Dora
Department of Regulatory Agencies
Division of Insurance

Subject	Question or Comment	Answer
10% HHS Trigger	10% HHS Trigger: For the 1/1/2014 effective rate filings, given that carriers comply with all of the PPACA requirements with their new non-grandfathered benefit plans, and that most of the members will be migrating to the new qualified plans, could you provide any guidance on how the Division would expect the 10% HHS trigger test to be applied?	We are still waiting for guidance and feedback from HHS on this issue.
3Rs	3Rs – need more information on how this will work	Index rate—(1) In general. Each plan year or policy year, as applicable, a health insurance issuer shall establish an index rate for a state market based on the total combined claims costs for providing essential health benefits within the single risk pool of that state market. The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the state. The premium rate for all of the health insurance issuer's plans in the relevant state market must use the applicable index rate, as adjusted for total expected market-wide payments and charges under the risk adjustment and reinsurance programs, subject only to the adjustments permitted in paragraph (d)(2) of this section. * An estimate of reinsurance recoveries should be built into the final index rate level * Similarly the risk adjustment should be reflected as an adjustment for in setting your index rate, any assumed differences in risk profile should be reflected in your index rates.
Abortion	The initial regulations for EHBs regarding elective abortions state that Federal assistance--e.g. premium or cost-sharing reductions--cannot be used for abortion coverage that extends beyond saving the life of the woman or for cases of rape or incest. Moreover: Plans that provide abortion coverage beyond that permitted with federal funds must create allocation accounts to segregate subsidies for premium payments and cost-sharing amounts for abortion services from premium and cost-sharing subsidies. States allowed to prohibit plans participating in the Exchange from providing coverage for abortions. A plan's exclusion of Abortion Coverage does NOT mean it fails to provide EHB. Abortion coverage is included in the benchmark plan, and the latest proposed rules state all services in the benchmark plans are considered EHB except for those specifically identified. Is our State recommending prohibiting plans from providing coverage for abortions, or are carriers going to be required to create allocation accounts to segregate subsidies for premium payments and cost-sharing amounts for abortion services from premium and cost-sharing subsidies?	Although the EHB-benchmark plan may cover abortion services, pursuant to section 1303(b)(1)(A) of the Affordable Care Act, a QHP issuer is not required to cover these services. Proposed section156.115(c) would extend this provision to all non-grandfathered individual and small group market plans.
Additional filings	Please confirm mid-year rate filings (with mid-year effective dates) will be allowed.	TBD
Additional Filings	Will there be any chance for additional filing after 5/1 for the 2014 plan year?	TBD - the cost sharing reductions need to be approved by HHS on July 31st.

Age	The rule requested state proposed variations of the age slope by 12/26/2012. If the CO DOI submitted a proposal to HHS on this issue, would the specifics of this proposal be available, and has there been any feedback from HHS that the DOI could share?	The HHS proposed adult age curve was already largely designed to "squeeze" the ends of the curve near age 21 and age 64. The Division intends on using the HHS age slope. Curve was developed from LG data which is thought to better model the population that will exist in the SG and Individual market following reforms in 2014. * Fit the uniform age curve to the 3:1 adult age rating limit by ''flattening'' the ends of the age curve derived from expected claim cost patterns in a manner that accommodates the 3:1 premium ratio limit for the highest and the lowest adult ages. * Under this approach the rate of premium change from one age to the next will closely mirror the rate of expected claims costs, except for those ages closest to age 21 and age 64. * This proposed approach would ensure that the fewest number of individuals (or employees, in the small group market) would be affected by the 3:1 premium ratio constraint, thereby mitigating premium disruption for the largest number of consumers, and reducing the need for significant risk adjustment across age bands. HHS may propose further refinements to the adult and children age factors in the final rule, will periodically update their age curve.
AV Calculator	AV Calculator – what are we going to do if we don't get this from the feds in time?	Must be used, supposed to be revised and released shortly
Basic & Standard Plans	Is CO considering changing requirements regarding Basic and Standard Plans?	Yes - they will be eliminated
Basic & Standard Plans	Please explain the phasing out of basic and standard plans	Division is requesting to repeal 10-16-102(6)(a), CRS in the Alignment bill. For guaranteed renewable plans there will need to be a transitional procedure. However, that is still to be determined.
Business Group of 1 plans	Please describe the transition of BG1 to individual market products	Division is requesting to repeal 10-16-102(6)(a), CRS in the Alignment bill. For guaranteed renewable plans there will need to be a transitional procedure. However, that is still to be determined.
Checklists	Will the carriers get a pre-filled sample of the checklist once finalized? There are columns that we are not sure as to how to respond: Column F, Substitute, and column G, Reference to Page, Section and Para of the Plan.	We are working. The checklist will be submitted on-exchange and off-exchange with the form and checklists will have the page number and reference where that provision is in the filing. Also, if a carrier is doing a substitution - need to understand that when reviewing the form. NOTE: EHB substitutions are highly discouraged.
Checklists	Is this checklist required only for on-exchange submissions?	Checklist would be required in and outside the exchange
Checklists	Is a PPACA checklist needed for each plan selection even if a filing as a variable field filing or if a variable field filing is it just needed for the range of plans within the metal level?	If carriers is using variable field, will need to know what will be in those variable fields. For form filings, looking for EHBs and discriminatory plan design.
Component Rates	On the "small group rating slide" in the "Rate Review 1-18-13" presentation it is commented that a "component rate" would only be needed at the employer's request. This differs from the verbal communication that composite rates would be required for all small group rating. Could you please clarify? Also, if the CO DOI submitted a proposal to HHS on this issue, would the specifics of this proposal be available, and has there been any feedback from HHS that the DOI could share?	Waiting for HHS response
Confidentiality	Rate Confidentiality – will DOI be posting any rates before the 5/1 deadline?	No, due to CORA (Colorado Open Records Act) the filings must be open record at time of filing. Also pursuant to House Bill 07-1234, required a rate summary be posted on the Colorado Division of Insurance's (Division) website, became effective January 1, 2008.
Conversion Policies	Could you please address the future treatment of conversion policies? We believe that the consumer need for these policies will no longer exist once all individuals have access to guaranteed issue individual health coverage and the loss of group coverage will constitute a qualifying event for purchasing such coverage outside of the enrollment period.	Conversion policies will go away.
Conversion Policies	If conversion policies do remain, it seems that these plans are not exempt from the new rating rules. Therefore it appears that they will have to be adjusted to comply, and the state rules regarding conversions will have to be re-interpreted in light of ACA rules. Does the State plan on issuing any guidance on how the new market rules would apply to conversion policies (EHB, AV, single risk pool, etc.) and what would the expected timing be for receiving such guidance?	10-16-108: If they were to remain they would have to meet all new rating reform laws, however they will go away.
Cost Benefit Ratio	Cost Benefit Ratio – will this be updated so Wellness Programs can be included in the "medical expense" bucket	Falls into MLR adjustment - (TBD) Quality Improvements in general in numerator. This is still to be determined by the Division.
Dental	When will final information on conversion of CHP+ Dental benefits annual maximum to visit limits as part of EHB be available?	TBD
Dental	Dental Anesthesia – required in CO different age than EHB – is it assumed that these are covered in the ped dental EHB or are these separate?	(TBD) The final EHB stakeholder will be hosted on February 15th.

Discontinuance	It would appear that the reasonable modifications process would not be necessary if existing non-grandfathered plan designs were discontinued as obsolete as provided for under §§10-16-201.5(1)(f) for individual and 10-16-201.5(6)(d) for small group. For individual, it would be necessary for the Commissioner to find that the plans are obsolete, but there is no such requirement for small group. Does the DOI have a position this issue? In particular, would the DOI agree that the existing non-grandfathered plans are by definition obsolete if they do not meet the EHB and AV requirements that will become effective 1/1/2014?	If a carrier wants to declare a non-grandfathered plan as obsolete in the individual market they will still need to comply with the requirements in CRS 10-16-201.5, where the commissioner would need to make a determination as to whether a plan was obsolete.
Effective Date	Will all policies new or renewed in 2014 be effective for 12-months, rather than effective only for the remainder of the year? As in, will a plan sold with an effective date of 7/1/2014 be a 12-month policy with a plan year deductible, or will it be forced to be a 6-month policy with a calendar year (6-month) deductible? (And the same question for maximum out-of-pocket.) Will this be up to the issuers to decide?	TBD
EHBs	EHBs – when will these be finalized and what is the clarification on CHP+ maximum	TBD
Enrollment	Will open enrollment periods be standardized on / off the Exchange?	Yes - this is our goal. This is addressed in the Alignment bill.
Enrollment	The proposed rule is very clear for small group (enrollment possible throughout the year, in or out of the exchange) and for individual in the exchange (enrollment only during open enrollment period), but it permits enrollment throughout the year for individual coverage outside the exchange. Does the CO DOI have a position as to what will and will not be allowed for individual enrollment outside the exchange?	Alignment bill - open enrollment periods will be the same inside outside the exchange. • Establishes individual market initial open enrollment period (October 1, 2013 to March 31, 2014) and annual open enrollment period (October 15 to December 7) thereafter; makes benefit year for individual plans a calendar year • Allows small employers to purchase a group health plan at any point in year and allows Commissioner to set dates for effectiveness of coverage by rule • Requires carriers to establish special enrollment periods for qualifying events with 30 days to elect coverage • Moves late enrollment period provisions from 10-16-102(26) to this section
Enrollment	CMS regulations, at least for some purposes, define the benefit year as the calendar year. How does the DOI interpret this? In particular, does the DOI anticipate that mid-year enrollees will experience benefit years shorter than 12 months in the initial year of enrollment?	Alignment bill - open enrollment periods will be the same inside outside the exchange. • Establishes individual market initial open enrollment period (October 1, 2013 to March 31, 2014) and annual open enrollment period (October 15 to December 7) thereafter; makes benefit year for individual plans a calendar year • Allows small employers to purchase a group health plan at any point in year and allows Commissioner to set dates for effectiveness of coverage by rule • Requires carriers to establish special enrollment periods for qualifying events with 30 days to elect coverage • Moves late enrollment period provisions from 10-16-102(26) to this section
Expenses	Everything that we have seen from HHS indicates that expenses must be determined at the risk pool level (and therefore in the index) and cannot be reflected differently by plan or in/out of the exchange. The 1/18/2013 presentation by the CO DOI presents conflicting statements on this issue (prohibited on slide 2, but HHS is considering allowing on slide 3 and on rate worksheet). Please clarify and comment on HHS communications to date on this issue, if possible.	Waiting for final rule on this issue. There has been much discussion around this. Need internal discussion on this. (1.C) Retention - carriers should adjust the Index Rate to include all retention from expenses, fees and profits that will be loaded into rates. Retention loads must be spread out across all rates in the NGF pool using the same rating factor. Retention rating factors may not vary between In Exchange and Out of Exchange plans. Differences in expenses due to Exchange fees and marketing cost differences are spread out across all NGF pooled plans.
Fees	Fees – will COHBE fees be required to spread across products inside and outside the exchange?	TBD - open questions
Filing Requirements	Timing of Data Lookback (4211) – how will this work given the new requirements?	A new rating regulation will be released for 2014 rating reforms. The experience period must include consecutive data no older than five months prior to the rate filing date.
Filing Requirements	Data Requirements in 4-2-11. Will the requirement under 4-2-11 Sec 6. N 4a for data no older than 9 months from the rate effective implementation date be waived? (This would require data no older than 3/31/2012 for a 1/1/14 filings. This will not be achievable with a 4/1/2013 filing due date)	There will be a new rate regulation released, the requirement will be 6 months prior to filing date
Filing Requirements	EOC Plan Documents – will this be standardized at all to comply with the new requirements – 4211?	1-1-6 will be revised with new filing requirements, EOC will not need to be standardized.
Filing Requirements	If it is a provision that is not allowed and we have no statement, since it is not allowed, what reference should be used, i.e. if we are not allowed to have a statement to "deny the mother/newborn eligibility, continued eligibility, to enroll or renew coverage to avoid these requirements" how do we answer if the policy is silent, can we indicate a N/A?	If a provision is not allowed by state or federal law should not be incorporated in a policy form.
Filing Requirements	Will CO have model EOC language available for Exchange related provisions (e.g., eligibility, appeals, contact information for customer services (Plan vs. COHBE vs. navigator), grace periods for individuals receiving APTC, definitions, etc.?	No

Forms	When carriers form file, the DOI requires only a certification attesting to the plan's compliance. However, in the Exchange scenario and where materials may be passed on to COHBE, will carriers be required to file the actual materials or will it be the same process as required by Bulletin B-4-18?	Forms will need to be submitted and reviewed through SERFF as well marketing materials. (with DOI created checklists and certifications.)
Forms	When carriers form file, the DOI currently requires a certification attesting to the plan's compliance. When the exchange is operational, materials may be passed on to COHBE. Will carriers be required to file the actual materials, or will it be the same process as required by Bulletin B-4-18?	Evidence of Coverage, Summary of Benefits and Coverage, Certification, checklist (Guidance to come in Bulletin and regulation)
Forms	It was answered in the previous meeting that forms will be included with the filing, that is EOCs will be uploaded in SERFF. We understand this to apply to on-exchange plans so that COHBE can access the forms, but will this requirement be applicable as well to off-exchange plans, meaning carriers do not have to upload EOCs to SERFF?	EOC will have to be submitted for both on and off the exchange plans.
Forms	Which specific forms will be required to be submitted in conjunction with the rates for 2014? Which forms can be submitted at a later date?	Forms: Evidence of Coverage, checklist, certification, Summary of Benefits of Coverage, Plan and Benefit template (CCIIO template)
Forms	Will the current Small Group standard application be modified for the small groups purchasing outside the Exchange?	Yes, we will be using application for both inside and outside the exchange
Forms	Will the current "pre-application" form for individual insurance outside of the Exchange be modified?	Yes- Addressed in Alignment Bill- The commissioner by rule, shall develop a uniform application form for health benefits plans……
Geographic Factors	The example provided in the "Health Reform Rating Schematic" indicates that an analysis of experience alone would not be acceptable for the setting of rating factors. Please provide detail as to what information/methods would be accepted by the Division in determining the experience for a region. Also, with respect to the CO DOI proposal to HHS of the nine rating areas provided for in 4-6-7, would the specifics of this proposal be available, and has there been any feedback from HHS that the DOI could share? In particular, the areas as listed in 4-6-7 are no longer reflective of actual MSAs and county populations, was an updated version presented to HHS?	* The area factor for the Denver MSA should be set at 1.0 for every carrier. All other area factors should be set relative to this 1.0 for the Denver area. * Area factors may not be developed to reflect health status or claims experience of members included in an area. Factors should be set assuming each area has the same average member risk profile and levels of member health. Hence claims experience may not be directly used as the basis for setting an area factor. Area factors are expected to reflect the following estimated cost differences between areas: * Differences in reimbursement levels between providers, * Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc… * Area factors should be actuarially justified and verified to have been set based upon the above criteria. * The DOI is currently okay with the MSA's as defined.
Grace Period	Is CO looking at revisions to the current grace period requirements for non-APTC recipients in the individual market?	Addressed in the Alignment Bill - changed to 90 days: individual and small employer health benefit plans must contain a provision specifying that the policyholder is entitled to a three-month grace period for payment of any premium due, other than the first premium, during which period the plan continues in force unless the policyholder submits written notice to the carrier, prior to discontinuance of the plan in accordance with terms of the plan, that the policyholder is discontinuing the coverage.
In/Out Exchange	Can a carrier file several on and off exchange plans, but decide later not to market some of the plans prior to Oct 1st? If for example, 30 plans are filed and approved, but then the carrier decides to only use 20 of those filed and approved plans, would that be acceptable? If so, what is the preferred method of communicating this to the department?	Yes would be able to. Would have to amend their filings to show what plans are actually being offered
In/Out Exchange	In / Outside the Exchange – must products be offered in both places?	No - Colorado does not have the authority to require carriers to offer the same plans that are offered inside the market to be offered outside. DOI to provide information through a bulletin.
Metal Plans/Tiers	When is the "2nd lowest silver plan" determined? As in, is it the 2nd lowest silver plan effective as of Jan 1 each year, and that remains the 2nd lowest silver plan throughout that calendar year for subsidy purposes even if a different plan becomes the 2nd lowest silver mid-year?	TBD
Metal Plans/Tiers	Metal tiers: our initial attempt at running plans through HHS' Actuarial Value calculator seems to suggest that we will have difficulty reaching the Bronze level without including deductibles significantly higher than $2,000 proposed. Given that carriers maintain the required $6,400 out-of-pocket maximum, does the Division have any limits on deductibles and/or coinsurances that would be acceptable?	We are still waiting for guidance and feedback from HHS on this issue.
Metal Rates/Tiers	What variations would be allowed for identification of a child in a tier structure as current proposed regulation varies the treatment of dependents under 21 and 21-26. Please clarify if the Division views the cap as applying to all family members under 21 or dependent child members only as referenced on the small group rating slide" in the "Rate Review 1-18-13" presentation. Also, if the CO DOI submitted a proposal to HHS on this issue, would the specifics of this proposal be available, and has there been any feedback from HHS that the DOI could share?	Intend on using the HHS age slope.

Multiple Filings	Will Carries be allowed to submit multiple filings during the one month period?	Yes, however if it's on an existing filing or product it will be subject to prior approval and significant justification to the change in rates will need to be supported.
Netwok Adequacy	When will carriers have details on network adequacy requirements, including Essential Community Provider requirements?	Division is working on issuing a regulation and Bulletin around the data elements
New/Old Products	Mapping of old products to new products – can it be clarified whether or not this will be prohibited? This is a critical concern that many people will not take affirmative action and will end up with a gap in coverage inadvertently.	Carriers cannot automatically enroll/map consumers into a new product. They need to give abide by the discontinuance requirements.
Pharmacy Formulary	I have seen the proposal by HHS to adopt the US Pharmacopoeia's formulary classification system. Am I correct in assuming that the State will follow the requirements from the HHS?	The answer is yes. The feds are requiring the formulary templates they developed to be used and the Division does not want to create any additional work, by requiring additional templates (when the federal templates will do). Carriers are required to cover one drug in every category or class or the same number of drugs in each category and class as the EHB benchmark plan.
Pharmacy Formulary	Is there any insight into the approval process for our formulary to ensure that it meets the HHS requirements? For Medicare Part D we submit the formulary to CMS yearly for approval and whenever we make changes. No changes can go into affect until the formulary has been approved.	Formularies will be reviewed for discriminatory plan designs. The Division will have a tool to review formularies.
Pharmacy Formulary	Populating the template will require significant man-hours to accomplish. Has there been a timeline outlined on when this will need to be submitted?	Templates will need to be submitted at the time of rate filing submission.
Pharmacy Formulary	It appears as if KP submits formulary template, they will just need to submit the template and then the rest is handled by SERFF. Is this correct?	Yes, that is correct. DOI will analyze the data with their own tools.
Plan Name	In a variable filing submission if we don't have a plan name selected can we file with a placeholder?	Carriers should assign a plan name - not really a variable field
Plans	Some state DOIs have provided guidance regarding the number of plans and substitutions that they expect to receive. Specifically, WA OIC recommends keeping it simple for 2014 – they strongly encourage one plan per carrier and strongly discourage any EHB substitution. They also go on to state that overly complicated filings will likely fall to the bottom of the review pile. Does the CO DOI have a similar warning?	Due to the workload of Companies, the Division of Insurance and to eliminate consumer confusion, the Division would encourage carriers to make one filing per carrier and strongly discourage EHB substitutions.
Rates	I'd also like to hear about rates, updates to the proposed use of the small group rating areas, and any other proposed changes from the federal proposed rule (age slope, smoking varying by age).	Colorado will be using the 9 small group rating areas - received a nod from the fed. Will discuss rating - next week - had to get some of the Q&As answered to get to rating. Federal Rule on Rating is being delayed.
Rating Areas	Could you please provide guidance on when and how rating areas will be defined for the exchange?	The Division intends on using MSAs and non MSAs geographical areas contained in Colorado Regulation 4-6-7 (there are a total of 9 areas). The proposed federal rule limits the geographical areas to 7, the Division has asked for flexibility in adopting 9 geographical areas. In the slide presentation, the Division did for stakeholders, earlier in January 2013 - on our website. The geographical rating would apply to individual and small group, inside and outside the exchange.
Rating Areas	Area Factors: Is there any update on whether HHS will allow Colorado to continue using the nine rating areas (as opposed to seven as listed in the proposed rules)?	We are anticipating that the 9 areas will be approved by HHS. We have received a nod from HHS.
Rating Areas	Final Rating Areas – need this asap	The Division has proposed to use the Small group rating areas pursuant to 4-6-7 (The Division is looking at fixing Denver as 1.0, then everything is comparable, NAIC White Paper)
Rating Areas	When will carriers know the geographical rating areas for Colorado?	We have submitted the 9 areas in the current small market to be approved by HHS
Reasonable Modifications	Current regulations indicate that if an HMO anticipates that a transaction will result in a 20% increase or decrease in membership over 12 months, the HMO may need to file a material modification. We've generally read that regulation as triggered when there's a sale/merger which might change the membership - and not when the change is from organic growth. Provided the network access plan/standards remain the same, would the fact that the exchange will bring new members to the HMO trigger a material modification filing (even if the carrier may see a 20% increase in membership)?	HMO's enrollment increase due to Federal Health Care Reform would not apply to Section 10-16-403(2), C.R.S. or Section 7 of Regulation 4-7-1. The Division of Insurance already knows that Federal Health Care Reform is going to increase the number of insured individuals in this state. The information that we want an HMO to file when they do make a material change to their existing plan of operation is the expected number of new enrollees, where those new enrollees are located, and the premium that those new enrollees will be charged. Those Federal Health Care Reform related numbers would be speculative and probably not that accurate for purposes of trying to determine any future adverse financial affects on the HMO.
Reasonable Modifications	Can Bulletin 4-34 Section B.2 be relied upon regarding the application of §10-16-201.5(8) -reasonable modification requirements for 2014 ACA filings?	If a carrier is adding additional benefits due to federal or state mandates it would not have to go through the reasonable modification process however if it's adding any benefits above and beyond the required benefits it would.

Reasonable Modifications	Bulletin 4-34 Section 2. When a form filing is submitted for a benefit modification regarding ONLY ACA changes, the requirements of §10-16-201.5(8), C.R.S. do not apply. The cover letter for such filing should clearly state the modifications that are being made to comply with ACA requirements and should give the rating impact for each modification. The Filing Type for this filing should be "FORM" and the appropriate TOI/Sub-TOI codes for the policy being submitted. The State Specific Code of "649 – Health Care Reform 2010" must be entered into the SERFF filing.	If a carrier is adding additional benefits due to federal or state mandates it would not have to go through the reasonable modification process however if it's adding any benefits above and beyond the required benefits it would.
Reference Guides	Will the DOI issue separate reference guides (both form and rates) within SERFF to account for exchange requirements—similar to what the DOI has done previously with mental health parity and PPACA?	Yes - the DOI will publish a bulletin and regulations for filing requirements for both rates and forms.
Risk Adjustment Factor	Will the state provide guidance on the state's risk score and the source of the analysis for the use and development of the rating factor as listed on the "Health Reform Rating Schematic".	Risk Adjustment program is being administered by the feds
SERFF Binder	SERFF Binder: Recently we have been made aware of a SERFF Binder (holding 8 templates). Will the Division require us to complete and submit these in our rate filings effective 1/1/2014?	Yes, all templates will be required to be filled out for both the inside and outside markets.
Service Areas	Small group regulations currently require that PPO plans have a statewide service area. To make products affordable, carriers may be considering a narrow network/service area. Is the DOI open to giving carriers the option of designing a PPO with a less extensive service area?	No- would have to abide by current small group market rules that we have today
State Mandated Benefits	When will final information be available regarding conversion of annual maximum to visit limits for state-mandated benefits be available?	Autism - $34,000 - 550 sessions from birth 0-8, 185 9-19, sessions 25 minutes Early intervention: 55 visits in 15 minute increments, a 45 minute visit counts as 3 billing increments. Mammography- 1 per year Pediatric Dental $600 - 2 oral exams, 2 fluoride applications, 1 x-ray, 1 cleaning, 2 other services included in CHP Dental Program procedure list DME:4 units under $1000, or 1 unit over $1000 (oxygen, wheel chair,…..)
Supplemental Reinsurance Program	Is CO considering a supplemental reinsurance program, in addition to the federal reinsurance program?	No, we will be using the federal reinsurance program and they will be administering it
Tobacco	The rule requested state proposed variations of the allowable tobacco rating by 12/26/2012. If the CO DOI submitted a proposal to HHS on this issue, would the specifics of this proposal be available, and has there been any feedback from HHS that the DOI could share?	Same as federal rule, 1.5 max
Trended Rates	Will trended rates be allowed to be filed for multiple effective dates as described under 4-2-11 Sec 7. C. 1? Will the answer vary by product (individual vs. Small Group) or inside vs. outside the exchange. (There are indications that the IRS will require only one individual rate per calendar year in the exchange to manage the calculation of the subsidy)	TBD - waiting for HHS response for inside the Exchange products. It will not vary by product
Trended Rates	Will trended rates be allowed to be filed for multiple effective dates as described under 4-2-11 Sec 7. C. 1? Will the answer vary by product (individual vs. Small Group) or inside vs. outside the exchange. (There are indications that the IRS will require only one individual rate per calendar year in the exchange to manage the calculation of the subsidy)	TBD - waiting for HHS response for inside the Exchange products. It will not vary by product