COLORADO ASSOCIATION OF HEALTH PLANS

March 15, 2013

Staff, Division of Insurance

Re: Open ACA Implementation Questions

Given the rapidly approaching deadlines for key components of ACA implementation, CAHP wanted to provide the Division a consolidated list of outstanding issues. Most of the issues below have come up before, however some are more recent developments. Also, we fully understand the Division may not be able to unilaterally answer some questions without clarification form the state's Alignment Bill or further federal guidance. We hope that this list will also help identify issues that the Division may not have thought of or considered to this point.

From a practicable standpoint, this list was put together with the goal of identifying the most likely source of providing a final answer. To that end, you'll see either "DOI", "HHS", or "COHBE" (or some combination) listed behind each question. The labeling is our best guess, so feel free to let us know if you think another entity needs to address a particular issue. Any question labeled "HHS" is copied below since we know the Division is in relatively frequent communication with your federal partners. If anything is marked as "Urgent", it just means that carries would like clarification as soon as possible to help them with the filing process that needs to be completed by May 1. Also, any ***bold and italicized*** print is simply information that has come forward since the question came up.

Finally, all of the HHS questions surrounding EHB and the AV Calculator have already been submitted to HHS, however they are included below for reference. I've also attached a complete list of both open and answered questions. Most of the answered questions were addressed in the numerous rules that came out in the last month.

Thank you for taking the time to consider the numerous questions below. We understand that the Division is working under an extreme workload right now, so we're more than happy to partner in anyway that can help.

Thanks again,

Marc

Rates and Forms Filing

Timing Issues ***(URGENT)***

- At the Friday, March 8 meeting between carriers and the Division, Division staff indicated that if a filing were rejected on May 1, there would not be an opportunity to resubmit the filing. We would like clarification on what would cause a "rejection" and why there would not be an opportunity to correct

mistakes. In short, what kind of errors would cause the Division to reject a filing with no recourse for the carrier? ***[DOI]***

May 1st is a hard deadline, however the Division will work with carriers that make a good faith effort to submit all required documents. If a filing is submitted missing several of the required documents and/ or SERFF fields, the filing will be deemed incomplete and therefore rejected.

Discontinuance of Current Plans and Passive/Facilitated Enrollment

- We are very interested in the Division's approach to "discontinuation" of our current product lines – will the DOI allow for a more streamlined approach, or will we be required to follow current regulations around notifications and timelines? In light of the great surprise expressed by the DOI staff that carriers (to a company) will be filing new plans rather than doing "modifications" to existing plans, we would like to get some clarity about that process as well (especially if the Division wants to monitor/control the rate increases experienced by members in the change-over). With such an expansion of benefits mandated, the rate increases may appear to be "large" or "excessive", but will actually simply be a function of higher levels of coverage. ***We understand that the Division intends to release a bulletin regarding "discontinuance" procedures. It may be helpful for the Division to adopt a standardized notice about pre-2014 discontinuance to relieve carrier and member confusion during this transitional time. [DOI]***
    - What timing, notification, and general processes outlined in 10-16-201.5 will be necessary? ***[DOI]***

A Bulletin is scheduled to be published by early next week for discontinuances and mid-year filings. If carriers are discontinuing plans but have new plans to offer then the notice is 90 days.

If a carrier is discontinuing all plans and is exiting the market then the notice is 180 days.

- How can carriers efficiently facilitate enrollment of current members from current (but soon to be discontinued) plans into new ACA compliant plans? ***COHBE is currently considering how it can establish a "facilitated" enrollment process for carriers to transition current members onto Exchange products. [DOI and COHBE]***

Carriers can facilitate enrollment if the current member gives written consent.

- "Carriers cannot automatically enroll/map consumers into a new product" is potentially problematic because carriers currently automatically enroll/map consumers to new products. Otherwise, there will be a gap in coverage for many

consumers. The regulation concerning discontinuance requirements (C.R.S 10-16-201.5) is silent regarding this and only specifies that carriers provide the insured the option to purchase any other comparable coverage. ***The DOI has indicated that "mapping" will not be allowed and there must be an affirmative decision by the members. However, that does not preclude some kind of facilitated enrollment for current members. [DOI]***

- Carriers would like to move forward with the ability to work as "assisters". Carriers have a lot of questions about how much they can say to current members who want to stay with the carrier, but move to the Exchange. It seems that COHBE has talked at length about navigators and brokers but the role of health plans and what is allowable has not yet been addressed. ***Proposed federal rules on Certified Application Councilors (CACs) will address this to an extent, but the question ties into the larger context of discounting current plans and facilitating enrollment in a corresponding plan within the same carrier. [COHBE and DOI]***

Proposed federal rule on navigator/brokers/assisters etc to be released in the next week.

Filing Requirements ***(URGENT)***

- 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? ***[DOI]***
- We would like to seek clarification that since most of the products offered through the exchange will be new products in 2014, issuers will not be required to report the "three year history of rate increases for the product associated with any rate increases," since that history will not exist. ***[DOI and HHS]***

Experience for rating purposes still will be required.

Forms ***(URGENT)***

- Under "Checklist" in the Q&A document, it states, "If carrier 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." The Evidence of Coverage for each product type (HMO, DHMO, HSA) has variable fields to account for the different cost share amounts associated with each of the plan designs (i.e., metal tiers). We are not clear on whether this means carriers will need to file forms showing the actual cost share amounts for every plan design with a product type. (The Summary of Benefits and Coverage document filed for each plan design will contain this information). In the past carriers have just filed the general forms for the HMO, DHMO and HSA products. ***COHBE has indicated they need individual plan EOCs. However, they have also acknowledged that the SBC and policy forms are better suited for plan comparison, so they may not***

need EOCs. We need the DOI to clarify whether they need an EOC with all variable fields completed for each plan design. [DOI]

The Division will review all forms which includes but is not limited to; policy forms, EOC, applications, notices, riders, etc. Brackets will not be allowed.

AV Calculator ***(URGENT)***

- Are there any specific expectations for filing plans that cannot be pushed through the AV calculator? ***Carriers have the ability to "attach" an actuarial value memo to the filing templates if there are filings unsupported by the calculator, however this process still needs further explanation. [DOI and HHS]***

AV Calculator: If a plan is a unique design with modifications that would significantly alter the AV, then the plan's actuary must submit an actuarial value certification supporting the change. Where in SERFF is this attached (same as with regular actuarial memorandum in rate filing, or attached to the template)? Embedded Pediatric Dental should be ignored for AV calculation…it is not significant according to HHS.

Index Rate Development and Rating Factors ***(URGENT)***

- Trended Rates: Can trended rates 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 in the exchange to manage the calculation of the subsidy. ***[DOI]***

Index Rate Development and Rating Factors: Same rating method used on and off Exchange. Individual may only submit one filing per year with only one rate used for the whole year. Small group not restricted to one filing and may trend rates monthly during the year.

Geographic Rating Factors ***(URGENT)***

- If someone permanently moves to a new geographic rating area mid-year, I know that they have a special enrollment period, but are they *required* to switch to a plan in the new rating area, or can they keep their other plan until the next 1/1? And if they do re-enroll, are the rates based on their age and tobacco use at the new enrollment date? ***[DOI and HHS]***
- For Individual business, if family members live (permanently) in different rating areas of the same state, are they able to purchase a family plan, or can a plan only cover members who reside in the same rating area? ***[DOI and HHS]***
- For Small Group business, if family members live (permanently) in different rating areas of the same state, are they able to purchase a family plan, or can a plan only cover members who reside in the same rating area? ***[DOI and HHS]***

- We would appreciate clarification on how to apply the geographic rating areas in the small group market. Specifically, should all employees be rated based on the geographic location of the employer's headquarters, or based on the location of each employee's residence? ***[DOI and HHS]***

  Geographic Rating Factors: For Individual and Small Employer business a family plan may be bought if family members live in different rating areas. Rating area has nothing to do with service area or coverage.

  For Individual HHS said they will need to provide future guidance on how members in different areas are rated.

  For SG business employees receive an area factor based on the employee's residence. An out of state member receives the area factor based on where the employer HQ is located in Colorado.

Marketing ***(URGENT)***

- Do general brand advertisements need to be submitted, or does this only apply to materials that discuss specific benefit plans? As a point of reference, CMS requirements for Medicare marketing do not require general brand advertisements to be reviewed/approved. ***[DOI]***
  Brand advertisements do not need to be filed.

- Do web-based "pay per click" ads need to be submitted if general brand advertising must be submitted? ***[DOI]***

- If new advertising materials are developed after the 6/30 deadline, can they be submitted and used upon DOI approval during the 2014 CY? Similarly, if a new advertising opportunity presents itself after the 6/30 deadline, how should carriers approach this? It is likely that paid media opportunities may arise later in 2013, but will carriers have to have submitted advertising for opportunities that may not exist? ***[DOI]***

  Additional Marketing Materials can be submitted throughout the year.

Riders ***(URGENT)***

- Carriers need clear guidance on what is allowed regarding riders including, but not limited to, the filing requirements, the pricing requirements, and the overall approach the Division plans to take with regard to riders. ***Final federal rules have made clear that all additional benefits beyond the EHB (riders) must be embedded in the plan and cannot be sold a la carte. However, does the Division anticipate producing any other filing guidance regarding [DOI and COHBE]***
  COBHE plans will not allow riders. The outside market currently is able to attach riders. We are waiting on federal guidance around this issue.

AV Calculator

Deductible Limits ***(URGENT)***

- HHS has indicated that federal deductible limits can be exceeded under certain circumstances in order to obtain a Bronze plan in the AV Calculator (for example, with some HSA plans). Will this capability be allowed with Silver plans as well? ***[HHS]***

  We have not seen anywhere that this would be allowed for Silver plans.

Pharmacy Trend

- We're concerned about how trend is applied to pharmacy. The standard 6.5% annual trend applied to all categories fails to capture the unique nature of pharmacy utilization. Pharmacy trend is heavily impacted by the patent expirations of brand drugs and the resulting shift in utilization to generic products. This impacts the utilization within each pharmacy category (generic, preferred brand, etc) and changes the impact of cost share on actuarial value, particularly for copay based plan designs. Increasing generic utilization also increases the average unit cost for generic drugs, as new generics are higher cost than existing products. A similar impact is seen on average brand unit costs since the brands that are losing utilization to generics are more likely to be older, lower cost products. ***[HHS]***
- The tool seems to undervalue specialty drugs though we believe one of the videos explained that the dataset that was used didn't have much specialty drug cost in it. Normally we'd expect specialty drugs to be about 20% of Rx costs, or 3% of total costs. ***[HHS]***

Calculation Issues ***(URGENT)***

- We'd like to understand a particular output from the AV tool which seems to show a strange pattern as the coinsurance decreases: Running with $4500 med deductible and $5500 med OOP max ($1000 Rx deductible, 100% Rx coins and $1000 Rx OOP max), with everything having a copay except specialty drugs, we get the following results ***[HHS]***
  - 100% coinsurance = 66.8% AV
  - 99% coinsurance = 59.0% AV
  - 95% coinsurance = 63.0% AV
  - 80% coinsurance = 65.8% AV
  - 70% coinsurance = 66.4% AV

We get a very small AV difference (0.1%) when we run the same plan, but starting it as a Bronze versus Silver, even when we've agreed to the prompt that asks if we want to run a Bronze plan with the Silver tables. It's immaterial but it's disconcerting. ***[HHS]***

Essential Health Benefits

Stand Alone Dental ***(URGENT)***

- According to the final rule, medical carriers outside the Exchange that don't have an approved standalone exchange-certified pediatric dental plan still have to embed the pediatric dental benefits within the medical plan for those off-exchange purchasers who choose not to purchase an exchange-certified standalone pediatric dental plan, even if such a plan is available to be purchased on the off-exchange market, offered by another carrier. Do we understand this correctly? ***[HHS and DOI]***
    - How are we to be reasonably assured that a person has purchased a certified standalone pediatric dental plan? ***[HHS and DOI]***

      There will need to be an attestation or proof of evidence that the individual has pediatric dental coverage.

Conversion of annual dollar limits to acceptable limits ***(URGENT)***

- When will final decisions be made around the conversion of dollar limits on state mandated benefits to visit/service limits? ***We assume that the numbers previously shared in conversion chart provided by the state will be used, however we need conformation as soon as possible. [DOI]***

  The conversion chart provided by the state will be released by April 1, 2013.

    - The draft alignment bill references two of the conversions that need to be made (autism and early childhood intervention) and indicates they'll be adopted in rule, however how will the remaining conversions be made? ***They will be adopted by Bulletin. Later by be adopted by reg. [DOI]***

Plan Standards ***(URGENT)***

- Habilitative Services: We support requiring coverage of habilitative services at parity with rehabilitative services, given that this is the practice most plans use today. We need final determinations on exactly what the habilitative service standards will be. ***[DOI]***
    - We ask that the State clarify that this means that plans would continue to cover the same types of services (e.g., physical therapy, occupational therapy, and speech therapy) that they do for rehabilitation today but that coverage for these services would be extended to habilitation. ***[DOI]***

      Yes this is correct

    - Plans should not be required to offer new categories of services for habilitation that are not covered today such as services that are not medical benefits (e.g., educational or vocational services). ***[DOI]***

- Further, we believe it is important to maintain the "improvement" standard, given how difficult it is to assess a "maintenance" standard and the need to balance access with affordability. ***[DOI]***
- We would also like to ask the State to clarify that health plans may continue to set annual limits on the number of visits based on the type of service, rather than the reason for that service, as they do today. For example, if a plan provides for 30 physical therapy visits each year, this limit would be inclusive of both rehabilitative and habilitative physical therapy visits. ***[DOI]***

Prescription Drugs

- We ask the State and HHS to clarify that issuers may make mid-year formulary changes to remove drugs that are found to be unsafe or ineffective or that become available over-the-counter. In such instances, we ask that issuers not be required to add a replacement drug to the formulary mid-year to match the number of drugs covered by the EHB benchmark plan, as long as at least one drug in the class remains covered. ***[HHS and DOI]***

Cost-Sharing and Out of Pocket Maximum

- With respect to the OOP maximum, we ask HHS to clarify that while EHB must accumulate to the OOP maximum, non-EHB may accumulate but are not required to. For instance, in order to design high deductible health plans (HDHPs) that are HSA-certified, issuers would be able to accumulate all services (EHB and non-EHB) to the OOP maximum. In such a case, issuers would also include these non-EHB in the calculation of AV, which would be done outside of the calculator. ***[HHS]***
- In the Preamble, HHS presents an example of a three-tiered network design and explains that the first two tiers would be considered in-network, and accumulate to the OOP maximum, while only the third tier would be out-of-network and not have to accumulate to the OOP maximum. We request, instead, that HHS permit issuers to consider the first tier as the primary in-network tier and accumulate only those costs to the OOP maximum as long as the first tier provides adequate access to providers, in compliance with network adequacy requirements. This would permit issuers to design a second tier that provides enhanced access to out-of-network providers relative to a third tier, with protections for members against significant costs from balance billing, without having to accumulate those costs to the OOP maximum. Requiring that these costs accumulate to the OOP maximum would make it unfeasible for issuers to offer members this benefit. ***[HHS]***
- We also request clarification that issuers may have flexibility in applying the annual limitation on deductibles in the small group market or to use other types of cost sharing. For instance, issuers should be permitted to apply a deductible to only a subset of EHB, or to use fixed dollar co-pays for some services (e.g., physician office visits or prescription drugs) rather than making them subject to the deductible. Issuers could also choose not to have a deductible at all. ***[HHS]***

Additional Required Benefits ***(URGENT)***

- We request clarification that while EHB must apply to the AV calculation and annual limitation on cost sharing, issuers may exclude additional state-required benefits that are outside the scope of the EHB from the AV calculation. Likewise, issuers would not be required to apply these additional state-required benefits to the annual limitation on cost sharing. ***[HHS]***
- We request further details on how states will reimburse issuers for benefit offer mandates (i.e., requirements to make a benefit optional through a rider) that are required to be offered in addition to the EHB. ***[HHS]***
    - Do we have any offer mandates in Colorado? ***[DOI]***

Multi-State Plan ***(URGENT)***

- What information exists about a "multi-state plan" operating in Colorado's Exchange? ***[DOI and COHBE]***

  The proposed federal rule has been released by OPM, DOI still to provide future guidance.

Alignment of Colorado and Federal Standards

Carrier Participation and Contribution Requirements

- Final market rules state that minimum contribution and participation rates are not enforceable under federal guaranteed availability standards. However, the rule allows for carriers to establish a special enrollment period (11/15-12/15) for small groups that do not meet the minimum requirements. Do the DOI and Exchange plan on establishing this enrollment period? ***[COHBE and DOI]***

  Yes, this is addressed in our alignment bill.

- May a carrier establish contribution/participation requirements outside of the SHOP? ***We assume yes, but just verifying given the new federal guidance. [DOI]***

  Yes – standards for inside the exchange are the same for outside.

Guaranteed Renewability

- We would like to seek additional clarification on whether an individual whose policy ends mid-2014 would be eligible for a special enrollment period (SEP) to enroll in coverage. For instance, an individual's policy might renew in April 2014, outside of the annual open enrollment period. We recommend that such an individual be afforded a SEP to select a new product on the exchange (that is compliant with the 2014 market reforms) at that time so that they might be able to take advantage of any advance premium tax credits that they are eligible for. ***HHS agrees that all members with an individual product that ends during***

2014 will have a special enrollment period during which they can enroll in a calendar year plan. The guidance also says, "States may wish to consider other strategies to ease the transition, such as directing issuers to pro-rate premiums for policies covering less than a full year, among other transitional measures." Is Colorado going to establish guidance on how to pro-rate individual premiums for policies covering less than a full year? [COHBE and DOI]

For the individual market – 2013 must end on Dec 31, 2013.
For the small group market- further guidance is forthcoming.

MLR

- We have previously commented that HHS should take immediate steps to expand the MLR credit for ICD-10 compliance costs to apply to the ICD-10 compliance extension that CMS announced. The MLR Final Rule only permits issuers to include 0.3% of premium for ICD-10 expenses for 2011 and 2012. Because the ICD-10 compliance extension spills into 2013, issuers should also be permitted to include ICD-10 compliance expenses in their 2013 MLR calculations. ***[HHS]***
- We have also previously commented that the MLR Final Rule fails to give issuers sufficient credit for fraud prevention programs by limiting fraud prevention expenses to the amount of fraud recoveries. ***[HHS]***
- We believe that issuers should be given credit in the MLR calculation for expenses attributable to contributing data to state all-payer claims databases (APCDs), as the creating legislation for state APCDs emphasizes that the databases are created for purposes of quality improvement. For example, the APCD legislation from Colorado, Tennessee, Vermont, and Massachusetts all specifically mention that the databases are being created to improve the quality of patient health. ***[HHS]***

Risk Adjustment, Reinsurance, Risk Corridors

Risk Corridors

- What is considered a QHP? If the same plan is offered on-exchange and off-exchange, are all claims and premiums rolled together as one QHP, or are they considered two QHPs for RC purposes? Similarly, if the same plan is offered in two different rating areas, is that two QHPs or one? Are all plan variations considered a single QHP for RC? ***[HHS]***

Risk Adjustment

- We ask that HHS provide preliminary quarterly results beginning in the first quarter of 2014. Having this information as soon as possible will help carriers to more accurately price their products as they begin to submit rates for 2015 products in early 2014. Without such interim information, issuers would not

know their risk adjustment status until mid-2015, which could not be incorporated into rates until 2017. ***[HHS]***

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