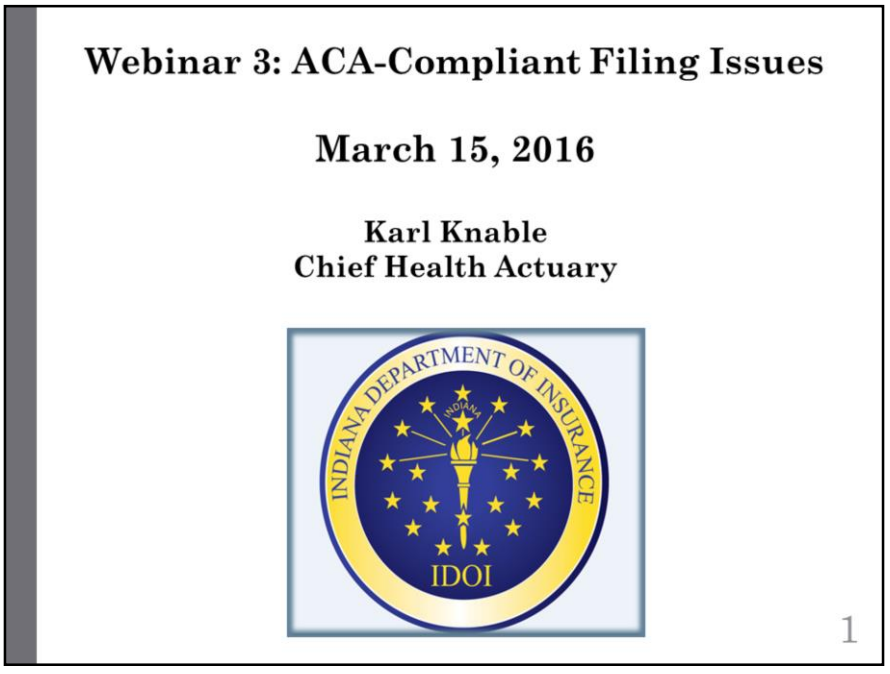
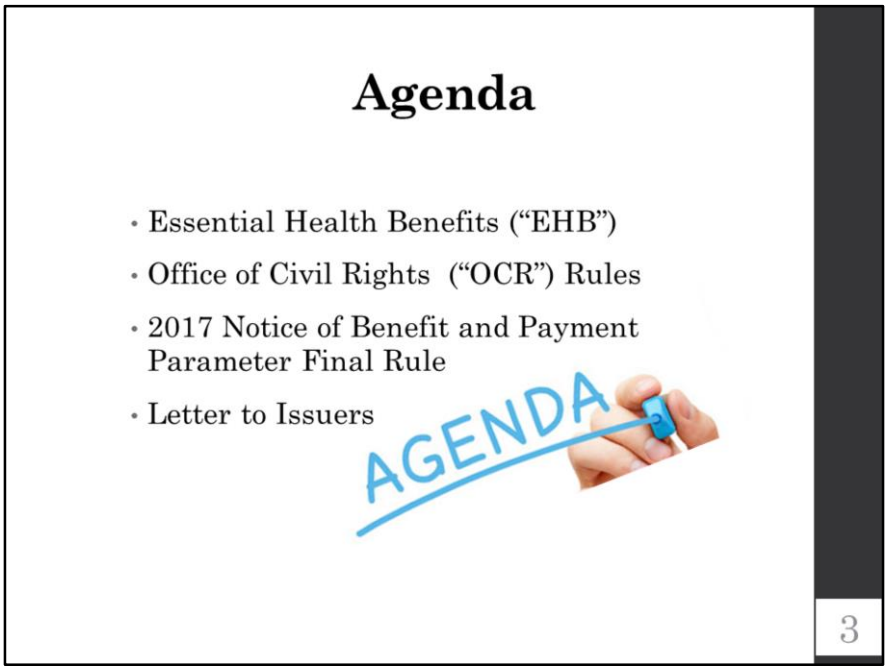


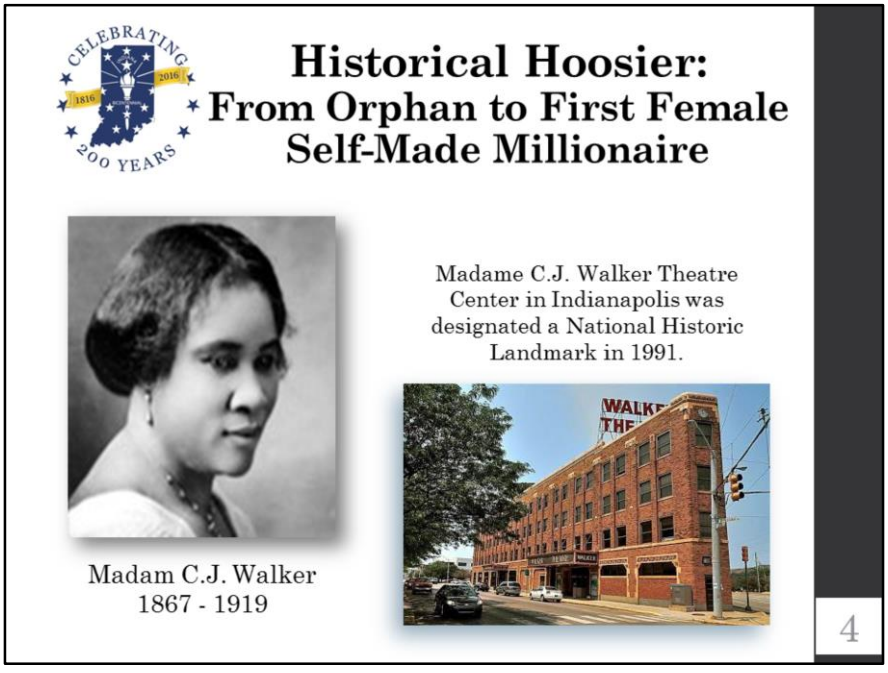

Welcome! Thank you for registering for the third round of our educational webinars. Let me introduce those in the room, we have myself, Karl Knable, and also in the room are from the health reform team, Greta Hockwalt, Stephen Chamblee, Cathleen Nine-Altevogt and Therese Sahm. From the rate and form 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.

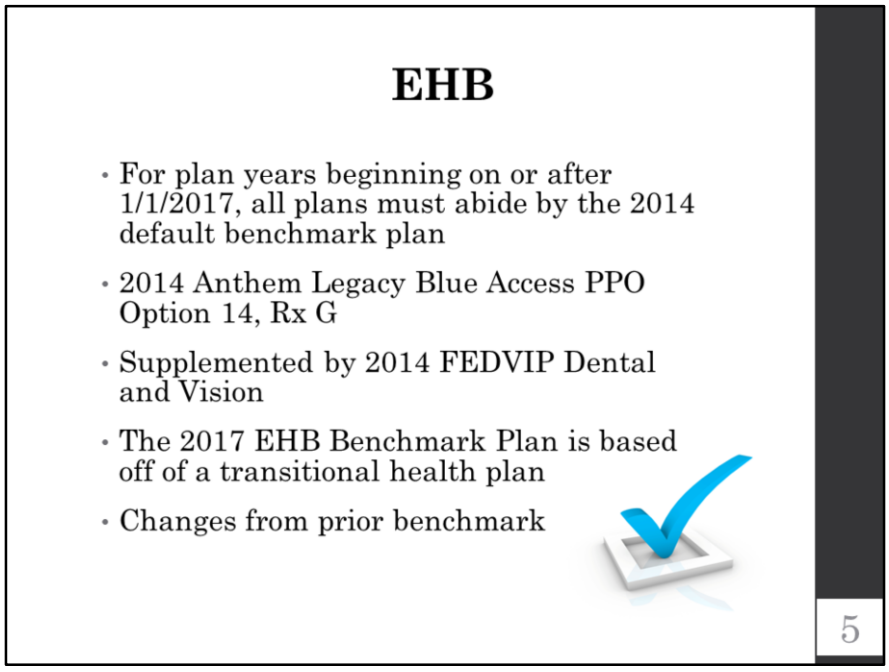

This webinar is focused on ACA compliant filings both individual and small group.




- EHB- Indiana has defaulted to the largest small group plan from 2014.
- OCR – A number of items were proposed that will address some discriminatory practices.
- 2017 NBPP – We will be highlighting a few key items.
- LTI – We will also key in on a few items of importance.



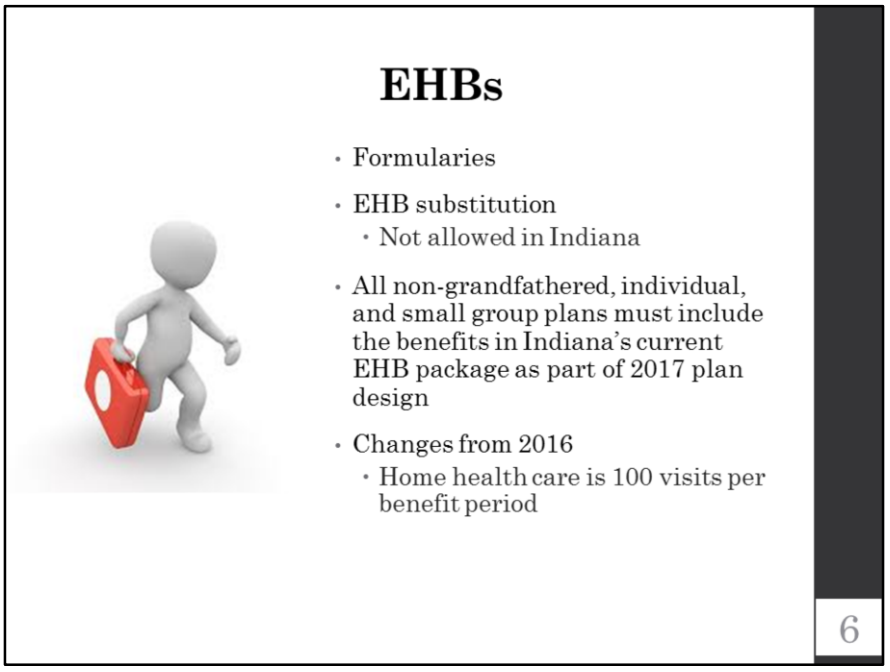

According to Visit Indy, Madame CJ Walker was the first self-made female millionaire in the United States after creating and marketing hair care products.




-The 2017 benchmark may be found under the compliance website in the resources section, https://secure.in.gov/idoi/2812.htm

- 2014 FEDVIP Dental and Vision are used to supplement the benchmark.

- The following changes are required to make the EHB benchmark plan fully compliant with applicable ACA requirements :
- (1) Habilitative Services Definition
- (2) Human Organ tissue transplant (“HOTT”)Benefits
- (3) Home health care-prior benchmark required 90 visits; new benchmark requires 100 visits.



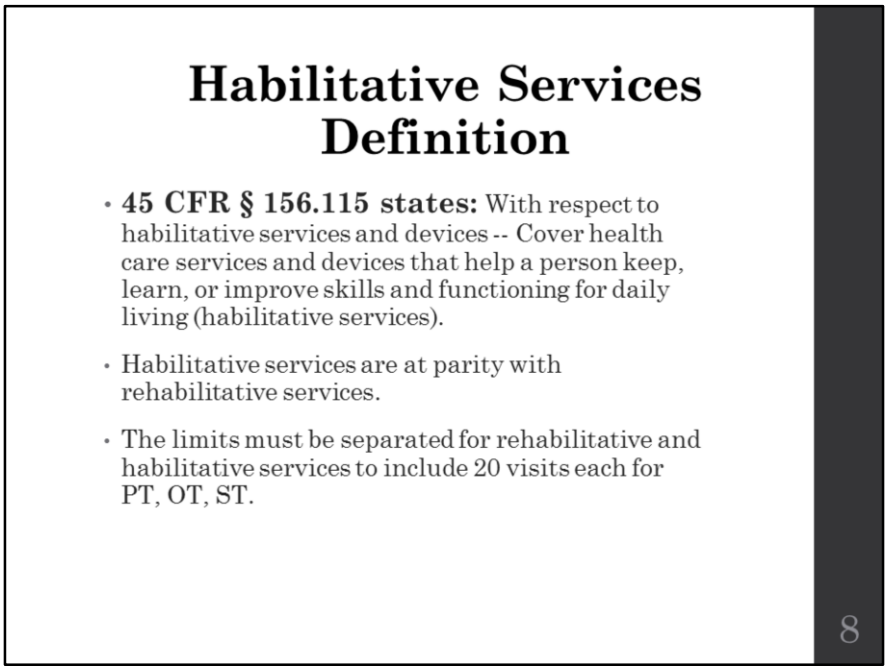

-The 2016 payment notice said that Pharmacy & Therapeutics (P&T) Committees would be required. At this time they have not provided any specific guidance.
- Indiana has worked with a group of pharmacy experts within the state to develop specific templates to evaluate the specific health needs of Hoosiers. This will most likely lead to additional scrutiny of formularies.
- Again, with the new benchmark, we do not allow substitution of benefits.
- We have some specific Indiana templates for those carriers not using the plans and benefit template
- For 2017, one change is that home health care must cover 100 visits.

## EHB Benefit Limits

- **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

7

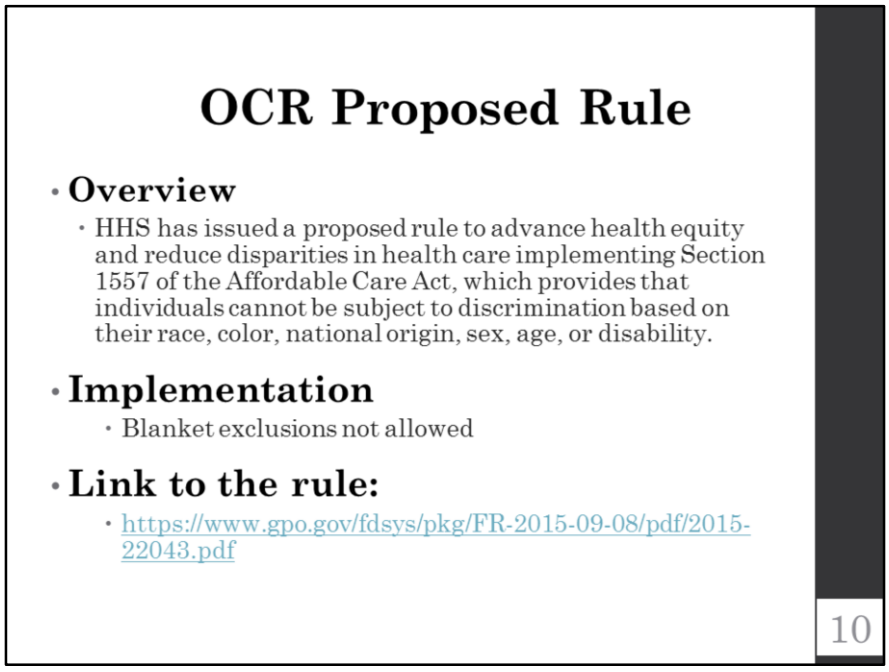
These are specific items that did not translate from dollar limits to service limits. As such, they are to be written as $ limits per incident or transplant.




Indiana has not defined this in the past. The current definition is what has been provided by CMS.

Last year, some states allowed combined rehabilitation and habilitation benefits, Indiana did not allow this. We will continue to require separate limit visits for PT, ST, and OT.

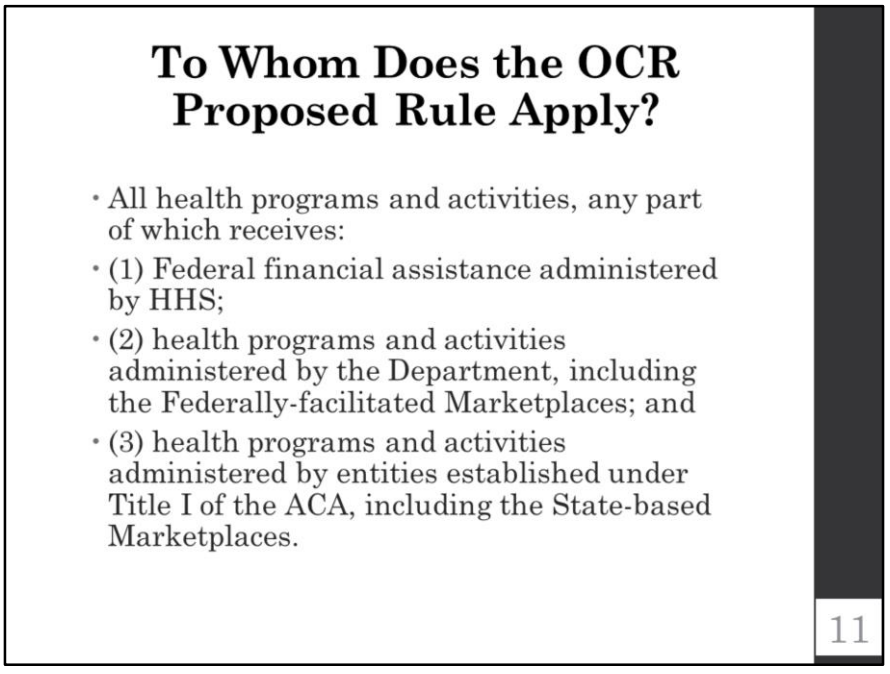

- We understand that the benchmark is based on a transitional product. Each carrier is responsible to ensure that there are no discriminatory benefit designs in the policy.
- Even if our benchmark has exclusions, if those exclusions would be considered discriminatory, the benefits must be covered. These benefits above the benchmark will continue to comply with EHB relating to allowable PTC.



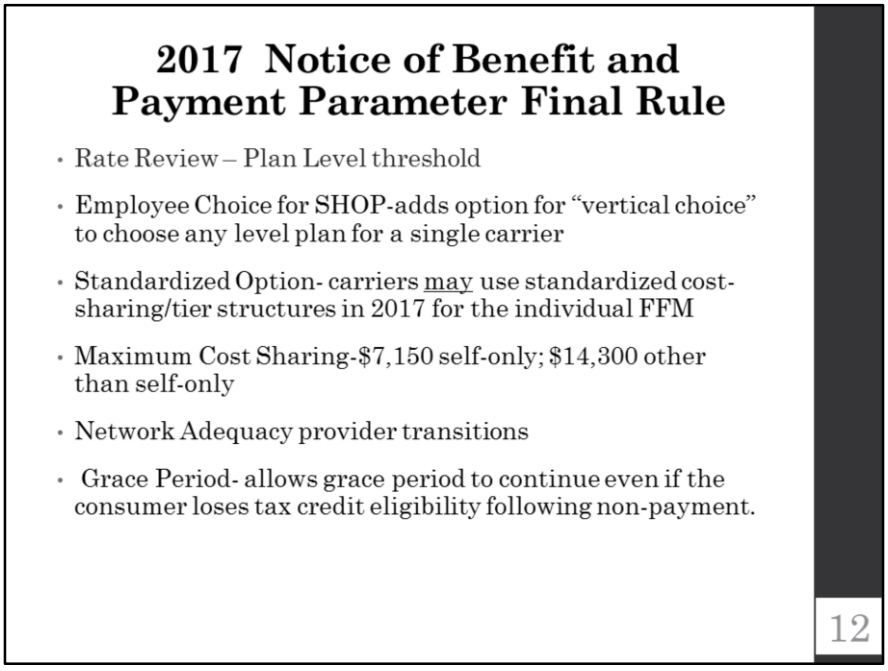

The rule does not require carriers to provide certain benefits. However, there cannot be a blanket exclusion. Also, covered benefits cannot be discriminatory based on gender, age or disability (which could impact some benefits that are only provided to minors.)

-Individuals cannot be denied health care or health coverage based on their sex or any other protected category

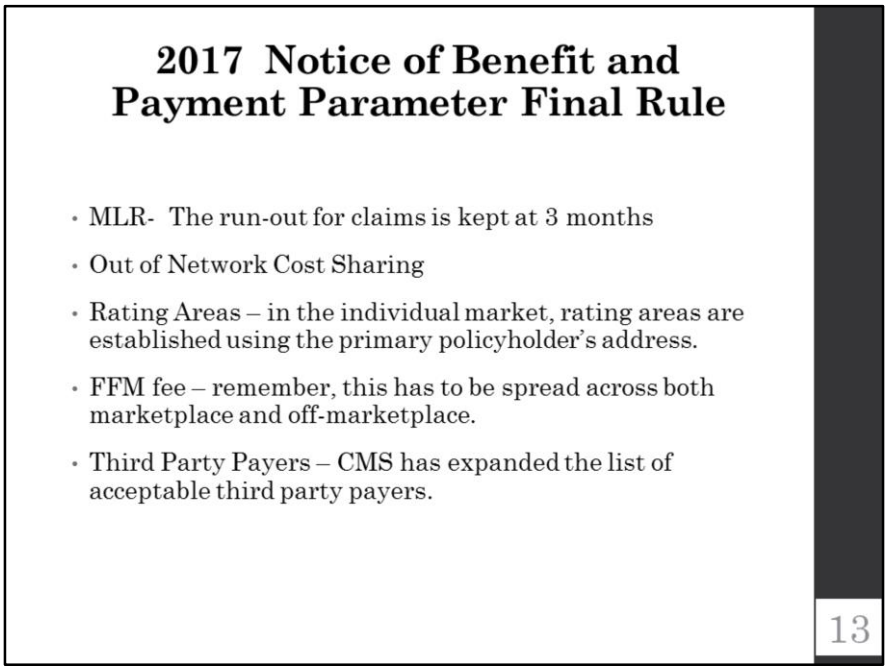
- .This is a link to the proposed rule.
- This applies to all companies that receive any federal funding
- Carriers are responsible for knowing these rules




Types of funds:
QHP receiving PTC
Reinsurance/Risk Adjustment
Medicare payments for MA
Medicaid
Tri-care
Just a partial list
Company example
A subsidiary would roll up to the parent level
All subsidiaries of the parent need to comply

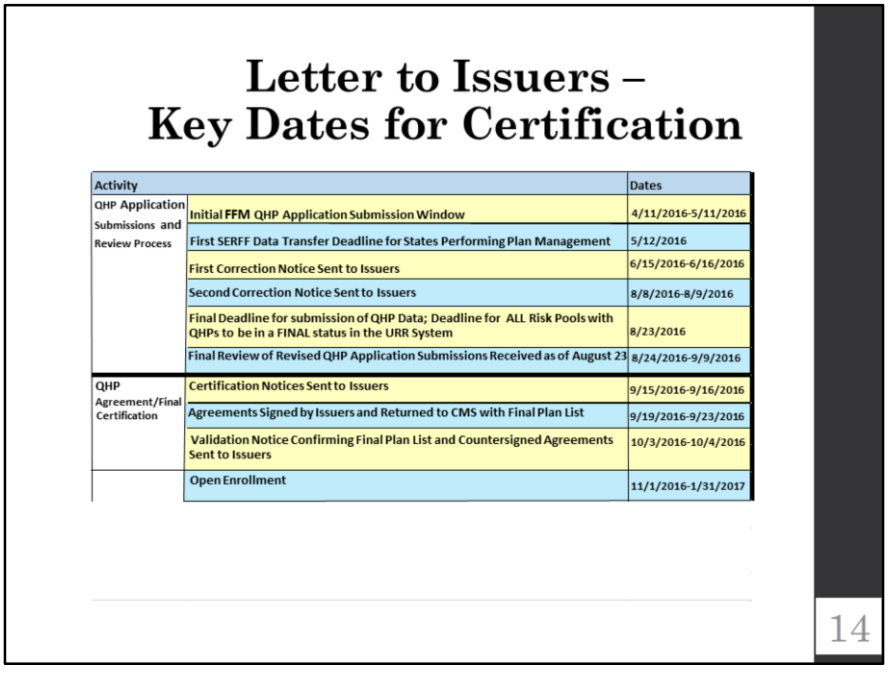



-Rate Review – We will be reviewing at a plan level for threshold increases.
-E'ee choice – This will be an option for any employer purchasing through the SHOP exchange. This is done at the SHOP level, not the company level.
-Standardized plans are not required. If you use them you need follow the guidelines in the NBPP. They will be identified as such in the plans and benefit template.
- Maximum cost sharing. Just to clarify, $7,150 is the maximum out of pocket for any one individual regardless of whether it is a family or individual plan.
- Network Adequacy – 156.230 page 525 there needs to be a period of time allowed for policyholders to transition to a new provider.
- The grace period applies to those that lose PTC for the full 90 days.




-MLR There was consideration in extending the run-out, however it was kept at 3 months.
-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.
-Rating area – This affects small group writers. – If you write small group, the premiums are based on the address of the business.

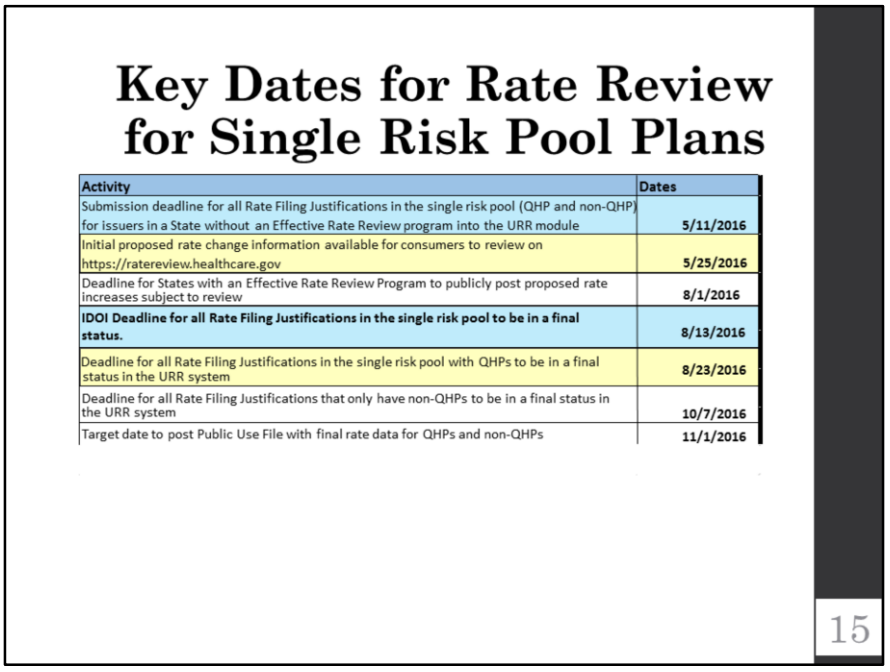
- Again as in the past, the FFM marketplace fee is spread across all insureds both on and off the marketplace.
- CMS has expanded the list of acceptable third party payors.
- Please remember, these are not exhaustive summaries of the CMS guidance, please make sure you are familier with the guidance and call if you have any questions.




Indiana is requiring both rates and forms and all templates to be submitted on May 11, 2016. This does include binder submissions which are required for both on and off the marketplace .

Any data correction notices will need approval from the state. Please make sure you send these in a fillable PDF that we can add signatures to electronically.

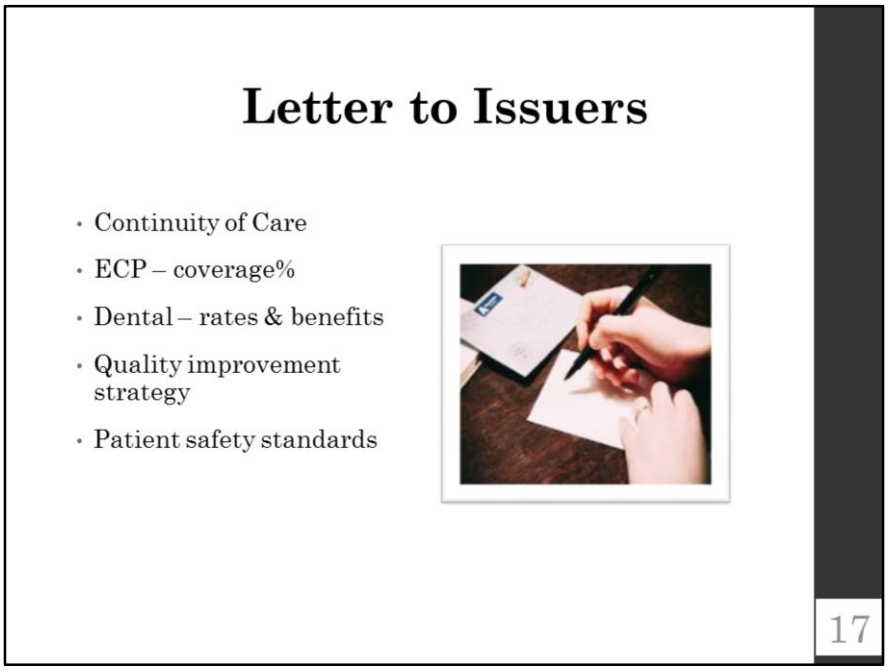
Our deadline for all policy and rate changes is August 13, 2016. This applies for both on and off marketplace carriers.




-Again the deadline is May 11, 2016.
-HHS has set a date of 5/25/16 for making data available. Indiana makes submissions transparent from the first day.
-We will be posting rates on submission. We will be using – SERFF filing access; a table with marketplace submission information; and a link to the healthcare.gov website when released.
- The deadline for the state to provide recommendations to HHS is August 23, 2016.

# Correction Notices

- Email the correction notice to kknable@idoi.in.gov, ghockwalt@idoi.in.gov, and compliance@idoi.in.gov
- If the deadline is one day, please call Karl Knable at 317-232-2416
- Fill out the fields provided within the interactive PDF using your computer
- DO NOT print and scan the correction notice

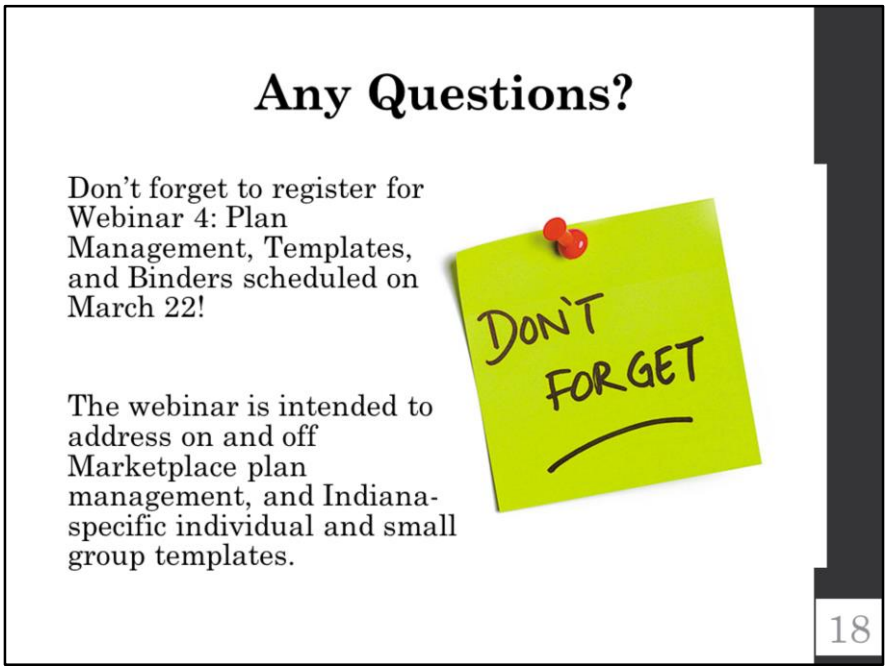



-Drugs/doctors- continuation of care is required for up to 90 days or through the course of treatment if the doctor is dropped from the network without cause.

- ECP – this will be combined with the network adequacy template this year. In addition, CMS has indicated they will be enforcing the 30% of ECP coverage in each service areas. You will need to contract in good faith with at least 1 of the 6 ECP categories in each county of your service area.
- Dental – You will have to indicate in the plans and benefit template if the rates are guaranteed or flexible. – Remember, in Indiana, you need to file for approval prior to changing any rates. To display on healthcare.gov, you need to cover check up, basic, and major.

-QIS – you must attest that you comply with the specific requrirements in accordance with 45 CFR 156.200(b)(5). Carriers must submit QIS to the marketplace if they meet criteria.

- QHP issuers must demonstrate compliance with patient safety standards. Specifically, if you contract with hospitals > 50 beds they must have a patient safety evaluation system and discharge program.




Upon review of our webinar 4 and 5, we have decided to combine these two. We will have our final webinar next week on March 22 at 2:00 PM EST. With this combination, we would expect next week's webinar to last most of the allocated time.