for multi-state plans.

A multi-state plan must meet benchmark standards set by the U.S. Office of Personnel Management.

§ 156.110 EHB-benchmark plan standards.

An EHB-benchmark plan must meet the following standards:

(a) *EHB coverage.* Provide coverage of at least the following categories of benefits:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

(b) *Coverage in each benefit category.* A base-benchmark plan not providing any coverage in one or more of the categories described in paragraph (a) of this section, must be supplemented as follows:

(1) *General supplementation methodology.* A base-benchmark plan that does not include items or services within one or more of the categories described in paragraph (a) of this section must be supplemented by the addition of the entire category of such benefits offered under any other benchmark plan option described in §156.100(a) of this subpart unless otherwise described in this subsection.

(2) *Supplementing pediatric oral services.* A base-benchmark plan lacking the category of pediatric oral services must be supplemented by the addition of the entire category of pediatric oral benefits from one of the following:

(i) The FEDVIP dental plan with the largest national enrollment that is described in and offered to federal employees under 5 U.S.C. 8962; or

(ii) The benefits available under that State's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(3) *Supplementing pediatric vision services.* A base-benchmark plan lacking the category of pediatric vision services must be supplemented by the addition of the entire category of pediatric vision benefits from one of the following:

(i) The FEDVIP vision plan with the largest national enrollment that is offered to federal employees under 5 USC 8982; or

(ii) The benefits available under the State's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(c) *Supplementing the default base-benchmark plan.* A default base-benchmark plan as defined in §156.100(c) of this subpart that lacks any categories of essential health benefits will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category:

(1) The largest plan by enrollment in the second largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(2) The largest plan by enrollment in the third largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(3) The largest national FEHBP plan by enrollment across States that is offered to federal employees under 5 USC 8903 (except for pediatric oral and vision benefits);

(4) The plan described in paragraph (b)(2)(i) of this section with respect to pediatric oral care benefits;

(5) The plan described in paragraph (b)(3)(i) of this section with respect to pediatric vision care benefits; and

(6) A habilitative benefit determined by the plan as described in §156.115(a)(5) of this subpart or by the State as described in paragraph (f) of this section.

(d) *Non-discrimination.* Not include discriminatory benefit designs that contravene the non-discrimination standards defined in §156.125 of this subpart.

(e) *Balance.* Ensure an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.

(f) *Determining habilitative services.* If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

§156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of §156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under §156.110(a)(5) of this subpart, comply with the requirements of §146.136 of this subchapter.

(4) Include preventive health services described in §147.130 of this subchapter.

(5) If the EHB-benchmark plan does not include coverage for habilitative services, as described in §156.110(f) of this subpart, include habilitative services in a manner that meets one of the following—

(i) Provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or

(ii) Is determined by the issuer and reported to HHS.

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;

(ii) Is made only within the same essential health benefit category; and

(iii) Is not a prescription drug benefit.

(2) Submits evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined regardless of cost-sharing.

(c) A health plan does not fail to provide EHB solely because it does not

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(c) *Supplementing the default base-benchmark plan.* A default base-benchmark plan as defined in §156.100(c) of this subpart that lacks any categories of essential health benefits will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category:

(1) The largest plan by enrollment in the second largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(2) The largest plan by enrollment in the third largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(3) The largest national FEHBP plan by enrollment across States that is offered to federal employees under 5 USC 8903 (except for pediatric oral and vision benefits);

(4) The plan described in paragraph (b)(2)(i) of this section with respect to pediatric oral care benefits;

(5) The plan described in paragraph (b)(3)(i) of this section with respect to pediatric vision care benefits; and

(6) A habilitative benefit determined by the plan as described in §156.115(a)(5) of this subpart or by the State as described in paragraph (f) of this section.

(d) *Non-discrimination.* Not include discriminatory benefit designs that contravene the non-discrimination standards defined in §156.125 of this subpart.

(e) *Balance.* Ensure an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.

(f) *Determining habilitative services.* If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

§ 156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of §156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under §156.110(a)(5) of this subpart, comply with the requirements of §146.136 of this subchapter.

(4) Include preventive health services described in §147.130 of this subchapter.

(5) If the EHB-benchmark plan does not include coverage for habilitative services, as described in §156.110(f) of this subpart, include habilitative services in a manner that meets one of the following—

(i) Provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or

(ii) Is determined by the issuer and reported to HHS.

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;

(ii) Is made only within the same essential health benefit category; and

(iii) Is not a prescription drug benefit.

(2) Submits evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined regardless of cost-sharing.

(c) A health plan does not fail to provide EHB solely because it does not

offer the services described in §156.280(d) of this subchapter.

(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

§156.122 Prescription drug benefits.

(a) A health plan does not provide essential health benefits unless it:

(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

(i) One drug in every United States Pharmacopeia (USP) category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the Exchange, the State, or OPM.

(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the Food and Drug Administration as a service described in §156.280(d) of this subchapter.

(c) A health plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.

§156.125 Prohibition on discrimination.

(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

(b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and

(c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

§156.130 Cost-sharing requirements.

(a) *Annual limitation on cost sharing.* (1) For a plan year beginning in the calendar year 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the annual dollar limit as described in section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that that is in effect for 2014; or

(ii) For other than self-only coverage—the annual dollar limit in section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.

(2) For a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in paragraph (e) of this section.

(ii) For other than self-only coverage—twice the dollar limit for self-only coverage described in paragraph (a)(2)(i) of this section.

(b) *Annual limitation on deductibles for plans in the small group market.* (1) For a plan year beginning in calendar year 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(i) For self-only coverage—$2,000; or

(ii) For coverage other than self-only—$4,000.

(2) For a plan year beginning in a calendar year after 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(i) For self-only coverage—the annual limitation on deductibles for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage as defined in paragraph (e) of this section; and

(ii) For other than self-only coverage—twice the annual deductible limit for self-only coverage described in paragraph (b)(2)(i) of this section.

(3) A health plan's annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage as defined in §156.140 of this subpart without exceeding the annual deductible limit.

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(b) *Coverage of preventive health services.* A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services, in accordance with section 2713 of the Public Health Service Act.

(c) *Application for family coverage.* For other than self-only coverage, each individual enrolled must meet the requirements of paragraph (a)(5) of this section.

[78 FR 13442, Feb. 27, 2013]

Subpart C—Qualified Health Plan Minimum Certification Standards

SOURCE: 77 FR 18469, Mar. 27, 2012, unless otherwise noted.

§ 156.200 QHP issuer participation standards.

(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.

(b) *QHP issuer requirement.* A QHP issuer must—

(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;

(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, § 155.705 of this subchapter;

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;

(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;

(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

(6) Pay any applicable user fees assessed under § 156.50; and

(7) Comply with the standards related to the risk adjustment program under 45 CFR part 153.

(c) *Offering requirements.* A QHP issuer must offer through the Exchange:

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act; and,

(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.

(d) *State requirements.* A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs.

(e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

(f) *Broker compensation in a Federally-facilitated Exchange.* A QHP issuer must pay the same broker compensation for QHPs offered through a Federally-facilitated Exchange that the QHP issuer pays for similar health plans offered in the State outside a Federally-facilitated Exchange.

(g) *Certification standard specific to a Federally-facilitated Exchange.* A Federally-facilitated Exchange may certify a QHP in the individual market of a Federally-facilitated Exchange only if the QHP issuer meets one of the conditions below:

(1) The QHP issuer also offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage as described in section 1302(d) of the Affordable Care Act;

(2) The QHP issuer does not offer small group market products in that State, but another issuer in the same

issuer group offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or

(3) Neither the issuer nor any other issuer in the same issuer group has a share of the small group market, as determined by HHS, greater than 20 percent, based on the earned premiums submitted by all issuers in the State's small group market, under §158.110 of this subchapter, on the reporting date immediately preceding the due date of the application for QHP certification.

[77 FR 18469, Mar. 27, 2012, as amended at 78 FR 15535, Mar. 11, 2013]

§156.210 QHP rate and benefit information.

(a) *General rate requirement.* A QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year.

(b) *Rate and benefit submission.* A QHP issuer must submit rate and benefit information to the Exchange.

(c) *Rate justification.* A QHP issuer must submit to the Exchange a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site.

§156.215 Advance payments of the premium tax credit and cost-sharing reduction standards.

(a) *Standards relative to advance payments of the premium tax credit and cost-sharing reductions.* In order for a health plan to be certified as a QHP initially and to maintain certification to be offered in the individual market on the Exchange, the issuer must meet the requirements related to the administration of cost-sharing reductions and advance payments of the premium tax credit set forth in subpart E of this part.

(b) [Reserved]

[78 FR 15535, Mar. 11, 2013]

§156.220 Transparency in coverage.

(a) *Required information.* A QHP issuer must provide the following information in accordance with the standards in paragraph (b) of this section:

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost-sharing and payments with respect to any out-of-network coverage; and

(8) Information on enrollee rights under title I of the Affordable Care Act.

(b) *Reporting requirement.* A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, the information described in paragraph (a) of this section to the Exchange, HHS and the State insurance commissioner, and make the information described in paragraph (a) of this section available to the public.

(c) *Use of plain language.* A QHP issuer must make sure that the information submitted under paragraph (b) is provided in plain language as defined under §155.20 of this subtitle.

(d) *Enrollee cost sharing transparency.* A QHP issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through an Internet Web site and such other means for individuals without access to the Internet.

§156.225 Marketing and Benefit Design of QHPs.

A QHP issuer and its officials, employees, agents and representatives must—

(a) *State law applies.* Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and

(b) *Non-discrimination.* Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

§156.230 Network adequacy standards.

(a) *General requirement.* A QHP issuer must ensure that the provider network of each of its QHPs, as available to all

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AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

issuer group offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or

(3) Neither the issuer nor any other issuer in the same issuer group has a share of the small group market, as determined by HHS, greater than 20 percent, based on the earned premiums submitted by all issuers in the State's small group market, under §158.110 of this subchapter, on the reporting date immediately preceding the due date of the application for QHP certification.

[77 FR 18469, Mar. 27, 2012, as amended at 78 FR 15535, Mar. 11, 2013]

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(b) [Reserved]

[78 FR 15535, Mar. 11, 2013]

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(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost-sharing and payments with respect to any out-of-network coverage; and

(8) Information on enrollee rights under title I of the Affordable Care Act.

(b) *Reporting requirement.* A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, the information described in paragraph (a) of this section to the Exchange, HHS and the State insurance commissioner, and make the information described in paragraph (a) of this section available to the public.

(c) *Use of plain language.* A QHP issuer must make sure that the information submitted under paragraph (b) is provided in plain language as defined under §155.20 of this subtitle.

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(a) *State law applies.* Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and

(b) *Non-discrimination.* Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

§156.230 Network adequacy standards.

(a) *General requirement.* A QHP issuer must ensure that the provider network of each of its QHPs, as available to all

enrollees, meets the following standards—

(1) Includes essential community providers in accordance with §156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) *Access to provider directory.* A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

§156.235 Essential community providers.

(a) *General requirement.* (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) *Alternate standard.* A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) *Definition.* Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111–8.

(d) *Payment rates.* Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) *Payment of federally-qualified health centers.* If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

§156.245 Treatment of direct primary care medical homes.

A QHP issuer may provide coverage through a direct primary care medical home that meets criteria established by HHS, so long as the QHP meets all

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enrollees, meets the following standards—

(1) Includes essential community providers in accordance with §156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) *Access to provider directory.* A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

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(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) *Alternate standard.* A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) *Definition.* Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111–8.

(d) *Payment rates.* Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) *Payment of federally-qualified health centers.* If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

§156.245 Treatment of direct primary care medical homes.

A QHP issuer may provide coverage through a direct primary care medical home that meets criteria established by HHS, so long as the QHP meets all

STATE OF WASHINGTON
BEFORE THE WASHINGTON STATE
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of: **Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings.**	**Docket No. 13-0293** **[PROPOSED] ORDER GRANTING SEATTLE CHILDREN'S HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT**

This matter, having come on for hearing on the Motion of Plaintiff Seattle Children's Hospital for Partial Summary Judgment, and the Hearings Unit having reviewed:

- SCH's Motion, with its Appendix items 1 through 9;
- Declaration of Michael Madden, with accompanying Exhibits A through D;
- Declaration of Eileen O'Connor, with accompanying Exhibits A through C;
- The OIC's Response, together with any accompanying declarations, exhibits, or attachments thereto;
- _____;

and the records and files herein,

NOW, THEREFORE,

The motion of Seattle Children's Hospital for partial summary judgment is GRANTED. The Chief Hearings Officer concludes that, as a matter of law, the OIC, in its review and approval of the Exchange plan rate request filings for Coordinated Care Corporation, BridgeSpan

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Health Company, and Premera Blue Cross: (1) failed to consider or apply controlling federal law under the Affordable Care Act, including 42 U.S.C. § 18022(b)(1), and 42 U.S.C. § 18031(c)(1)(C), as well as 45 C.F.R. § 156.020, § 156.110, § 156.115, § 156.200, § 156.230, and § 156.235, which require that Exchange plans include pediatric hospital services within their networks unless certain conditions are shown to exist; (2) failed to give required consideration to the unique pediatric services available in this state only at SCH; and (3) failed to consider the consequences of allowing these plans to exclude SCH from their exchange networks.

For these reasons, the OIC approvals of the Exchange plans for Coordinated Care Corporation, BridgeSpan Health Company, and Premera Blue Cross are hereby vacated, and review of these Exchange plans is remanded to the Commissioner for consideration under proper standards.

ENTERED AT TUMWATER, WASHINGTON this _____ day of _____, 2014, pursuant to Title 34 RCW; Title 48 RCW; and regulations pursuant thereto.

_____
PATRICIA D. PETERSON
CHIEF PRESIDING OFFICER

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CERTIFICATE OF SERVICE

I certify that I served a true and correct copy of this document on all parties or their counsel of record on the date below by hand delivery on today's date addressed to the following:

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I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Executed at Seattle, Washington, this 17th day of January, 2014.

Julia Crippen
Legal Assistant

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