

Webinar 3: ACA-Compliant Filing Issues

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Audience For Today's Webinar

ACA-Compliant Filings – individual and small group,
including dental



Agenda

- Essential Health Benefits (“EHB”)
- Office of Civil Rights (“OCR”) Rules
- 2017 Notice of Benefit and Payment Parameter Final Rule
- Letter to Issuers



AGENDA

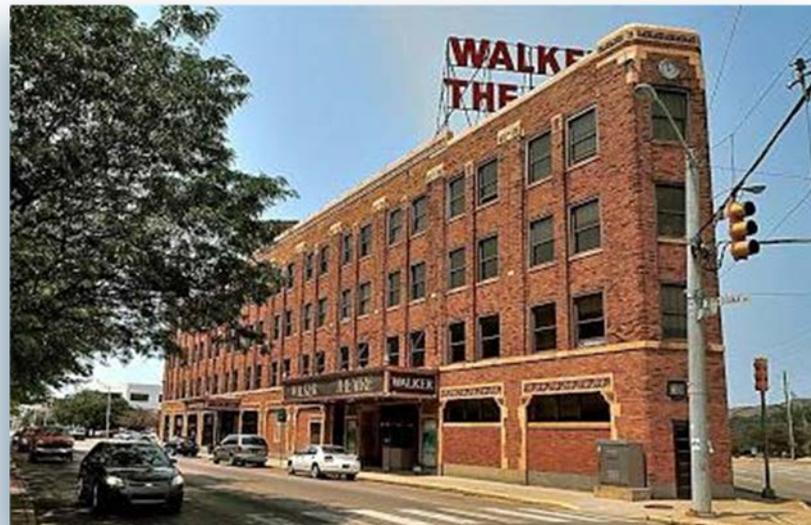


Historical Hoosier: From Orphan to First Female Self-Made Millionaire



Madam C.J. Walker

Madame C.J. Walker Theatre
Center in Indianapolis was
designated a National Historic
Landmark in 1991.



EHB

- For plan years beginning on or after 1/1/2017, all plans must abide by the 2014 default benchmark plan.
- 2014 Anthem Legacy Blue Access PPO Option 14, Rx G
- Supplemented by 2014 FEDVIP Dental and Vision
- The 2017 EHB Benchmark Plan is based off of a transitional health plan.
- Changes from prior benchmark



EHBs

- Formularies
- EHB substitution
 - Not allowed in Indiana
- All non-grandfathered, individual, and small group plans must include the benefits in Indiana's current EHB package as part of 2017 plan design.
- Changes from 2016
 - Home health care is 100 visits per benefit period.



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





Habilitative Services Definition

- **45 CFR § 156.115 states:** With respect to habilitative services and devices -- cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services).
- Habilitative services are at parity with rehabilitative services.
- The limits must be separated for rehabilitative and habilitative services to include 20 visits each for PT, OT, ST.

Discriminatory Benefit Design

- An insurance company can employ appropriate medical necessity standards for coverage of the benefits.
- The essential health benefits benchmark may have included discriminatory benefit design to which it is the determination by CMS that such occurrences must abide by the standards set forth in 45 CFR 156.125. Issuers are responsible for meeting the standard regardless of the benefit design in the current state benchmark.
- Coverage of benefits that were previously excluded in a policy and have been subsequently determined discriminatory per 45 CFR 156.125 should be considered “at EHB” in terms of determining appropriate rating practices.



OCR Proposed Rule

- **Overview**

- HHS has issued a proposed rule to advance health equity and reduce disparities in health care implementing Section 1557 of the Affordable Care Act, which provides that individuals cannot be subject to discrimination based on their race, color, national origin, sex, age, or disability.

- **Implementation**

- Blanket exclusions not allowed

- **Link to the rule:**

- <https://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf>

To Whom Does the OCR Proposed Rule Apply To?

- All health programs and activities, any part of which receives:
 - (1) Federal financial assistance administered by HHS;
 - (2) health programs and activities administered by the Department, including the Federally-facilitated Marketplaces; and
 - (3) health programs and activities administered by entities established under Title I of the ACA, including the State-based Marketplaces.

2017 Notice of Benefit and Payment Parameter Final Rule

- Rate Review – Plan Level threshold
- Employee Choice for SHOP-adds option for “vertical choice” to choose any level plan for a single carrier
- Standardized Option- carriers may use standardized cost-sharing/tier structures in 2017 for the individual FFM.
- Maximum Cost Sharing-\$7,150 self-only; \$14,300 other than self-only
- Network Adequacy provider transitions
- Grace Period- allows grace period to continue even if the consumer loses tax credit eligibility following non-payment.

2017 Notice of Benefit and Payment Parameter Final Rule

- MLR – The run-out for claims is kept at 3 months
- Out of Network Cost Sharing
- Rating Areas – in the individual market, rating areas are established using the primary policyholder's address.
- FFM fee – remember, this has to be spread across both marketplace and off-marketplace.
- Third Party Payers – CMS has expanded the list of acceptable third party payers.

Letter to Issuers – Key Dates for Certification

Activity	Dates	
QHP Application Submissions and Review Process	Initial FFM QHP Application Submission Window	4/11/2016-5/11/2016
	First SERFF Data Transfer Deadline for States Performing Plan Management	5/12/2016
	First Correction Notice Sent to Issuers	6/15/2016-6/16/2016
	Second Correction Notice Sent to Issuers	8/8/2016-8/9/2016
	Final Deadline for submission of QHP Data; Deadline for ALL Risk Pools with QHPs to be in a FINAL status in the URR System	8/23/2016
	Final Review of Revised QHP Application Submissions Received as of August 23	8/24/2016-9/9/2016
	QHP Agreement/Final Certification	Certification Notices Sent to Issuers
Agreements Signed by Issuers and Returned to CMS with Final Plan List		9/19/2016-9/23/2016
Validation Notice Confirming Final Plan List and Countersigned Agreements Sent to Issuers		10/3/2016-10/4/2016
	Open Enrollment	11/1/2016-1/31/2017

Key Dates for Rate Review for Single Risk Pool Plans

Activity	Dates
Submission deadline for all Rate Filing Justifications in the single risk pool (QHP and non-QHP) for issuers in a State without an Effective Rate Review program into the URR module	5/11/2016
Initial proposed rate change information available for consumers to review on https://ratereview.healthcare.gov	5/25/2016
Deadline for States with an Effective Rate Review Program to publicly post proposed rate increases subject to review	8/1/2016
IDOI Deadline for all Rate Filing Justifications in the single risk pool to be in a final status.	8/13/2016
Deadline for all Rate Filing Justifications in the single risk pool with QHPs to be in a final status in the URR system	8/23/2016
Deadline for all Rate Filing Justifications that only have non-QHPs to be in a final status in the URR system	10/7/2016
Target date to post Public Use File with final rate data for QHPs and non-QHPs	11/1/2016

Correction Notices

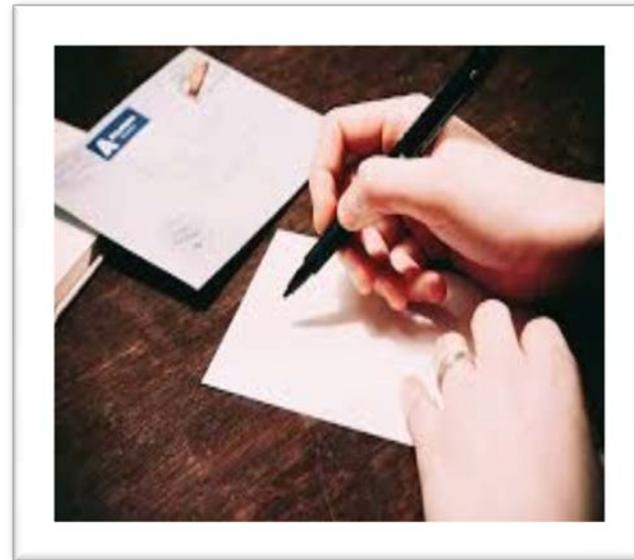
- Email the correction notice to kknable@idoi.in.gov, ghockwalt@idoi.in.gov, and compliance@idoi.in.gov
- If the deadline is one day, please call Karl Knable at 317-232-2416
- Fill out the fields provided within the interactive PDF using your computer
- DO NOT print and scan the correction notice!



CORRECTION

Letter to Issuers

- Continuity of Care
- ECP – coverage%
- Dental – rates & benefits
- Quality improvement strategy
- Patient safety standards



Any Questions?

Don't forget to register for Webinar 4: Plan Management, Templates, and Binders scheduled on March 22!

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

