Webinar 2:
MHPAEA, Student Health Plans, & Renewal Letters, March 8, 2016

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1

Welcome! Thank you for registering for this second 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.

Audience for Today's Webinar

Major medical, major medical supplement, student health, dental, grandfathered, transitional, and ACA-compliant plans with rate and form filings

2

This webinar is focused on Major medical, major medical supplement, student health, dental, grandfathered, transitional, and ACA-compliant plans.

The slides today will address several items including changes in SERFF, changes in some of our templates and just a review of some key aspects for a filing in Indiana.

Agenda

- Rate review justification ("RRJ")
- Mental Health Parity Addiction Equity Act ("MHPAEA")
- Federal notices
- Student health plans
- Major medical supplement

3

Rate review justification is still used for transitional and grandfathered filings that exceed the 10% threshold increase.
Mental Health Parity Addiction Equity Act is applicable to most Major Medical plans.
Federal Notices covers the renewal or termination notices required by CMS.
Student Health Plans will be for college and university students. This does not apply to grade school, high school students or summer student type coverage normally submitted as a blanket submission.
Major Medical Supplement is also referred to as Limited Wraparound coverage.

Food For Thought: A Famous Hoosier

4

Keeping with our 200th year as a state theme, - Food for thought ... “Indiana Fried Chicken” doesn’t have the same ring to it as “Kentucky Fried Chicken” however, Colonel Harland David Sanders is also from Indiana, according to Visit Indiana. He added restaurateur to his list of jobs, including rail worker, farmhand and insurance salesman.

Rate Review Justification

A. Base Period Data

Start Period: 06/01/2013 **End Period:** 05/01/2014

Categories	Months	Allowed	Claims	Cost Sharing	Sharing PMPM	PMPM	PMPM
Inpatient	329,035	$ 13,764,767.77	$ 12,180,033.35	$ 1,584,734.42	$ 4.82	$ 37.02	$ 41.83
Outpatient	329,035	$ 22,579,430.68	$ 12,866,623.44	$ 9,712,807.24	$ 29.52	$ 39.10	$ 68.62
Professional	329,035	$ 26,000,813.77	$ 15,849,982.51	$ 10,150,831.25	$ 30.85	$ 48.17	$ 79.02
Prescription Drugs	329,035	$ 3,724,933.64	$ 2,382,188.80	$ 1,342,744.83	$ 4.08	$ 7.24	$ 11.32
Other	329,035	$ 4,674,195.26	$ 3,743,675.40	$ 930,519.86	$ 2.83	$ 11.38	$ 14.21
Capitation	329,035	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Total	329,035	$ 70,744,141.11	$ 47,022,503.50	$ 23,721,637.60	$ 72.09	$ 142.91	$ 215.00

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period: 01/01/2014 **End Period:** 12/31/2014

Categories	Medical Trend	Allowed PMPM	Claims	Cost Sharing
Inpatient	1.1052	$ 46.24	$ 40.91	0.1151
Outpatient	1.1052	$ 75.84	$ 43.22	0.4302
Professional	1.1052	$ 87.34	$ 53.24	0.3904
Prescription Drugs	1.1052	$ 12.51	$ 8.00	0.3605
Other	1.1052	$ 15.70	$ 12.57	0.1991
Capitation	0.0000	$ 0.00	$ 0.00	0.0000
Total		$ 237.63	$ 157.95	0.34

B2. Claims Projection for Future Rate

Start Period: 01/01/2015 **End Period:** 12/31/2015

Categories	Medical Trend	Allowed PMPM	Claims	Cost Sharing
Inpatient	1.1800	$ 54.56	$ 48.28	0.1151
Outpatient	1.1800	$ 89.49	$ 51.00	0.4302
Professional	1.1800	$ 103.05	$ 62.82	0.3904
Prescription Drugs	1.1800	$ 14.76	$ 9.44	0.3605
Other	1.1800	$ 18.53	$ 14.84	0.1991
Capitation	0.0000	$ 0.00	$ 0.00	0.0000
Total		$ 280.40	$ 186.37	0.34

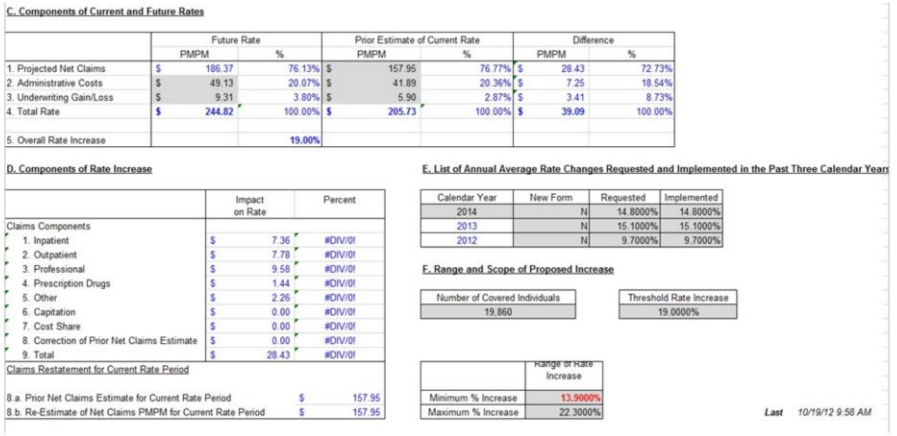
B3. Medical Trend Breakout

Factor	Impact
Utilization	18.3500%
Unit Cost	30.5800%
Other Factors	51.0800%

5

The rate increases showing here should align with the rate/rule schedule. In addition, any premium and losses need to match numbers in the experience workbook.
There is a link to the location of the RRJ in our rate instructions.

Rate Review Justification



C. Components of Current and Future Rates

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	$ 186.37	76.13%	$ 157.95	76.77%	$ 28.43	72.73%
2. Administrative Costs	$ 49.13	20.07%	$ 41.89	20.36%	$ 7.25	18.54%
3. Underwriting Gain/Loss	$ 9.31	3.80%	$ 5.90	2.87%	$ 3.41	8.73%
4. Total Rate	$ 244.82	100.00%	$ 205.73	100.00%	$ 39.09	100.00%
5. Overall Rate Increase		19.00%				

D. Components of Rate Increase

	Impact on Rate	Percent
Claims Components		
1. Inpatient	$ 7.36	#DIV/0!
2. Outpatient	$ 7.78	#DIV/0!
3. Professional	$ 9.58	#DIV/0!
4. Prescription Drugs	$ 1.44	#DIV/0!
5. Other	$ 2.26	#DIV/0!
6. Capitation	$ 0.00	#DIV/0!
7. Cost Share	$ 0.00	#DIV/0!
8. Correction of Prior Net Claims Estimate	$ 0.00	#DIV/0!
9. Total	$ 28.43	#DIV/0!

Claims Restatement for Current Rate Period

8.a. Prior Net Claims Estimate for Current Rate Period	$ 157.95
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	$ 157.95

E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Calendar Year	New Form	Requested	Implemented
2014	N	14.8000%	14.8000%
2013	N	15.1000%	15.1000%
2012	N	9.7000%	9.7000%

F. Range and Scope of Proposed Increase

Number of Covered Individuals	Threshold Rate Increase
19,860	19.0000%

	Range of Rate Increase
Minimum % Increase	13.9000%
Maximum % Increase	22.3000%

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6

Please make sure that the threshold rate increase showing here matches with the Overall % rate impact in the rate/rule schedule tab of the SERFF submission.
The RRJ should be submitted in the supporting document section of the SERFF submission.
If you have a threshold rate increase greater than 10, then the submission needs to also provide a justification in HIOS. We as the state reviewer will then also post a sign off in HIOS on completion of our review.
The minimum and maximum on this page also needs to match the Rate/Rule Schedule.
We expect the rate review justification to be used with grandfathered, transitional and student health filings.

MHPAEA

Who is subject to MHPAEA?

- A group health plan offering medical/surgical benefits and mental health or substance use disorder benefits.
- A health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits in connection with a group health plan.
- A health insurance issuer offering individual health insurance coverage.

MHPAEA

- If a plan provides mental health/substance use disorder ("MH/SUD") benefits in any classification, MH/SUD must be provided in every classification in which medical/surgical benefits are provided.
- Classification of Benefits
  - Inpatient, in-network
  - Inpatient, out of network
  - Outpatient, in network
  - Outpatient, out of network
  - Emergency Care
  - Prescription Drugs

8

Documentation of compliance with MHPAEA regulations found in 45 CFR 146.136. Such documentation shall include a filing from an actuary demonstrating how each financial requirement applicable to mental health or substance abuse benefit in the plan design is no more restrictive than the predominant financial requirement that applies to substantially all of the medical/surgical benefits in the same classification. There is a two step process. First the determination is that either a copay or coinsurance is the substantially all cost share structure. This is defined as the cost sharing that makes up at least 2/3rds of the benefits. The second step is then to determine the predominant level of payment. This should documented within the actuarial memorandum.

MHPAEA

- What IDOI review will entail:
  - Template requirements shall be submitted.
  - Demonstration that mental health benefits are in parity with medical/surgical benefits.
    - Need to show justification that either primary care or specialist care is the primary benefit.
  - Drug parity is required.

9

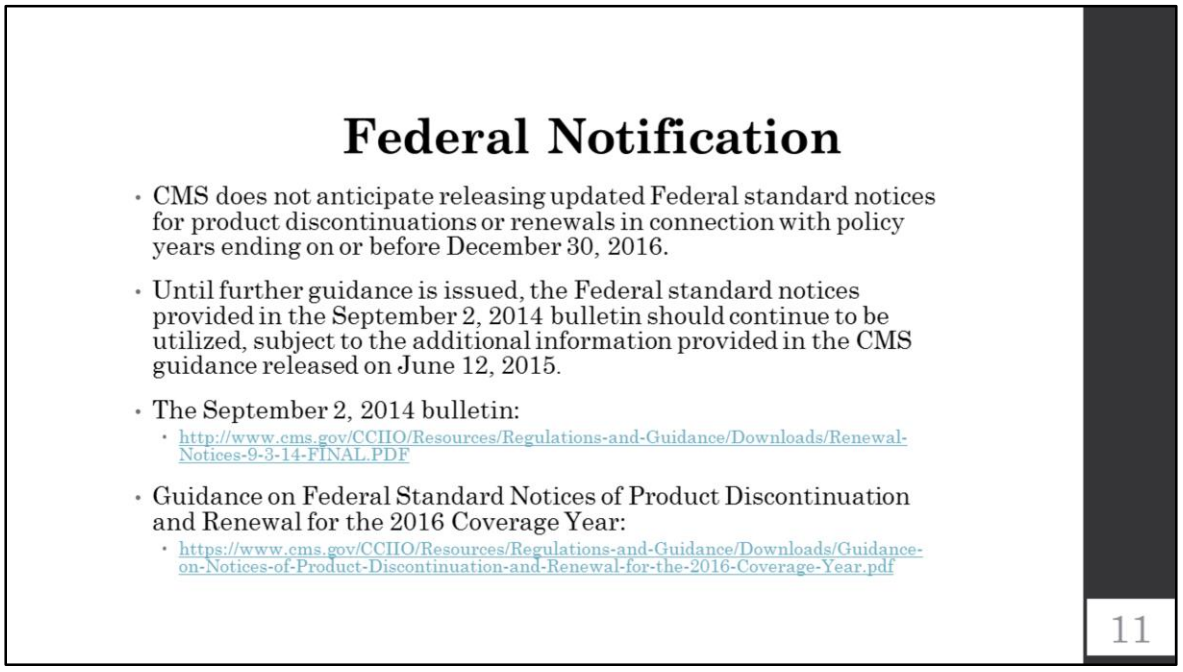
We have specific templates that are required for MHPAEA. If you are an off exchange carrier including large group, we have a separate template for you to use. For on exchange carriers, we have a different templates that will be used. These will be covered in a later webinar when we discuss all templates.

Federal Notification

- IDOI will use federal notification standards.
- Under 45 CFR §§ 146.152, 147.106, 148.122, an issuer that discontinues or renews a particular product (as defined in §144.103) in the group or individual market (including a renewal with modifications) must provide written notice of such discontinuation or renewal in a form and manner specified by the Secretary of HHS.
- Each year, carriers must send a notice of renewal or discontinuance to all policyholders pursuant to 45 CFR § 156.1255.

10

We will ask that you submit a sample of any letter that will be used for either renewal, auto-renew or product discontinuance.



1 – Renewal notice for the individual market where coverage is being renewed **outside** the Marketplace.
2 – Renewal notice for the individual market where coverage is being renewed **under the same product** in a QHP offered through the Marketplace.
3 – **Discontinuation** notice for the individual market **outside** the Marketplace and the issuer is automatically **enrolling** the enrollee in a new plan **outside** the Marketplace.
4 – Notice for the individual market where coverage was **in a QHP** offered through the Marketplace and the issuer is automatically enrolling the enrollee **in a new product**.
5 – **Discontinuation** notice for the individual market outside the Marketplace and the issuer **is not automatically** enrolling the enrollee in a new plan.
6 – **Discontinuation** notice for the individual market where coverage being discontinued was in a QHP offered through the Marketplace and the **issuer is not automatically** enrolling the enrollee in a new plan.

Federal Notification

- Product Discontinuance
  - Applicable for both grandfathered and non-grandfathered coverage in the large group, small group and individual market on and off Marketplace.
  - Notification must be sent 90 calendar days in advance before the date the coverage will be discontinued.

12

There were a few years where CMS allowed you a grace period for small group with using the federal notifications.
For this year, we will expect all carriers to follow the federal guidelines.

Federal Notification

- Notice of renewal
  - Non-grandfathered in the individual market
    - An issuer must provide to each individual market policyholder written notice of renewal before the first day of the next annual open enrollment period.
  - Grandfathered coverage in the individual market, and grandfathered and non-grandfathered coverage in the small group market.
  - An issuer must provide to each plan sponsor or individual, as applicable, written notice of renewal at least 60 calendar days before the date of the renewal of the coverage.

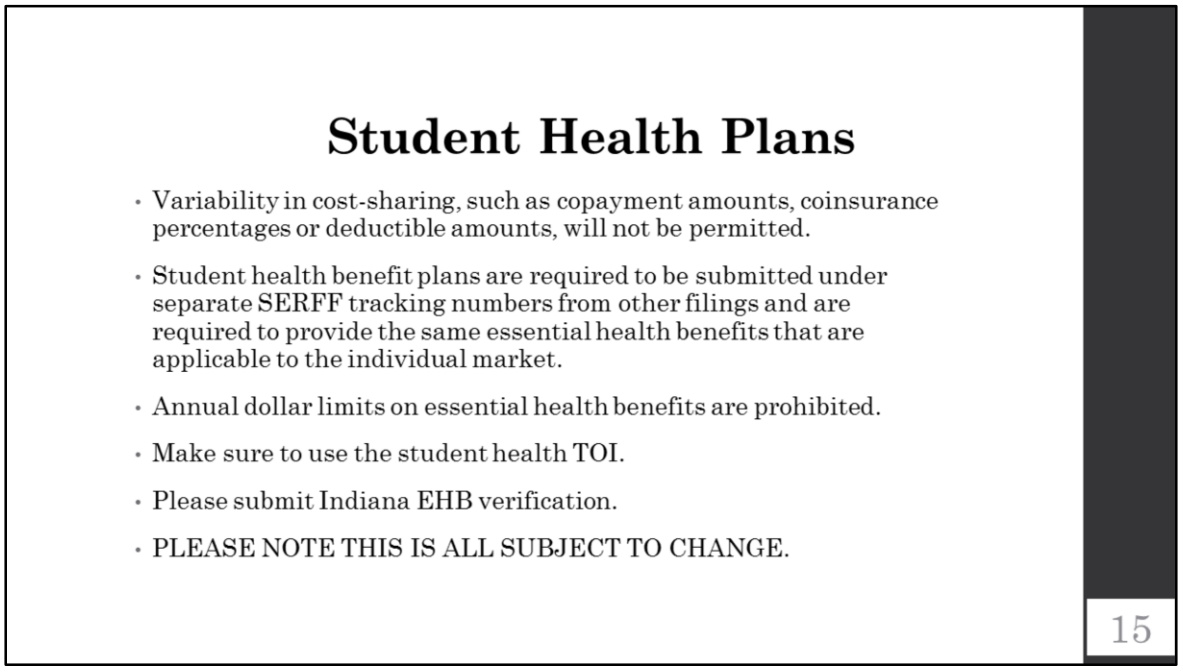
State Timing for Small Group and Individual Market Withdrawal

- **Small Group**
  Pursuant to IC 27-8-15-20, provide notice to the commissioner and affected plans at least **one year** prior to withdrawal.

- **Individual**
  Pursuant to IC 27-1-20-36, provide notice to the commissioner at least **180 days** prior to withdrawal.

14

I'm sure everyone is aware of this timing. Please keep this in mind anytime you wish to withdraw and be aware that you do need to inform the commissioner with a letter and send an email to compliance@idoi.in.gov.



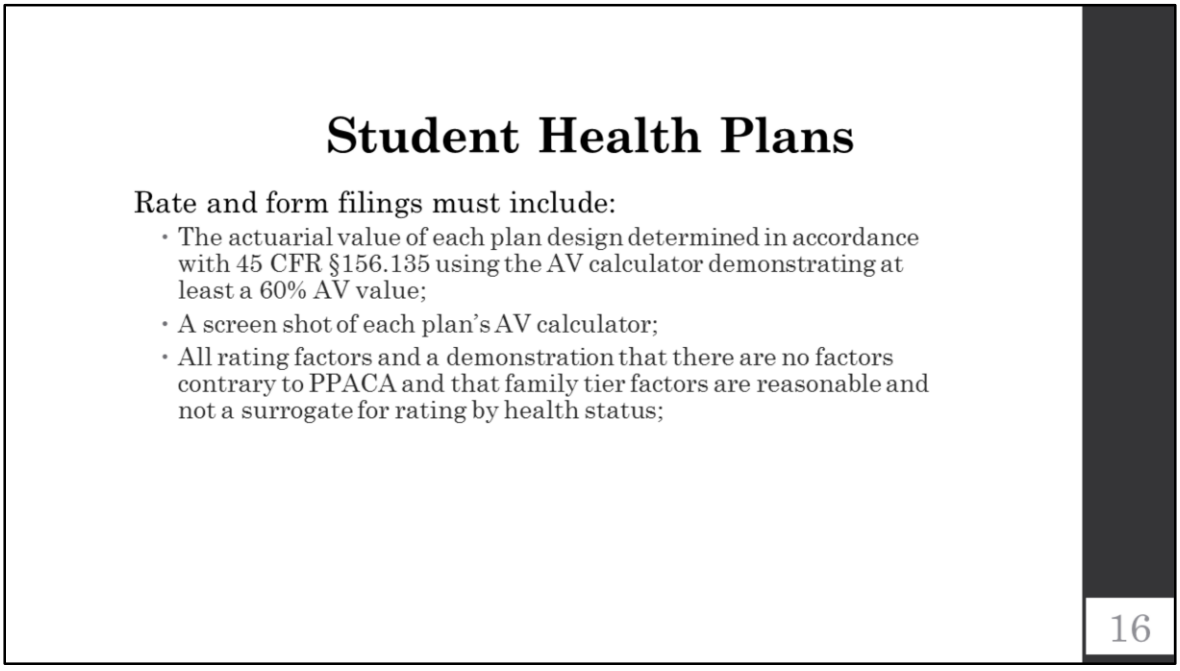
Variability in cost-sharing, such as copayment amounts, coinsurance percentages or deductible amounts, will not be permitted within the same class of insured. Carriers are required to file a separate schedule or benefit form for each benefit design.

- Student health benefit plans are required to be submitted under separate SERFF tracking numbers from other filings and are required to provide the same essential health benefits that are applicable to the individual market.
- Annual dollar limits on essential health benefits are prohibited
- Each filing for a health benefit plan is required to include:
  - Certification that the health benefit plan's prescription drug benefit complies with 45 CFR 156.122 ;
  - Documentation of compliance with MHPAEA regulations found in 45 CFR 146.136. Such documentation shall include a filing from an actuary demonstrating how each financial requirement applicable to mental health or substance abuse benefit in the plan design is no more restrictive than the predominant financial requirement that applies to

substantially all of the medical/surgical benefits in the same classification

- Subject to index rate set methodology of the single risk pool. This would still be separate for larger pool and could create smaller pools as long as they are not health-related factors. Plan level adjustments are limited.

We will require a completed drug template.



Multiple risk pools allowed per school. What this means is you are allowed to have a separate pool for under-graduate, graduate and international students.
Each filing should include:

- The actuarial value of each plan design determined in accordance with 45 CFR §156.135 using the AV calculator developed and made available by HHS demonstrating at least a 60% AV value;
- A screen shot of each plan's AV calculator;
- All rating factors and a demonstration that there are no factors not allowed by PPACA and that family tier factors are reasonable and not a surrogate for rating by health status;
- Demonstration of the medical loss ratio calculation to show that the medical loss ratio is at least 80%.

Student Health Plans

Rate and form filings must include the following templates:

- Formulary template
- Rates template

17

We also need these templates.
Back to the EHB template, we will need you to provide any variations due to university, undergraduate, graduate and international student.
If this is a topic of interest email our compliance email with Student Health Plans in the subject line.
CMS continues to refine their guidance around student health plans.

Major Medical Supplement

Rate and form filings must include:

- Major medical supplements need to coordinate with Major Medical plans.
- There is a specific SERFF tracking number to be used for these.
- This is also called limited wrap-around product.
- We will provide additional guidance as we receive it from CMS. If this is a topic of interest email our compliance email with Limited Wrap-around in the subject line.

Any Questions?

Don't forget to register for Webinar 3: ACA-Compliant Filing Issues!

The intended audience for this March 15 webinar is ACA-Compliant Filings – individual and small group, including dental