Nebraska Department of Insurance
Life & Health Division

FORM REVIEW CHECKLIST
For Non-Grandfathered Individual and Small Group Health Plans (Major Medical)
Plan Year 2020

This checklist must be submitted with all Individual and Small Group Major Medical filings, including those submitted for certification as qualified health plans (QHPs), subject to the Affordable Care Act (ACA) and applicable federal and Nebraska state regulations. This checklist is also to be used for Major Medical plans not offered through the Marketplace. These standards are summaries only. Review of the entire statute or rule may be necessary. Complete each item by marking the check box to verify a "yes" response and indicate the page on which it can be found. Not submitting a completed checklist may cause your filing to be considered incomplete and returned without review. The following standards are subject to change.

Company Name: _____

Product Name: _____

Plan(s): _____

Category	State Law	Federal Law	Requirements	Page Number(s)
☐ **No pre-existing condition exclusions.** ☐ **Cannot discriminate based on age, life expectancy or disability.** ☐ **Must be guarantee issue with no medical underwriting.**		PHSA §2704, §2702, §2705, §1255 (75 Fed Reg 37188, 45 CFR §147.108)		
☐ **No eligibility waiting periods that exceed 90 days**		PHS Act section §2708		

☐ **Termination of Coverage**		45 CFR §155.430(b), 45 CFR §156.270	The Exchange must permit an enrollee to terminate his or her coverage in a QHP. The Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage, in the following circumstances: • The enrollee is no longer eligible for coverage in a QHP through the Exchange; • Non-payment of premiums for coverage of the enrollee, and the 3-month grace period required for individuals receiving advance payments of the premium tax credit has been exhausted; • the enrollee's coverage is rescinded; • the QHP terminates or is decertified; or • the enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period. Coverage terminates on last day of month (except date of death).	
☐ **Coordination of Benefits**	Chapter 39		Nebraska Chapter 39 Revised – now allows coordination with non-group plans.	
☐**Network Adequacy** On-line, up to date, accurate, complete provider directory with URL that is direct view without password, policy # or account. Identify which providers are not accepting new patients, location, specialty, contact info.		45 CSR 156.230 (b)	Certification signed by Officer. Reasonable access standards, travel time, number of specialists including specialists in mental health + substance use disorder services. Publish provider directory online and provide hard copy on request.	

☐ **Provides Essential Health Benefits** ☐ Ambulatory patient services ☐ Emergency services ☐ Hospitalization ☐ Maternity and newborn care ☐ Mental health and substance use disorder services, including behavioral health treatment ☐ Prescription drugs ☐ Rehabilitative and habilitative services ☐ Laboratory services ☐ Preventive and wellness services and chronic disease management ☐ Pediatric services, including oral and vision care		PHSA §2707	No waiting period for EHB's.	
☐ **Mental Health and Substance Abuse Coverage**		Essential Health Benefit Requirement	Coverage must comply with federal Mental Health Parity and Addiction Equity Act requirements. Benefits, cost sharing and managed care requirements must be the same as for any other medical or surgical coverage. Must include coverage for Alcoholism. Check Quantitative and Non-Quantitative limitations – Review CB-130 (amended). Habilitative – No limitation on # of visits.	
☐ **No lifetime limits on the dollar value of Essential Health Benefits.** **Applies to both in and out of network.** ☐ **No annual limits on the dollar value of EHB.** **Applies to both in and out of network.**		PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126) PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply.	

☐ **No rescissions except in cases of fraud or intentional misrepresentation of material fact.** • Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected.		PHSA§2712 (75 Fed Reg 37188, 45 CFR §147.128)	In a case of retroactive cancellation, the only conditions listed in the contract acceptable are fraud or intentional misrepresentation of material fact.	
☐ **Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance when in-network providers are used.** Covered preventive services include: • 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). • Contraceptive methods and counseling	Mammography: NE Rev.Stat. § 44-785, Diabetes: § 44-790 Colorectal Screening: § 44-7,102 Child immunization: § 44-784; newborn hearing screening: §44-796	PHSA §2713 (75 Fed Reg 41726, 45 CFR §147.130)	Issuers may use reasonable medical management techniques to determine frequency, method, treatment, or setting for USPSTF recommendations if not specified by the USPSTF. Issuers may have cost-sharing for office visits. Examples of allowed and not allowed cost sharing: • preventive service is billed separately from an office visit – cost-sharing ok for the office visit; • preventive service is the primary purpose of the office visit and is not billed separately from the office visit – cost-sharing may not be imposed; • preventive service is provided but is not the primary purpose of the office visit and is not billed separately – cost-sharing ok for the office visit. • All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. • Plans must provide breastfeeding support, counseling, and equipment for the duration of breastfeeding. Plans must cover the cost of a breast pump and may offer either a rental or new.	

☐ **Coverage for dependents must be available up to age 26 if policy offers dependent coverage.** ☐ **Eligible children are defined based on their relationship with the participant.** Limiting eligibility is prohibited based on: • financial dependency on primarysubscriber, • residency, • student status, • employment, • eligibility for other coverage, • marital status.	NE Rev.Stat. §44-710.01, §44-761, §44-799	PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)	Issuers are not required to cover the child of a child dependent.	
☐ **Continuing coverage for children to age 30.**	§44-7,103			

☐ **Coverage for emergency services required**		PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138)	• Cannot require prior authorization; • Cannot be limited to only services and care at participating providers; • Must be covered at In-Network cost-sharing level (patient is not penalized for emergency care at Out-of-Network provider); • 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. • Cost-sharing other than copays and coins generally applied to Out-of-Network benefits may be imposed on Out-of-Network emergency services.	
☐ **For network plans requiring a primary care provider to be designated and requiring referrals**: ☐ allow each enrollee to designate any participating primary care provider who is available to accept such individual ☐ a physician specializing in pediatrics may be designated as PCP ☐ no referral required for services from in-network OB/GYNs	OBGYN: NE Rev.Stat. § 44-786	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138)		

□ **Out-of-Network**		45 CFR 156.230 (e)	Count the cost sharing paid by the insured for an EHB provided by Out-of-Network provider in an In-Network setting toward the insured's Out of Pocket Maximum. For Out-of-Network non-emergency services, the contract MAY NOT be vague or illusory as to what the company will pay.	

☐ **Maternity coverage (see EHB) and required benefits for hospital stays in connection with childbirth:** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. 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. No prior authorization required for 48/96 hour hospital stay	Adopted child from date of placement: NE Rev.Stat. § 44-799; Newborn from moment of birth: § 44-710.19	PHSA §2725 (45 CFR §148.170)	The issuer is not allowed to: • Deny the mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements; • Provide monetary payments/rebates to encourage mothers to accept less than the minimum requirements; • Penalize an attending provider who provides services in accordance with these requirements; • Provide incentives to an attending provider to induce the provider to provide care inconsistent with these requirements; • 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; • Require the mother to give birth in hospital; • Require the mother to stay in the hospital for a fixed period of time following the birth of her child. • Exclude maternity benefits for a dependent child. Issuer must make it clear in forms when the newborn is subject to a separate deductible. No premium charge for automatic newborn coverage first 31 days. Premium & application due to continue beyond 31 days.	

☐ **Coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act)**	NE Rev.Stat. § 44-797	PHSA §2727	Note: NE Statute does not limit mastectomy to cancer diagnosis only.	

☐ **Coverage is guaranteed renewable**		PHSA §2702 (45 CFR §148.122)	Face page of contract must have renewability provision.	

☐ **Catastropic Plan**			It is only offered to individuals eligible to enroll in such a plan. People under age 30 and people with hardship exemptions may buy a "catastrophic" health plan.	
☐ **Providers operating within their scope of practice cannot be discriminated against**		PHSA §2706	Service / treatment is covered with no limitations on licensed providers who can provide that service. Providers cannot charge for services provided to immediate family as defined by statute.	
☐ **Coverage for individuals participating in approved clinical trials.**		PHSA §2709	• Issuer must cover "routine patient costs" – items and services consistent with benefits for typically covered services. • An "Approved clinical trial" – is a 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 as outlined in PHSA 2709.	
☐ **Special enrollment period**		IR Code 1986; Part D of title XVIII of the Soc Sec Act	Plans in the Marketplace must have special enrollment periods if a qualifying life event occurs, such as getting married. Must allow enrollment in or change health insurance plan outside the open enrollment period. Most special enrollment periods last 60 days from the date of the qualifying life event. Applicant must provide documentation to verify the qualifying event within 30 days.	

☐ **Open enrollment period is required**			Small Group Issuers may determine the number and length of open enrollment periods.	
☐ **Minimum 60% actuarial value is required for individual coverage.**		ACA §1302	URRT must be submitted to HIOS and in the SERFF rate filing. SERFF rate filing must include rate schedule, Actuarial Memorandum, Actuarial Certification, URRT and Rate template.	
☐ **Claims procedures, including applicable time frames** ☐ **Time and process for urgent care (pre-service, post-service):** • Determination for urgent care made within 72 hours. • Notice of the determination within 72 hours of receipt of the claim. • Notice of urgent care decisions include a description of the expedited review process applicable to such claim. • No extension of the determination time-frame is permitted. • 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. • The claimant must have at least 48 hours to provide the specified information. • 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).		45 CFR §147.136; 29 CFR § 2560.503-1 ERISA		

☐ **Time and process for concurrent urgent care (at the request of the claimant):** • Claim for concurrent urgent care: if a claimant requests to extend the course of treatment beyond time/number of treatments. • Claim must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. • Determination must be made within 24 hours. • Notification is required within 24 hours of the claim's request				
☐ **Time and process for pre-service claim:** • Determination and written notice of decision for a pre-service claim must be made within 15 days of the request of the claim. • Extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. • Notice of the extension prior must be provided to the claimant prior to expiration of the initial 15-day period. • Claimant has 45 days from receipt of notice of insufficient information to provide specified information.		ERISA 29 CFR 2560.503-1	Review Title 210 NAC Chapter 61, Unfair Claims Settlement Practices • The issuer must identify for the claimant the circumstances requiring the extension and date by which the issuer expects to render a decision. • 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.	

☐ **Time and process for post-service claim:** • Acknowledge any claims correspondence within 15 days. • Determination and written notice of decision for post-service claim must be made within 30 days of receipt of claim. • Written notice of denial must be sent within 15 days of determination. • Electronic prompt payment within 30 days. • Extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. • Notice of the extension must be provided to the claimant prior to expiration of the initial 30-day period. • The claimant has at least 45 days from the receipt of notice to provide the specified information.	NE Rev.Stat. § 44-8004 Prompt payment Chapter 61, 006, 008 § 44-710.03 (8)	ERISA 29 CFR 2560.503-1	• The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision. • If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information needed to make a decision.	
☐ **Internal Appeal** (other than Adverse Benefit Determination appeal)	44-7308		See NE Grievance Procedures for Managed Care Plans (PPO, HMO Major Medical, Dental with Preferred Providers)	

☐ **In the case of an adverse benefit determination, the notification shall include:** • 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); • 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. • Specific reason(s) for the determination, • Description of available internal appeals and external review processes. • Information on how to initiate an appeal. • Information about the availability of, and contact information for NE Department of Insurance. • Statement that the claimant is entitled to receive copies of all documents, etc relevant to the claim.	Chapter 61 §008			

☐ **Internal appeals of adverse determinations - processes, rights and required notices:** • Enrollees have a right to appeal an adverse benefit determination. • Enrollees may review the claim file and submit evidence as part of the internal appeals process. • Enrollees have at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal. • Determination must be made in writing within 15 working days after receipt of the claimant's request.	NE Grievance Procedures: NE Rev.Stat. §44-7310.	PHSA §2719 (75 Fed Reg 43330; 76 Fed Reg 37208, 45 CFR §147.136)	• No extensions of determination time periods. • Must be reviewed by peers in similar specialty who were not involved in initial adverse determination. • If differences are not resolved, another written grievance may be filed.	
☐ **Expedited Reviews:** • Enrollees must have access to an expedited review process.	NE Rev.Stat. § 44-7311		• The issuer must provide the claimant with written or electronic notice of the determination in a culturally and linguistically appropriate manner. • Expedited review is not available for retrospective adverse determinations.	

☐ **Written Appeal Decision shall include:** • The names, titles and credentials of reviewers. • Notice of Covered Person's right to contact Director's Office, with telephone # and address. • The detailed rationale for the decision. • Reference to documentation or evidence used as the basis for the decision. • Instructions for External Review.	NE Rev. Stat. §44-7308 (3), Chapter 87			

☐ **An adverse benefit determination means:** • a denial, reduction, termination of, failure to provide or make payment for a benefit; • a denial, reduction, termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to participate in a plan; •a denial, reduction, termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review; • failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational; • or the service was determined to be not medically necessary or appropriate. • A rescission of coverage must be treated as an adverse benefit determination. • The definition of 'Adverse Benefit Determination' must be included in the policy or certificate.			• If an issuer fails to adhere to all of the requirements listed with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate an external review or any remedies available under state law. • The 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 • That the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the claimant. • Ongoing (concurrent care) decisions: • Issuer is required to provide continued coverage pending the outcome of an appeal; • must provide benefits for an ongoing course of treatment; and • cannot reduce or terminate benefits. • Provide advance notice and an opportunity for a review in advance of reducing or terminating benefits.	

☐ **External Appeal processes rights and required notices:** ☐ External review of an adverse benefit determination for: • medical necessity; • appropriateness; • health care setting; • level of care; • effectiveness of a covered benefit; and • rescission. ☐ Claimant must have at least 4 months to file for external review after the receipt of the notice of adverse benefit determination. ☐ Forms for requesting an External Review are found on www.doi.nebraska.gov. ☐ The Director of the NE DOI receives the External Review request and gets preliminary information from the Health Carrier within 5 business days. ☐ The Director assigns an IRO within 1 business day and notifies Health Carrier and Covered Person. ☐ IRO decision is binding on the issuer. ☐ For standard reviews (not urgent), the IRO must inform the issuer and the claimant in writing of its decision within 45 days from receipt of the request for review.	NE Chapter 87. NE Rev.Stat. §44-1308 through 44-1317	PHSA §2719 (75 Fed Reg 43330; 76 Fed Reg 37208,45 CFR §147.136);	• External review of adverse benefit determinations for experimental or investigational treatments or services. • 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. • Issuers must provide effective written notice to claimants of external review rights in plan materials, and in each notice of adverse benefit determination. • If exhaustion of internal appeals is required prior to external review, requirement to exhaust does not apply if: • issuer did not meet internal appeal process timelines (with limited exceptions); • in cases of urgent care. • Cost of an external review must be borne by the issuer. • Claimant cannot be charged a filing fee greater than $25. • Restriction on the minimum dollar amount of a claim is not allowed. • Chapter 87 contains sample forms for requesting an External Review. Forms are also available on DOI website.	

☐**External Appeal of Experimental / Investigational adverse benefit determination:** Same as above, except the IRO selects a Clinical Reviewer within 1 business day. Clinical Reviewer opinion is due within 20 days after selection. IRO makes decision within 20 days after receipt of opinion.				
☐ **Expedited External Appeal:** • The process must provide for expedited external review of urgent care claims. • The IRO must inform the issuer and the claimant of an urgent care decision within 72 hours from receipt of the request for review. • If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification.				
NOTE: SUMMARY OF BENEFITS AND COVERAGE MUST BE FILED IN THE BINDER FOR EACH PLAN FILED IN NEBRASKA.				