

Form Review Checklist - Individual Health Insurance (nongrandfathered - 2014)
Draft January 9, 2012

Company Name:	
Product Name:	
Plan:	
<input type="checkbox"/>	60% AV (Bronze)
<input type="checkbox"/>	70% AV (Silver)
<input type="checkbox"/>	80% (Gold)
<input type="checkbox"/>	90% (Platinum)
<input type="checkbox"/>	Child-only
<input type="checkbox"/>	Catastrophic Plan (no minimum AV requirement, only available to individuals under age 30 or those with hardship/affordability exemption)

YES: Check this box if all contract provisions in the section meet minimum requirements.

NO: Check this box if any of the contract provisions do not meet minimum requirements, restrict coverage in a way not allowed by law, or for any other reason are inconsistent with the law.

N/A: Check this box if a contract does not have to meet this requirement (e.g., does not use Primary Care Physicians and therefore does not have to include designation of PCP option).

Category	Federal & State Law	Comments	Yes	No	N/A
<input type="checkbox"/> No pre-existing condition exclusions for child under age 19 <input type="checkbox"/> No pre-existing condition exclusions <input type="checkbox"/> "Pre-existing condition exclusion" means a limitation or exclusion on benefits based on the fact that the condition was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was received before that day. <input type="checkbox"/> A pre-existing condition exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or date of denial).	PHSA §2704 PHSA §1255 (75 Fed Reg 37188, 45 CFR §147.108)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					

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<input type="checkbox"/> No lifetime limits on the dollar value of Essential Health Benefits (EHB): <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No annual limits on the dollar value of EHB: <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No rescissions except in cases of fraud or intentional misrepresentation of material fact <input type="checkbox"/> Rescission is a cancellation of coverage that has retroactive	PHSA§2712 (75 Fed Reg 37188, 45 CFR		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<p>effect. It includes a cancellation that voids benefits paid .</p> <p><input type="checkbox"/> Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected.</p>	§147.128)				
<p><input type="checkbox"/> Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance.</p> <p><input type="checkbox"/> Covered preventive services include:</p> <ul style="list-style-type: none"> • Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); • Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and • Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (do not include recommendations issued in or around Nov. 2009). <p><input type="checkbox"/> Coverage without cost-sharing (deductibles, co-payments, co-insurance)</p>	PHSA §2713 (75 Fed Reg 41726, 45 CFR §147.130)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					
<p><input type="checkbox"/> Provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits.</p>	PHSA 2715 (75 Fed Reg 41760)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					

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<input type="checkbox"/> Coverage for dependents must be available up to age 26 if policy offers dependent coverage. <input type="checkbox"/> Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: <ul style="list-style-type: none"> • financial dependency on primary subscriber, • residency, • student status, • employment, • eligibility for other coverage, • marital status. <input type="checkbox"/> Terms of the policy for dependent coverage cannot vary based on the age of a child.	PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					
<input type="checkbox"/> Provides Essential Health Benefits – <input type="checkbox"/> Form reviewer: complete EHB form review	PHSA §2707		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coverage for emergency services required (See EHB above) and: <input type="checkbox"/> Cannot require prior authorization; <input type="checkbox"/> Cannot be limited to only services and care at participating providers; <input type="checkbox"/> Must be covered at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider); <input type="checkbox"/> Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer’s general formula for determining payments for out-of-network services); or (3) the Medicare rate. <input type="checkbox"/> “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity that a person would reasonably expect the absence of	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138) SSA §1395dd		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<p>immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn child.</p> <p><input type="checkbox"/> “Emergency medical services” means a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department to evaluate the condition; and within the capabilities of the staff/facilities available at the hospital, examination/ treatment required to stabilize the patient.</p> <p><input type="checkbox"/> “Stabilize” means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.</p>					
Explanation:					
<p><input type="checkbox"/> For network plans requiring a primary care provider to be designated and requiring referrals:</p> <p><input type="checkbox"/> allow each enrollee to designate any participating primary care provider who is available to accept such individual</p> <p><input type="checkbox"/> a physician specializing in pediatrics may be designated as PCP</p> <p><input type="checkbox"/> no referral required for services from in-network OB/GYNs</p> <p><input type="checkbox"/> Notice of these is required when issuer provides primary subscriber with a policy, certificate, or contract of health insurance.</p>	<p>PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138)</p>	<ul style="list-style-type: none"> • 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					

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<p><input type="checkbox"/> Maternity coverage (see EHB) and required benefits for hospital stays in connection with childbirth:</p> <p><input type="checkbox"/> Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section.</p> <p><input type="checkbox"/> EXCEPTION: this does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay.</p> <p><input type="checkbox"/> No prior authorization required for 48/96 hour hospital stay</p> <p><input type="checkbox"/> Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital.</p> <p>The issuer is not allowed to:</p> <p><input type="checkbox"/> Deny the mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements;</p> <p><input type="checkbox"/> Provide monetary payments/rebates to encourage mothers to accept less than the minimum requirements;</p> <p><input type="checkbox"/> Penalize an attending provider who provides services in accordance with these requirements;</p> <p><input type="checkbox"/> Provide incentives to an attending provider to induce the provider to provide care inconsistent with these requirements;</p> <p><input type="checkbox"/> Restrict benefits for any portion of a period within the 48/96-hour stay in a manner less favorable than the benefits provided for any preceding portion of such stay;</p> <p><input type="checkbox"/> Require the mother to give birth in a hospital;</p> <p><input type="checkbox"/> Require the mother to stay in the hospital for a fixed period of time following the birth of her child.</p> <p><input type="checkbox"/> <i>An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with</i></p>	<p>PHSA §2725 (45 CFR §148.170)</p>	<p>N</p> <p>•</p>	<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>

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<i>an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother.</i>					
Explanation:					
<input type="checkbox"/> Parity in Mental Health and Substance Use Disorder Benefits	PHSA §2726		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act) <input type="checkbox"/> If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient. Coverage must include: <input type="checkbox"/> Reconstruction of the breast on which the mastectomy was performed (all stages); <input type="checkbox"/> Surgery and reconstruction of the other breast to produce symmetrical appearance; <input type="checkbox"/> Prostheses; and <input type="checkbox"/> Treatment of physical complications at all stages of mastectomy. <input type="checkbox"/> This benefit can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the coverage. <input type="checkbox"/> The issuer is prohibited from denying a patient eligibility to enroll or renew coverage solely to avoid these requirements; penalizing or offering incentives to an attending provider to induce the provider to furnish care inconsistent with these requirements. <input type="checkbox"/> Notice about the availability of mastectomy-related benefits must be given at issue and annually.	PHSA §2727	•	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					

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<p><input type="checkbox"/> Coverage for dependent student on <u>medically necessary leave of absence</u> (“Michelle’s Law”)</p> <p><input type="checkbox"/> Issuer cannot terminate coverage due to a medically necessary leave of absence before:</p> <ul style="list-style-type: none"> • The date that is 1 year after the first day of the leave; or • The date on which coverage would otherwise terminate under the terms of the coverage. <p><input type="checkbox"/> Change in benefits prohibited – child on medically necessary leave of absence is entitled to the same benefits as if the child continued to be a covered student who was not on a medically necessary leave of absence; however, if there is a change in the manner in which the beneficiary/parent is covered and continues to cover the dependent, the changed coverage will apply for the remainder of the period of the medically necessary leave of absence.</p> <p><input type="checkbox"/> Eligibility for protections: a dependent child under the terms of the coverage of the beneficiary, enrolled in the coverage on the basis of being a student immediately before the first day of the medically necessary leave of absence involved.</p> <p><input type="checkbox"/> “Medically necessary leave of absence” means: a leave of absence or change of enrollment of a dependent child from a post-secondary education institution that:</p> <ol style="list-style-type: none"> 1. Commences while the child is suffering from a serious illness or injury; 2. Is medically necessary; and 3. Causes the child to lose student status for purposes of coverage under the terms of coverage. <p><input type="checkbox"/> Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the terms for continued coverage during medically</p>	<p>PHSA §2728 (45 CFR §147.145)</p>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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necessary leaves of absence.					
Explanation:					
<input type="checkbox"/> Coverage is guaranteed renewable <input type="checkbox"/> May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	PHSA §2702 (45 CFR §148.122)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					
<input type="checkbox"/> Coverage is not based on <u>genetic information (GINA)</u> An issuer is not allowed to: <ul style="list-style-type: none"> <input type="checkbox"/> Adjust premiums based on genetic information; <input type="checkbox"/> Request /require <u>genetic testing</u>; <input type="checkbox"/> Collect genetic information from an individual prior to/in connection with enrollment in a plan, or at any time for <u>underwriting purposes</u>. EXCEPTION FOR MEDICAL APPROPRIATENESS (only if the individual seeks a benefit under the plan): <ul style="list-style-type: none"> <input type="checkbox"/> If an individual seeks a benefit under a plan, the issuer may limit or exclude the benefit based on whether the benefit is medically appropriate and the determination of whether the benefit is medically appropriate is not for underwriting purposes. <input type="checkbox"/> If a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information (the issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness). <input type="checkbox"/> The incidental collection of genetic information is permitted, as long as it is not used for underwriting purposes. 	PHSA §2753 (74 Fed Reg 51664, 45 CFR §148.180)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<p>EXCEPTIONS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. <input type="checkbox"/> An issuer can obtain and use results of a genetic test for making a determination regarding payment (minimum amount of information necessary to make the determination). <input type="checkbox"/> An issuer may request but not require that a beneficiary undergo a genetic test if the request is pursuant to research and the following conditions are met: <ul style="list-style-type: none"> <input type="checkbox"/> Research must be in accordance with Federal regulations and applicable state/local law or regulations; <input type="checkbox"/> The issuer makes a written request, and the request clearly indicates that compliance is voluntary, and noncompliance will have no effect on eligibility for benefits; <input type="checkbox"/> No information collected can be used for underwriting purposes; <input type="checkbox"/> The issuer completes a copy of the “Notice of Research Exception under the Genetic Information Nondiscrimination Act” <input type="checkbox"/> “Genetic information” is information about an individual’s/family members’ genetic tests, the manifestation of a disease or disorder in family members of the individual, or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual/family member. <ul style="list-style-type: none"> • With respect to a pregnant woman, genetic information includes information about the fetus. • With respect to an individual using assisted reproductive technology, genetic information includes information about the embryo. • Genetic information does NOT include information about the sex or age of any individual. 					

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<input type="checkbox"/> “Manifestation” means that an individual has been or could reasonably be diagnosed with a disease, disorder, or pathological condition; not manifested if the diagnosis is based principally on genetic information. <input type="checkbox"/> “Genetic services” means a genetic test, genetic counseling or genetic education. <input type="checkbox"/> “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. A genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. <input type="checkbox"/> “Underwriting purposes” means: <ul style="list-style-type: none"> • Rules for determination of eligibility for benefits under the coverage; • The computation of premium or contribution amounts under the coverage; • The application of any pre-existing condition exclusion under the coverage (until 2014); and • Other activities related to the creation, renewal, or replacement of a contract of health insurance. 					
Explanation:					
<input type="checkbox"/> Providers operating within their scope of practice cannot be discriminated against <input type="checkbox"/> Issuers may not discriminate against any provider operating within their scope of practice.	PHSA§2706		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					
<input type="checkbox"/> Coverage for individuals participating in approved clinical	PHSA §2709		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<p>trials:</p> <p><input type="checkbox"/> Issuer must cover “routine patient costs” – items and services consistent with benefits for typically covered services.</p> <p><input type="checkbox"/> If an in-network provider is participating in a clinical trial, the issuer may require participation in the trial through the participating provider if the provider will accept the individual as a participant.</p> <p><input type="checkbox"/> An individual may participate in an approved clinical trial conducted outside the state in which the individual resides.</p> <p><input type="checkbox"/> “Qualified individual” – eligible to participate according to trial protocol and referring health care professional/ medical information establishing appropriateness.</p> <p><input type="checkbox"/> “Approved clinical trial” – phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.</p>					
Explanation:					
Special enrollment period	*further guidance needed*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open enrollment period(s) required [If no state standard, issuers may determine the number and length of open enrollment periods.]	*further guidance needed*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><input type="checkbox"/> Minimum 60% actuarial value is required for individual coverage.</p> <p><input type="checkbox"/> Individual policies must meet the AVs in the metal tiers.</p> <p><input type="checkbox"/> <i>Reviewer check:</i> included printout of AV calculator and methodology.</p>	ACA §1302		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<input type="checkbox"/> <i>Reviewer check:</i> included disclosure of how benefits were defined and entered into AV calculator.					
Explanation:					
<input type="checkbox"/> Claims procedures, including applicable time frames <input type="checkbox"/> General requirements: <input type="checkbox"/> required to include a description of: <ul style="list-style-type: none"> ○ claims procedures, ○ procedures for obtaining prior approval, ○ preauthorization procedures, ○ utilization review procedures, and ○ applicable time frames <input type="checkbox"/> The claims procedure cannot unduly inhibit the initiation or processing of claims. <input type="checkbox"/> A “claim for benefits” is a request for benefits made by a claimant in accordance with an issuer’s reasonable procedure for filing benefit claims, including pre-service and post-service claims. <input type="checkbox"/> Time and process for urgent care (pre-service, post-service): <input type="checkbox"/> Determination for urgent care made within 72 hours. <input type="checkbox"/> Notice of the determination within 72 hours of receipt of the claim. <input type="checkbox"/> Notice of urgent care decisions include a description of the expedited review process applicable to such claim. <input type="checkbox"/> No extension of the determination time-frame is permitted. <input type="checkbox"/> If the claimant fails to provide sufficient information, issuer must notify the claimant within 24 hours and must include specific information necessary to complete the claim.	45 CFR §147.136; 29 CFR § 2560.503-1	•			

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<ul style="list-style-type: none"> <input type="checkbox"/> The claimant must have at least 48 hours to provide the specified information. <input type="checkbox"/> A determination must be made within 48 hours of receiving specified information or expiration of time afforded to the claimant to provide the specified information (whichever is earlier). <input type="checkbox"/> Time and process for concurrent urgent care (at the request of the claimant): <ul style="list-style-type: none"> <input type="checkbox"/> Claim for concurrent urgent care: if a claimant requests to extend the course of treatment beyond time/number of treatments. <input type="checkbox"/> Claim must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. <input type="checkbox"/> Determination must be made within 24 hours. <input type="checkbox"/> Notification is required within 24 hours of the claim's request <input type="checkbox"/> Time and process for pre-service claim: <ul style="list-style-type: none"> <input type="checkbox"/> Determination for a pre-service claim must be made within 15 days of the request of the claim. <input type="checkbox"/> Notice of the determination within 15 days of the claim. <input type="checkbox"/> Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. <ul style="list-style-type: none"> <input type="checkbox"/> Notice required of the extension prior to the expiration of the initial 15-day period, <input type="checkbox"/> The issuer must identify for the claimant the circumstances requiring the extension and date by which the issuer expects to render a decision. <input type="checkbox"/> If the claimant fails to provide sufficient information, the issuer must notify the claimant and specifically describe the required information needed to render a decision. <ul style="list-style-type: none"> <input type="checkbox"/> Claimant has 45 days from receipt of notice of insufficient information to provide specified 					

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<p>information.</p> <p><input type="checkbox"/> Time and process for on-going services/treatment (concurrent care decisions):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reduction/termination of benefits of ongoing courses of treatment (concurrent care) before the end of the time/treatments is considered an adverse benefit determination. <input type="checkbox"/> Determination for concurrent care must be made sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. <input type="checkbox"/> Notice of the determination sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. <p><input type="checkbox"/> Time and process for post-service claim:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Determination for post-service claim must be made within 30 days of receipt of claim. <input type="checkbox"/> Notice of the determination within 30 days of receipt of the claim. <input type="checkbox"/> Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer: <ul style="list-style-type: none"> <input type="checkbox"/> Notice of the extension must be provided to the claimant prior to expiration of the initial 30-day period, <input type="checkbox"/> The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision. <input type="checkbox"/> If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information necessary to render a decision. 					

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<p><input type="checkbox"/> The claimant has at least 45 days from the receipt of notice to provide the specified information.</p> <p><input type="checkbox"/> Standards for all required notices:</p> <p><input type="checkbox"/> Issuer must provide the claimant with written or electronic notification of any adverse benefit determination for pre-service, post-service, and concurrent treatment claims.</p> <p><input type="checkbox"/> All notices of adverse benefit determination (including final internal adverse benefit determinations) must be provided in a culturally and linguistically appropriate manner and must include:</p> <p><input type="checkbox"/> Information sufficient to identify the claim involved including date of service, health care provider, and, upon request, diagnosis/treatment codes and their meanings;</p> <p><input type="checkbox"/> Specific reason for the adverse determination, including the denial code and its corresponding meaning and a description of the issuer's standard that was used in denying the claim;</p> <p><input type="checkbox"/> A <u>final internal adverse benefit</u> decision must include:</p> <p><input type="checkbox"/> a discussion of the decision;</p> <p><input type="checkbox"/> a description of available internal appeals and external review processes;</p> <p><input type="checkbox"/> a description of how to initiate an appeal.</p> <p><input type="checkbox"/> An adverse benefit determination must describe:</p> <p><input type="checkbox"/> applicable expedited review process,</p> <p><input type="checkbox"/> availability of and contact information for health insurance consumer assistance or ombudsman.</p>					
Explanation:					
<p><input type="checkbox"/> Internal appeals of adverse benefit determinations - processes, rights and required notices:</p>	PHSA §2719 (75 Fed Reg 43330; 76	•			

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<ul style="list-style-type: none"> <input type="checkbox"/> Enrollees have a right to appeal an adverse benefit determination. <input type="checkbox"/> Enrollees may review the claim file and present evidence and testimony as part of the internal appeals process. <input type="checkbox"/> Enrollees have at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal. <input type="checkbox"/> Enrollees must have access to an expedited review process. <ul style="list-style-type: none"> <input type="checkbox"/> Requests for expedited review must be allowed to be submitted orally or in writing. <input type="checkbox"/> <u>Pre-service claim:</u> <ul style="list-style-type: none"> <input type="checkbox"/> Determination must be made within 30 days after receipt of the claimant's request. <input type="checkbox"/> Notice of the determination within 30 days after receipt of the claimant's request. <input type="checkbox"/> <u>Post-service claim:</u> <ul style="list-style-type: none"> <input type="checkbox"/> Determination must be made within 60 days after receipt of the claimant's request. <input type="checkbox"/> Notice of the determination within 60 days after receipt of the claimant's request. <input type="checkbox"/> <u>Urgent claim:</u> <ul style="list-style-type: none"> <input type="checkbox"/> Determination must be made within 72 hours after receipt of the claimant's request. <input type="checkbox"/> Notice of the determination within 72 hours after receipt of the claimant's request. <ul style="list-style-type: none"> <input type="checkbox"/> If claimant fails to provide sufficient information to determine covered/payable benefits for an urgent claim, the issuer must: <ul style="list-style-type: none"> <input type="checkbox"/> Notify the claimant within 24 hours of the information necessary to complete the claim. <input type="checkbox"/> Give the claimant at least 48 hours to provide the 	Fed Reg 37208, 45 CFR §147.136)				

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<p>specified information.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provide notice of the determination within 48 hours of the earlier of receiving the specified information and the end of the time period provided to return the specified information. <input type="checkbox"/> The issuer must provide the claimant with written or electronic notice of the determination in a culturally and linguistically appropriate manner. <input type="checkbox"/> In the case of an adverse benefit determination, the notification shall include: <ul style="list-style-type: none"> <input type="checkbox"/> Information sufficient to identify the claim involved (including date of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning); <input type="checkbox"/> Diagnosis/treatment codes and meanings must be provided as soon as practicable. Requests for this information cannot be considered a request for an internal appeal or external review. <input type="checkbox"/> Specific reason(s) for the determination, including the denial code and corresponding meaning, as well as a description of issuer's standard that was used in denying the claim (including a discussion of the decision in final internal adverse benefit determination). <input type="checkbox"/> Description of available internal appeals and external review processes. <input type="checkbox"/> Information on how to initiate an appeal. <input type="checkbox"/> Information about the availability of, and contact information for, office of health insurance consumer assistance or ombudsman. <input type="checkbox"/> A statement that the claimant is entitled to receive reasonable access to/copies of all documents, records, and 					

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<p>other information relevant to the claim.</p> <p><input type="checkbox"/> An <i>adverse benefit determination</i> means a denial, reductions, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.</p> <p><input type="checkbox"/> A rescission of coverage must be treated as an adverse benefit determination.</p> <p><input type="checkbox"/> If an issuer fails to adhere to all of the requirements listed with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate an external review or any remedies available under state law.</p> <p><input type="checkbox"/> The internal claims and appeals process will not be deemed exhausted if the violation did not cause harm to the claimant so long as the issuer demonstrates that the violation was for good cause or due to matters beyond the control of the issuer, and</p> <p><input type="checkbox"/> That the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the claimant.</p> <p><input type="checkbox"/> <u>Ongoing (concurrent care) decisions:</u></p> <p><input type="checkbox"/> Issuer is required to provide continued coverage pending the outcome of an appeal;</p> <p><input type="checkbox"/> must provide benefits for an ongoing course of treatment; and</p> <p><input type="checkbox"/> cannot reduce or terminate benefits.</p>					

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<input type="checkbox"/> Provide advance notice and an opportunity for a review in advance of reducing or terminating benefits.					
Explanation:					
<input type="checkbox"/> External review processes rights and required notices: <ul style="list-style-type: none"> <input type="checkbox"/> External review of an adverse benefit determination for: <ul style="list-style-type: none"> <input type="checkbox"/> medical necessity; <input type="checkbox"/> appropriateness; <input type="checkbox"/> health care setting; <input type="checkbox"/> level of care; <input type="checkbox"/> effectiveness of a covered benefit; and <input type="checkbox"/> rescission. <input type="checkbox"/> External review of adverse benefit determinations for experimental or investigational treatments or services. <ul style="list-style-type: none"> <input type="checkbox"/> Have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. <input type="checkbox"/> Issuers must provide effective written notice to claimants of external review rights in plan materials, and in each notice of adverse benefit determination. <input type="checkbox"/> If exhaustion of internal appeals is required prior to external review, requirement to exhaust does not apply if: <ul style="list-style-type: none"> <input type="checkbox"/> issuer did not meet internal appeal process timelines (with limited exceptions); <input type="checkbox"/> in cases of urgent care. <input type="checkbox"/> Cost of an external review must be borne by the issuer. <input type="checkbox"/> Claimant cannot be charged a filing fee greater than \$25. <input type="checkbox"/> Restriction on the minimum dollar amount of a claim is not allowed. <input type="checkbox"/> Claimant must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination (including final internal adverse benefit determination). 	PHSA §2719 (75 Fed Reg 43330; 76 Fed Reg 37208, 45 CFR §147.136)	<ul style="list-style-type: none"> • 			

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<input type="checkbox"/> IRO decision is binding on the issuer. <input type="checkbox"/> For standard reviews (not urgent), the IRO must inform the issuer and the claimant in writing of its decision within 60 days from receipt of the request for review. <input type="checkbox"/> Urgent care: <input type="checkbox"/> The process must provide for expedited external review of urgent care claims. <input type="checkbox"/> The IRO must inform the issuer and the claimant of an urgent care decision within 4 business days from receipt of the request for review. <input type="checkbox"/> If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification.					
Explanation:					

DRAFT