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John R. Kasich, Governor

Mary Taylor, Lt. Governor/Director

Industry Training Webinar
March 7, 2017

Introductions

Presenters

- Laura Miller, Assistant Director of Product Regulation and Actuarial Services
- Nancy Hubler, Chief Health Actuary
- Theresa Schaefer, Chief Life and Health Product Regulation
- Marjorie Ellis, Chief Life and Health Product Regulation
- Chris Wright, Regulatory Process Manager Life and Health Product Regulation

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AGENDA

- Deadlines
- Rate Filing Guidance
- Form Filing Guidance
- Binder Filing Guidance
- Questions – planmanagementquestions@insurance.ohio.gov

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2017 ODI Filing Deadlines

Filing Submission Deadlines

- **March 13, 2017 –** All ***Student Health Plan* Form** Filings for the 2017/2018 school year.
- **March 27, 2017** - All ***Student Health Plan* Rate** Filings
- **April 17, 2017** – Individual and Small Group, ***Dental,*** On and Off Exchange **Rate** Filings. All Individual and Small Group, ***Major Medical*** and ***Dental***, On and Off Exchange **Form** Filings. This includes all amendments, endorsements, riders and new forms that will be used in 2018
- **May 10, 2017** – All **Binder** submissions for on-exchange ***Major Medical*** plans and ***SADPs*** that are on-exchange and off-exchange certified
- **May 26, 2017** – Individual and Small Group ***Major Medical,*** On and Off Exchange **Rate** Filings.
- **August 28, 2017** – Large Group **Form** and **Rate** Filings

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RATE FILING GUIDANCE

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2018 Rate Filing Guidance

- Changes
  - De minimus actuarial value changes
  - Risk Adjustment User Fee
  - Child Age Rating

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2018 Rate Filing Guidance

- **De minimus actuarial value changes:**
  - For most metal levels, the de minimus range changes to -4% to +2%
  - Broader de minimis range of -4% to +5%, for the actuarial value of a bronze plan
    - when the plan covers at least one major service, other than preventive services, before application of the deductible;
    - or is a high deductible health plan (HDHP)
  - CSR Silver Plans not impacted

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2018 Rate Filing Guidance

- **Risk Adjustment User Fee:**
  - Basis changed to billable member months (was monthly enrollment). Change excludes children who do not count toward family rates or family policy premiums. Made effective for the 2016 benefit year risk adjustment user fee to be collected in the summer of 2017
  - User fee rate is increasing to $0.14 PMPM for 2018.

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2018 Rate Filing Guidance

- **Child Age Rating:**
  - One age band for individuals age 0 through 14
  - Single-year age bands for individuals age 15 through 20

AGE	PREMIUM RATIO
0 – 14	.765
15	.833
16	.859
17	.885
18	.913
19	.941
20	.970

  - Effective for plan years or policy years beginning on or after January 1, 2018
  - Factors, overall, are higher than the current child rating factor of .635

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2018 Rate Filing Guidance

- Timing of Rate Filings vs the Binder Filings
  - Binder Filings – May 10th
  - Rate Filings (Major Med) – May 26th
- Binder requirements for Rates
  - Rate filing materials (e.g., URRT, Actuarial Memo) are not required to be "associated" in the Binder
  - Provide SERFF Tracking number for corresponding rate filing(s) in a "Note to Filer" in the Binder
  - Rate Data Template should contain best estimates

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FORM FILING GUIDANCE

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2018 Form Filing Guidance

- Resources
- Ways to Improve Review Times
- New Ohio Statutory Requirements

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2018 Form Filing Guidance

Resources

- Published on the ODI Health Plan Management Toolkit and Filing Guidance site
  - Watch for update
  - Will receive update notification if registered for them
- Ohio Benchmark Plans
- ACA Compliant Form Filing Guidance – read carefully when <u>developing</u> forms

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2018 Form Filing Guidance

Resources (cont.)

- Required ACA Form Filing Checklists
- EHB Locator
  - Submitted with form filing but also used for rate filing and binder (if applicable) reviews
- Training PowerPoints from prior years
- FAQs for current and previous years

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2018 Form Filing Guidance

Ways to Improve Review Times

- Review the Health Plan Management Toolkit and Filing Guidance prior to submitting all filings
- Properly complete the checklist and EHB locator
- Coordinate internally so that the form submission is consistent with the binder submission

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2018 Form Filing Guidance

Ways to Improve Review Times (cont.)

- Use previously approved forms as a base for this year's filing
  - Provide SERFF Tracking Numbers
  - Provide redlines showing differences between the approved form and the proposed form.
    - Use contrasting colors, gray or black are difficult to distinguish
    - Attach the redline version to the Supporting Documentation tab along with a certification of accuracy

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Ways to Improve Review Times (cont.)

- Call Reviewer for clarification if request is unclear
- Ask for additional time if unable to respond by due date
- Address entire objection
- Apply requested changes to all forms as applicable

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New Ohio Statutory Requirements

- Prior Authorization or Utilization Review of Opioid Analgesics Prescriptions for the Treatment of Chronic Pain
  - Ohio Sub SB 319, 131st General Assembly (2016)
  - ORC §§1739.05, 1751.691, 3923.851
  - Effective Date: contracts delivered, issued or renewed on or after 1/1/2018
  - The contract must state the prior authorization requirements or other utilization review measures
  - Certain circumstances are excepted

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New Ohio Statutory Requirements

- Screening, Diagnosis and Treatment of Autism Spectrum Disorder Coverage
  - Ohio Sub HB 463, 131st General Assembly (2016)
  - ORC § § 1739.05, 1751.84, 3923.84
  - Effective Date: contracts delivered, issued or renewed on or after 1/1/2018
  - Excludes non-grandfathered plans in the individual and small group markets and other specified types of contracts

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New Ohio Statutory Requirements

- Autism Spectrum Disorder Coverage (cont.)
  - Mandates minimum benefit requirements for enrollees or insureds *under age 14*
    - 20 visits each per year for speech and language therapy or occupational therapy
    - Clinical therapeutic intervention in accordance with a health treatment plan of 20 hours per week
    - 30 visits per year of mental and behavioral health outpatient services

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New Ohio Statutory Requirements

- <u>Autism Spectrum Disorder Coverage</u> (cont.)
  - Carriers cannot impose dollar limits, deductibles or coinsurance amounts that are less favorable than the dollar limits, deductibles, or coinsurance amounts that apply to substantially all medical/surgical benefits in the plan.
  - Contract MUST provide that coverage for services is available contingent upon the individual receiving both prior authorization for the services <u>and</u> the services being prescribed by a developmental pediatrician or a psychologist trained in autism.

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New Ohio Statutory Requirements

- Prior Authorization
  - Ohio Sub SB 129 & Sub HB 505, 131st General Assembly, (2016)
  - Effective Date: contracts issued on or after 1/1/2017 and 1/1/2018 (staggered effective dates)
  - "Prior authorization requirement" means any practice implemented by the Insurer in which coverage of a *health care service, device, or drug* is dependent upon a covered person or a health care practitioner obtaining prior approval and includes prospective or utilization review procedures

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New Ohio Statutory Requirements

- <u>Prior Authorization</u> (cont.)
  - Review process of a prior authorization request
    - ORC §§3923.041(B)(1)-(5), 1739.05(B), 1751.72(B)(1)-(5)
    - Decision within **48 hours** of receipt for urgent care request as defined in statute
    - Decision within **10 calendar days** of receipt for a request that is NOT urgent
    - The process does not apply to emergency services as defined in §1753.28

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New Ohio Statutory Requirements

- Prior Authorization (cont.)
  - Streamlined appeal process for an adverse prior authorization determination
    - ORC §§3923.041(B)(12), 1751.71(B)(12)
    - Appeal shall be conducted between the requesting provider and a clinical peer.
    - Appeal decisions deadlines
      - Urgent care services – within 48 hours of receipt of the appeal
      - All other services – within 10 calendar days of receipt of the appeal

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New Ohio Statutory Requirements

- Prior Authorization (cont.)
    - If applicable, External Review under ORC Chapter 3922 is available when the appeal is not resolved.
  - Requirements effective January 1, 2017
    - Treatment of existing prior authorizations
      - Prior approval for medications for chronic condition policy provision
    - Retroactive denial of a prior authorization restrictions

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BINDER FILING GUIDANCE

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2018 Binder Filing Guidance

Proposed Plan Management Binder Review Timeline*

2018 Plan Year Activity	Dates
Ohio Form Filings Due (Major Medical and Stand-Alone Dental)	4/17/2017
Ohio Rate Filings Due - Stand-Alone Dental - Major Medical	 4/17/2017 5/26/2017
Ohio QHP Binder Submissions Due	**5/10/2017**
CMS Deadline for initial SERFF Binder Data Transfer -No new plans may be submitted after this date -No changes to plan type can be made after this date -Service area changes will a require a petition and approval by CMS after this date	6/21/2017
CMS 1st Correction Notices	8/1/2017-8/2/2017
CMS Deadline for Service Area Petition	8/4/2017
CMS Deadline for Final SERFF Data Transfer -No additional data corrections will be processed by CMS between this date and Certification	**8/16/2017**
CMS Final Correction Notice, Agreements and Plan List Confirmation sent to Issuers	9/14/2017-9/15/2017
Issuers return signed QHP Agreements, final plan lists and Crosswalk to CMS	9/16/2017-9/27/2017
CMS sends Certification Notices with final plan lists and countersigned Agreements to Issuers	10/11/2017-10/12/2017
CMS Limited data correction window for CMS approved changes and CMS reviews and finalizes data for Open Enrollment	9/15/2017-10/7/2017
Open Enrollment (Proposed)	11/01/2017-12/15/2017

*Dates may be subject to change

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New for PY 2018

- Some changes to Data Templates and/or instructions, including:
  - Changes to accommodate Additional Pediatric Age Bands
  - 2018 AV Plans and Benefits Template Changes
- Check regularly for updates to CCIIO QHP Application website
- Register in REGTAP for CMS QHP issuer training webinars

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New for PY 2018 (cont.)

- 2018 Simple Choice Standardized Plan Options
  - New HSA-eligible bronze High Deductible Health Plan
  - 2018 Simple Choice plans will require new Plan IDs
- Essential Community Providers (ECPs)
  - Percentage threshold standard moved from 30% to 20% (proposed)
  - SADP threshold standard calculated using all contracted ECPs + good faith contract offers to dental ECPs
    - Must be detailed in narrative justification

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QHP Issuer Accreditation

- Initial year on Exchange (if not already accredited)
  - Must schedule or plan to schedule an accreditation review, and document Binder
- Entering 2nd or 3rd year
  - Must be accredited in at least one category (Commercial, Medicaid or Marketplace) 90 days prior to open enrollment
- Entering 4th year or later must have one of the following:
  - "Accredited" status from AAAHC
  - Marketplace accreditation with a status of "Excellent," "Commendable," "Accredited," or "Provisional" from NCQA
  - Marketplace accreditation with a status of "Full" or "Conditional" from URAQ

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Quality Improvement Strategy (QIS)

- Applies to QHP issuers in marketplace for two or more consecutive years
- New QIS plans and updates to existing plans required in 2018 Binders
  - QIS Master Tool = review standards/methodology
  - Use checklist provided in Technical Guidance and User Guide
- QIS also required in 2018 for Health Savings Account eligible products
- Address potential concerns identified in “2017 Post Certification Assessment” in Implementation Plan sections of 2018 QIS form

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Quality Improvement Strategy (QIS) (cont.)

- Use updated "2018 QIS Implementation Plan and Progress Report Form" for all QIS Submissions
  - Submit only the CMS fillable/electronically readable PDF form
  - Don't leave any required items blank
- Resources for Additional Information:
  - CMS Marketplace Quality Initiatives website:

    https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html
  - REGTAP Library - webinar slides from QIS QHP Issuer Training modules

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Associate Schedule Items Tab

- Forms association for each Plan ID should be complete and accurate
  - Most current filed version of each form that will be issued for a plan ID (including all applicable plan variants)
  - Update the Associated Schedule Items tab to coincide with form filing updates that involve a change in the forms that will be issued for a plan ID (e.g., added or withdrawn form)
- No need to associate Rate Schedule Items (e.g., URRT or Actuarial Memorandum), or Supporting Documentation

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Benefit Package Data Requirements

- Explanation Field
  - Reference the “Ohio Essential Benefit Resource Document for 2018 Plan Year” on ODI Plan Management webpage
  - Complete for each individual Benefit Package tab
- All benefit data
  - Must align with coverage in associated forms
  - Review to ensure correlation of SBC and Plan Brochure information to Plans & Benefits data
    - Add detail from SBC or Plan Brochure to Explanation field text

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Plans & Benefits Template (PB) Cost Sharing Tab

- Coding for correct display on Healthcare.gov

Display Logic For Healthcare.gov		
Copay value in PB	**Coinsurance value in PB**	**What will display on Healthcare.gov**
"Not Applicable"	A % greater than 0 but less than 100	The entered Coinsurance Value
A $ value greater than 0 but less than 100	"Not Applicable"	The entered Copay Value
Any	100%	"Not Covered"
"No Charge After Deductible"	"No Charge After Deductible"	"No Charge After Deductible"
"Not Applicable"	"No Charge After Deductible"	"No Charge After Deductible"
"No Charge After Deductible"	"Not Applicable"	"No Charge After Deductible"
"0" or "No Charge" or "Not Applicable"	"0" or "No Charge" or "Not Applicable"	"No Charge"
"$0 After Deductible" or "No Charge After Deductible" or "Not Applicable"	"0% After Deductible" or "No Charge After Deductible" or "Not Applicable"	"No Charge After Deductible"
A value greater than 0	A value greater than 0	Both Copay and Coinsurance values are displayed
"Not Applicable"	"Not Applicable"	This combination is not permissible. See above options for how to reflect instances when there is no copay/coinsurance for a benefit.

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Plans & Benefits Template (PB) Cost Sharing Tab (cont.)

- Coding for correct display on Healthcare.gov (cont.)

Rules for Copay/Coinsurance Data Entry in the PB			
Plan Feature	**Copay Field**	**Coinsurance Field**	**Notes**
Plan has no Out of Network benefits	"Not Applicable"	100%	
Copay only (no Coinsurance)	Copay Value	"Not Applicable"	
Coinsurance only (no Copay)	"Not Applicable"	Coinsurance Value	
Plan has multiple in-network tiers but a particular benefit(s) does not	For benefit(s) without multiple in-network tiers, enter "Not Applicable" for "In Network(Tier 2)"	For benefit(s) without multiple in-network tiers, enter "Not Applicable" for "In Network(Tier 2)"	Clarify specifically in the "Benefit Explanation" field on the Benefit Package tab
Copay/Coinsurance varies on service or provider under that benefit	If the most typical cost-sharing structure includes a Copay, enter the most typical Copay Value; or enter “Not Applicable” if most typical cost sharing structure is Coinsurance only	If the most typical cost-sharing structure includes Coinsurance, enter the most typical Coinsurance Value; or enter “Not Applicable” if most typical cost sharing structure is Copay only	Clarify In the "Benefit Explanation" field on the Benefit Package tab with details for any cost sharing structure or values that differ from the most typical cost sharing information entered on the Cost Sharing tab.

– “No Charge” in any cost sharing field = benefit or service is covered at 100%

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URLs

- Correct format (must begin with “http://” or “https://”)
  - Actual URL (not a placeholder)
- Correct for final data transfer (“data lockdown”)
  - Do not need to be live until contract signing
- Link directly to plan-specific content (e.g., network, formulary, SBC, etc.)
- Summary of Benefit and Coverage (SBC) URL’s
  - Required for plan to display on Healthcare.gov
  - Required to link directly to SBC for specific standard plan or plan variant

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Prescription Drugs (Rx) Requirements

- Expected changes to CMS Formulary Review Suite Tools:
  - Non-Discriminatory Formulary Outlier review tool
    - Review of additional USP categories/classes
  - Non-Discrimination Clinical Appropriateness review tool
    - Review for additional medical conditions

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Prescription Drugs (Rx) Requirements (cont.)

- USP MMG Version 6.0 is the basis for 2018 PY drug categorization
- All FDA-approved drugs available to the issuer should be included in a formulary if required to meet EHB category/class count requirements
- Individual component drug RxCUIs don’t quality as a substitute for a combination drug RxCUI in a particular category/class
  - E.g., Coverage of both RxCUIs for “Acetaminophen” and “Butalbital” doesn’t count as coverage of the distinct RxCUI for “Acetaminophen; Butalbital”

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Prescription Drugs (Rx) Requirements (cont.)

- Rx Justifications required for "Unmet" Formulary Review Suite results should be answered completely and with adequate detail
  - If "available as a generic" is used, include generic drug in the formulary and list the generic drug RxCUI in the Justification
  - If "discontinued by the manufacturer" is used there should be no other drug available to meet the minimum category/class count
  - If a drug is "covered under the medical benefit" enter it on the Rx template under a "Medical Service Drugs" tier (this Justification is no longer valid)

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Plan Withdrawal

- Plans may be withdrawn during two timeframes
  - During the review process, prior to final transfer
  - At Agreement signing
- Plan withdrawal during the review cycle
  - Notify the ODI Binder review team as early as possible
  - The ODI Binder review team will provide specific instruction regarding whether any changes to template data are required
    - <u>Do not remove data for a withdrawn plan from any templates</u>
  - Complete a CMS plan withdrawal form and email it to CMS with a copy to the ODI Binder review team

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Communications:

- Binder review team contact information:
  - Chris Wright / Chris.Wright@insurance.ohio.gov / 614-644-3348
  - Laura Schimpf / Laura.Schimpf@insurance.ohio.gov / 614-644-2680

Please send email communications to both

- Verify that contact information is accurate and up-to-date in your Binder (with both an email address and direct phone number please)

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QUESTIONS

- Please send questions to:

  Planmanagementquestions@insurance.ohio.gov

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