

**Webinar 4: Plan Management, Templates,
Binders and Actuarial Topics
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Welcome! Thank you for registering for the final round of our educational webinars. Let me introduce those in the room, we have myself, Karl Knable, and also in the room from the health care reform team, are Greta Hockwalt, Stephen Chamblee, Cathleen Nine-Altevoigt and Therese Sahn. From the rate and form filings area we have Bobbi Henn, Paul Hyslop, Kim Collins and Kate Kixmiller.

Your lines will be muted throughout the duration of the webinar. If you have a question, please enter it in the chat section of your control panel. We will monitor for questions that need immediate response, otherwise we will address all at the conclusion of the program.

Audience For Today's Webinar

- This webinar is intended to address on and off Marketplace plan management, Indiana-specific individual and small group templates, and actuarial topics.



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As a reminder, this is the last webinar. We have combined the 5th webinar with this.

Additionally, we plan to have our Indiana specific templates available in the binder on April 1. That is the date that you can safely initiate your binders.

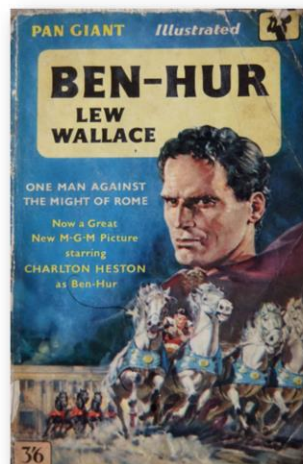
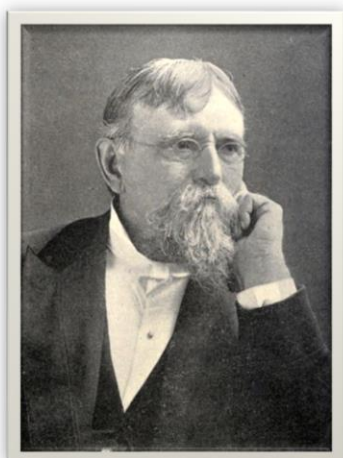
Agenda

- Market Withdrawal/Product Discontinuance
- CMS Plan Management Templates
- Uniform Modification
- IDOI EHB Verification Template
- IDOI Rate/Crosswalk Template
- URRT
- Actuarial Value Calculator



-All small group, individual, SADP both on and off exchange need to submit Binders.

Lew Wallace: Famous Hoosier Writer and Inspiration for Insurance



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He served as an adjutant general in the Civil War where he commanded the 11th Indiana Infantry Regiment. He was later the Governor of the New Mexico territories and was a minister to Turkey. He wrote the famous novel Ben Hur which inspired an insurance company, Ben HUR Life association, now known as USA LIFE ONE INSURANCE COMPANY

Market Withdrawal/Product Discontinuance – Non-Grandfathered

- Plans are expected to keep same plan IDs
- Service Area
 - Increases-OK
 - Decreases-Conditional
- Market withdrawal is defined as:
 - All products are withdrawn
 - Triggers 5 year ban
- Product withdrawal means:
 - None of the plans offered in the previous year under a product are offered again

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If you are recertifying a plan, keep the same plan ID as 2016.

A carrier only sells Product A.

In 2016 – Product A only has plans 1,2,3

In 2017 – Product A has plans 4,5,6 This is considered a product withdrawal. Thereby triggering a market withdrawal. Please read the details in the payment notice and the URRT instructions as this could create an unintentional market withdrawal.

If you plan to decrease your service area, you need to have discussion with us prior to submission of your filing.

Our overarching goal is to keep plans consistent from year to year for policyholders.

Consistency of Coverage

- Plans should stay as consistent as possible from year to year
- All plans offered in 2016 must be crosswalked to a plan for 2017
 - This includes plans the carrier would like to discontinue
- Crosswalking must follow the Federal crosswalking hierarchy described in the Plan ID Crosswalk Template instructions.
 - When possible, continue the same plan. If the plan must be discontinued then try to map to another plan with the same metal level in the same product. If no such plan exists, then:
 - If the old plan is Silver then the new plan must be Silver even if this changes products
 - If the old plan is not silver, then the new plan should be in the same product as the old

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- Both on and off Exchange 2016 plans will need to crosswalk to 2017 plans.
- CMS has updated the crosswalk hierarchy so that silver plans are always crosswalked to silver plans.
- We will be reviewing plans and cross-walking to ensure that there are no discriminatory practices taking place.

Binder Issues



- The templates between HIOS and SERFF binders must always match!
- The Binders (not filings) should house all templates.
- The Indiana Actuarial Memorandum is the only document that should be included in both the Binder and the normal SERFF filing.

- Templates cannot be different between SERFF and HIOS.
- All companies will submit binders this year. In order to submit a binder you need to submit a list of plan ID's, off exchange carriers will use a "light" version of the plans and benefit template.
- We do not have the name for the "light" version but have been told it will have only 3 columns.
- We will be implementing the SERFF filing instructions on April 1.

IDOI Template Versions Log

- Challenge: The templates between HIOS and SERFF binders must always match!
- Solution: For each revision of a Federally created Plan Management template, carriers attest that the template in HIOS is identical to the template in SERFF using the IDOI Template Versions Log.

IDOI Template Versions Log		Version 1.0	Last updated: 3/22/2016
<p>The Federally created Plan Management Templates must be posted both in HIOS and in SERFF. This template will be a written record of the changes made to these templates and when the updated template was submitted to both HIOS and SERFF. Every time a Federally created Plan Management Template is updated or corrected, 1) a new version will need to be submitted to HIOS, 2) a new version will need to be submitted to SERFF in the Binder, 3) A record of the update will need to be added to this template and this updated Template Versions Log will need to be resubmitted to SERFF. This log does not need to be completed for any templates that are not also posted in HIOS, such as state created templates.</p>			
Template	Date Submitted to HIOS	Date Submitted to SERFF	Brief Description of Most Important Changes

- This is an excel spreadsheet that we are requiring to help track any changes that occur during the filing process.
- Changes in templates has been an issue in prior filing seasons.
- This will be part of your Binder submission.
- The template versions log will need to be completed whenever any changes are made to the submitted templates.
- This log will only be required for templates that are submitted to both HIOS and SERFF. All templates whose name begins with "IDOI" is a state created template, and will not need to be tracked using this log.

Plans and Benefits Template and MHPAEA

- MHPAEA Tips
 - For each plan and for each classification, choose a cost-sharing type (copay, coinsurance)
 - Use coinsurance for “substantially all” medical surgical benefits or
 - Use copays for “substantially all” medical surgical benefits
 - Substantially all means at least 2/3rds weighted by allowed claims
- SG must offer morbid obesity in at least one product
- Link for MHPAEA final rule:
<https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>



Issuers may divide benefits provided on an outpatient basis into two sub-classifications; 1) office visits, and (2) all other outpatient items and services, in determining the substantially all definition.

If you do not have a type of cost-sharing that fits the substantially all definition, then there is no cost-sharing allowed for mental health coverage.

Uniform Modification



- Can change benefits as long as all plan adjusted index rates do not change by more than 2%
- New plan submissions cannot be a Uniform Modification of any plan offered in the prior 12 months
- If a plan is being continued, it must have the same plan ID
- Changes to cost-sharing should be kept to a minimum but may be necessary for AV and MHPAEA compliance

We want any changes in benefits that are not due to the new EHB to be detailed in the actuarial memorandum. We will expect a demonstration showing that the change is less than 2% for all plans under that product.

Remember that Indiana does not allow substitution of benefits. You cannot bring back a plan that was terminated.

Formulary Template



- The Prescription Drug Template should be a comprehensive list of coverage
- Include coverage for HIV drugs that aligns with HRSA
 - We will be reviewing to ensure the most recent approved drugs are covered.
- Be judicious with your use of prior authorization and step therapy
- Make sure your template is complete and consistently formatted
- We will be running the template against our own tools developed with the help of pharmacy experts in the state to insure the inclusion of clinically appropriate drugs.

- There is an updated RXCUI Norm spreadsheet from CMS.
- The drug template is supposed to be an exhaustive list of all drugs covered.
- Student Health Plans will need to submit Federally created Prescription Drug Template, which is available at:
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html>

IDOI EHB Verification Template

- Benchmark Benefits Package tab
 - Very different from last year's version
 - Details a set of benefits offered in the Benchmark for comparison to benefits offered in all Products
 - **Corrections may be made in red**
 - We will also include a list of changes made to the new benchmark to ensure ACA compliance

Instructions: This is the Benchmark Benefits Package for Indiana. You will use the Product Comparison tab to describe the differences in benefits between each product and Indiana's benchmark's benefits for plan year 2017 listed below.

Corrections, clarification, exclusions, benefit explanations, or additions that apply to most of your products may be entered in this table in red.

Benefit Information		Out of Pocket		
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantit
Primary Care Visit to Treat an Injury or Illness	Yes	Covered		
Specialist Visit	Yes	Covered		
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered		

- No product specific information will be collected on this tab. This merely indicates what is covered within the EHB.
- If you have benefits that need to be added to a product, then you should add that in red at the end of the existing list.
- The entire IDOI EHB Verification Template is required for all carriers filing major medical plans through Binders (including carriers only submitting Off-Exchange only plans) as well as Student Health Plans (who will not submit Binders).

IDOI EHB Verification Template

- Product Comparison tab
 - New for plan year 2017
 - List EVERY product for plan year 2017
 - If you have 5 products, all 5 need to be listed here
 - Compare EVERY product to the Benchmark Benefits Package
 - Comparisons are freeform

Instructions: List every product ID and for each product, describe in detail the differences between the Benchmark Benefits Package and the benefits offered by that product. Keep in mind that two different products must have differences in their benefits.

HIOS Product ID (12345IN001)	Product Specific Benefit Variation from the Base Benefits Package

We do not expect a column by plan, this is strictly a product level comparison.

IDOI EHB Verification Template

- Plan tab
 - Nearly the same as last year's version
 - Plan ID, Market, Metal Level,...

Instructions: Please provide the following for each plan.						
HIOS Plan ID (12345IN0010001)	HIOS Issuer ID (12345)	HIOS Product ID (12345IN001)	Market Coverage	Off Exchange Only?	Plan Marketing Name	Formulary ID

Carriers did a good job of completing this tab last year. We need every plan to be listed for each product.

IDOI EHB Verification Template

- MHPAEA tab
 - New for plan year 2017
 - Plan level check for Substantially All/Predominant test
 - Simplified cost-sharing is recommended to help pass this requirement
 - Captures the following at the plan level:
 - Financial requirement type (substantially all test)
 - Predominant level
 - Mental health cost-sharing

Financial Requirement Type (Copay/Coinsurance/Both) Applied to Substantially All (at least two-thirds of) Medical/Surgical Benefits							Predominant Level		
Inpatient (In-Network)	Inpatient (Out-Of-Network)	Outpatient Office Visits (In-Network)	Outpatient Other (In-Network)	Outpatient Office Visits (Out-Of-Network)	Outpatient Other (Out-Of-Network)	Emergency Care	Inpatient (In-Network)	Inpatient (Out-Of-Network)	Outpatient Visits

- A version of this sheet (the IDOI MHPAEA Template) will be required from Large Group filers.

See 29 CFR 2590.712 for further details.

IDOI Rate/Crosswalk Template

- This template is very important for ACA Rate Review in Indiana
- This template is used to analyze
 - Service area
 - Premium increases
 - Rates
 - Crosswalking
 - Second lowest cost silver in each county
 - Non-discrimination review
 - Product/plan discontinuation



Both new plans and plans with increasing service areas should be marked as “New Offering” in that county.

You will still need to complete the federal crosswalk template.

IDOI Rate/Crosswalk Template

- Must include all plans that were offered in 2016 and all plans that will be offered in 2017
- Follow Federal crosswalking hierarchy rules
- Mark new plans that are not the target of crosswalking, as “New Offering”
- New counties for existing plans
- Do not include Marketing Name

County	Rating Area	2016 HIOS Plan ID (12345IN0010001)	Plan Year -1			
			2016 Metal Level	2016 Service Area ID	2016 Network ID	2016 Age 21 Non-Tobacco Rate
Adams	Rating Area 3	12345IN0010001	Silver	INS001	INN001	300
Allen	Rating Area 4	New Offering				
Bartholomew	Rating Area 12	12345IN0010002	Gold	INS001	INN001	400

Both new plans and plans with increasing service areas should be marked as “New Offering”.

ECP/ Network Adequacy Template

- CMS will assess provider networks using a “reasonable access” standard.
- For off marketplace plans, we will rely on an issuer certification.

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Make sure you have all 6 specialties covered following the CMS guidelines contained in the letter to issuers

Rate Data Template

- Rounding Rules

Category	Unrounded Premium (after applying all rating factors and plan level adjustments using full precision)	Rounded Premium	Revised Rounded Premium (to avoid exceeding the 3:1 and 1.5:1 maximum variation for age and tobacco use, respectively)
21 year old non-tobacco user	\$100.40	\$100	\$100
64 year old non-tobacco user	\$301.20	\$301	\$300
21 year old tobacco user	\$150.60	\$151	\$150
64 year old tobacco user	\$451.80	\$452	\$450

- Premiums for non-grandfathered plans in the individual or small group markets generally are rounded to the nearest penny. (Given the rate does not exceed the 3:1 or 1:1.5 max variation for age or tobacco use)

Rates may only be rounded at the final stage and therefore will only be allowed to be rounded once. Issuers may not round rates at intermediate steps. If you choose to round premiums to the dollar for one plan in the risk pool, you must round premiums for all plans in the risk pool.

Please remember that May 11, 2016 is the last day to submit your final rates to the IDOI. If for any reason the IDOI finds a reason for your rates to be adjusted, we will require that you submit some form of work showing your methodology on how you formulated your first submission of rates.

Service Area Template

- Follow the directions from CMS
- Partial counties are not allowed in Indiana
- Small Group concerns



When a network plan offered in a State has a limited service area, we noted that this policy could result in an issuer having to make a plan available under the guaranteed availability rules to an employer-because the employer has an employee who lives, works, or resides in the service area-but not be able to apply a geographic rating factor under the current rule-because the issuer might not have established rates applicable to the location of the employer's principal business address outside the plan's service area.

We proposed to amend § 147.102 to provide for an additional principal business address to be identified within a plan's service area in these circumstances so that the plan can be appropriately rated for sale to the employer. In such instances, the additional principal business address would be the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year, or, if there is no such business address, an address within the service area.

CMS requires that states ensure that service areas are created in a non-discriminatory fashion. We will consider a safe-harbor to be covering all counties within a Rating Area.

URRT

- Plan level threshold rate increase
- Including experience of discontinuing plans
- % of benefits that are EHB
- Consistency-We expect that most plans will be continued each year.
- Final version to come out just before May 11th
 - Carriers should use the draft version for submission

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- Threshold level increase is keyed on plans.
- All discontinuing plans need to be mapped to a plan for 2017.
- Remember, you cannot discontinue all your plans as that would be a market withdrawal.
- For marketplace plans the % of EHB needs to be included.

Actuarial Value Calculator

- Provide screen shots of the AV Calculator for every plan that will be offered in 2017
- Plan ID's can and should be added to the AV Calculator
- Unique plan design.
- New Maximum Out of Pocket (MOOP)
- Trended continuance tables



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- I just want to emphasize that we receive screen shots for all calculations and these should tie with the URRT and the PBT, if not provide explanation.
- Please make sure that the plan ID appears on all screen shot copies.
- Please provide screen shots for all cost share variations.
- If a plan design is a unique plan design we still need an AV screen shot.
- \$7,150.00

Any Questions?



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A few miscellaneous items that we wanted to emphasize: 1.) If you have any cost share variances due to using the standardized option as set forth by CMS, you will need to file a new EOC and you should not add additional benefits to a standardized plan 2.) Examples of potentially discriminatory benefit design according to CMS within the letter to issuers is not covering a single tablet but a multiple tablet regimen when one tablet is just as effective; another example is putting all drugs that treat a specific condition in the highest cost formulary tier. 3.) QHP issuers must provide the same compensation to agents/brokers for QHPs in the Marketplace as is provided to similar plans that are off the market.

With regard to cost share variances, if you did not submit a variable schedule for 2016 and you want to add additional cost sharing variances, we will require a new EOC for 2017.

Questions received in advance that we will now answer:

Out of Network Cost Sharing - Surprise out of network costs within an in network facility, the costs will count towards the deductible and maximum out of pocket.

- Is this required to be applied to the network deductible and MOOP, or can it be

applied to the non-par deductible/MOOP in a PPO plan.

- *These excess fees should be applied to the in network deductible and MOOP.*
- HMO non-par providers must be covered in these situations, correct? *Yes, they are covered to the extent that the insured expected an in-network provider to be used.*

Drugs/doctors- continuation of care is required for up to 90 days or through the course of treatment if the doctor is dropped from the network without cause.

- So this applies to a pharmacy that is no longer network? Or are you referring to a drug that is no longer in the formulary? *Our understanding is that both of these situations would be continued.*

These are specific items that did not translate from dollar limits to service limits. As such they are to be written as \$ limits per incident or transplant.

- Accidental Dental-- \$3000 per incident
- Human Organ Tissue Transplant (“HOTT”) transportation and lodging-- \$10,000 per transplant
- HOTT unrelated donor search-- \$30,000, per transplant

Question:

- Do you mean to remove the \$ limit or keep it. In past filings you had indicated these were considered EHB's. As such a \$ limit can't be applied.
- *A lifetime or annual dollar is not allowed however per incident or per transplant limits are allowed.*

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