



Plan Year 2021 Filing Webinar

Rates, Forms, and Provider Networks



OFFICE of the
**INSURANCE
COMMISSIONER**
WASHINGTON STATE

Agenda

Housekeeping

Welcome and Overview

- Forms
- Provider Networks
- Rates
- Binder

Next Steps

Housekeeping

This PowerPoint Deck will be provided after the presentation.

Questions:

- Send questions via Zoom Chat function. We will answer what we can during the presentation.
- If your question is not answered during the presentation, send it to Rfhealthplan@oic.wa.gov

Please keep your audio muted at all times.

Plan Year 2021 Overview

Molly Nollette, Deputy Commissioner Rates, Forms, and Provider Networks



Welcome to Plan Year 2021!

This is the 8th annual plan year presentation by the Division of Rates, Forms, and Provider Networks.

Today's presenters:

- Kim Tocco, Health Forms Program Manager
- Jennifer Kreidler, Provider Network Oversight Program Manager
- Lichiou Lee, Chief Actuary
- Rocky Patterson, Actuarial Analyst
- Molly Nollette, Deputy Commissioner RFPN

Important Dates for Plan Year 2021

May 21st, 2020: the filing deadline.

- Filings not timely submitted on or before May 21, 2020 will be rejected without review.

September 16, 2020: WAHBE Board Meeting scheduled to certify QHPs and QDPs

November 1, 2020: Open Enrollment!

What must be filed May 21st?

- All plan year 2021 individual health plans,
- All plan year 2021 small group health plans,
- All plan year 2021 stand-alone dental plans that provide pediatric dental benefits as one of the essential health benefits, and
- All school year 20/21 higher education student health plans

May 21, 2020, is the filing deadline for PY21!

Renewal plan requirements

One renewal plan per Control Group as described in 45 CFR 147.106(d)(4) must be filed for plan year 2021. Renewal plans must meet federal Uniform Product Modification Justification requirements.

Higher education student health plans

Higher education student health plans:

- Student health insurance coverage is a type of individual health insurance coverage (as defined in 45 CFR § 144.103) that is provided pursuant to a written agreement between an institution of higher education and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents.

Please file higher education student health plans early so that we can send off the first round of objections prior to the major medical filings coming in.

GFI revision project is complete

- In 2018, we began a project to revise the content of the General Filing Instructions (GFI).
- In 2019, we redrafted the GFIs and created the Speed to Market (STMs) tools and documents.
- In 2020, we completed rulemaking, separating out the Rate GFIs from the Form GFIs, and formally created SERFF Binder GFIs.

We intend to post the latest version of the GFIs today, after this presentation.

Updated and newly created STMs will be posted as well.

GFIs and STMs

General Filings Instructions are required.

- Compliance with GFIs is required to get your filing through the door in SERFF.
- Following GFIs does not mean your filing will be approved.

Speed to Market tools, processes, documents are optional.

- Following STMs gets your filing reviewed more quickly and gets your product to approval
- Using STMs does not mean your filing will be accepted for review.

Speed to Market: front of the queue

STMs are checklists, process descriptions, and other tools to help accelerate review time.

- They are based upon most common and time-consuming review difficulties, and most common objections

If a filing does not include completed Analyst Checklists, the first objection will be a request for the Analyst Checklists to be completed.

We will prioritize filings with completed Analyst Checklists.

Universal Objections

Sometimes we identify a question that we must ask of all health plans under active review. We call these “Universal Objections”.

Potential triggers of Universal Objection include changes in state or federal law such as:

- final NBPP for 2021;
- new preventive services from USPSTF;
- completed rulemaking;
- mid-year effective dates.

Cascade Care

Standardized Plans:

- Individual market health plan issuers are required to offer Standardized Plan gold and silver metal level plans in each county in their service area. If a non-Standardized bronze plan is offered in a county, then a Standardized bronze Plan must also be offered in that county.
- Forms and Rates will be reviewed for compliance with the Standardized Plan benefit design, including Actuarial Value requirements
- WAHBE will be releasing plan naming requirements which will be incorporated into the GFIs
- STMs have been developed for Standardized Plans

Cascade Care

Public Option:

- All Public Option plans are also Standardized Plans
- WAHBE will be releasing plan naming requirements specific to Public Option plans which will be incorporated into the GFIs

Quality filings please!

- Submit accurate and internally consistent product filings.
- You will not be allowed to make changes just because you changed your mind.
- Issuers will be permitted to amend filings only at the direction of the commissioner.

Forms

Kim Tocco, Health Forms Program Manager

Definitions of “Product” and “Plan”

Product (same benefits and provider network type)

- discrete package of health coverage benefits
- use a particular provider network type(HMO, PPO, EPO, POS or indemnity)
- within a service area.
- Differences in the scope of benefits (such as limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the amount, scope or duration of treatment) mean different products.
- Differences in the amount of payment for a service owed by the consumer (differences in “cost-sharing structure”) do not mean different products.
- A product can be modified in some ways, yet remain the same product. (“Uniform Modification”: 45 CFR §146.152(f), §147.106(e), or §148.122(g)).

Plan (same product, different cost-sharing structure, actual provider network, and/or service area)

- The pairing of a set of benefits (product) and a particular cost-sharing structure, provider network, and service area.
- The combination of all service areas of the plans offered within a product constitutes the service area of the product.

Definitions of "Product" and "Plan"

Resources on Product vs. Plan

- Pg. 1 of the Uniform Product Modification Justification form
- CMS Qualified Health Plan (QHP) Series XII Slides, *"Federal Definitions for Health Insurance Products and Plans"* is available dated 02/06/2020
 - Copy of slides available on RegTAP or upon request
- 45 CFR §144.103

Structure of Form Filing Reviews

Preliminary Review

- “Products” and “Plans” correctly sorted and same number in rates, forms, and binder?
- Metal Level requirements met?
- Electronic Review Tool Results submitted with Binder filing?
- Redlines attached for any “Revised” forms?
- Are the HIOS IDs correct?
- Is there at least one renewal product to prevent market withdrawal?

Substantive Review

- Begins when Preliminary Objections are Resolved
- Using applicable Analyst Checklist

Structure of Form Filing Reviews

Review of Plans in Groups

Priority: Student Health Plans, then Plans for Sale on the Exchange, then Off-Exchange plans

- Sometimes Individual and Small Group filings from the same carrier can be reviewed together; depends on whether they're similar enough
- A carrier's On- and Off-Exchange filings in the same market will usually be reviewed together

You designate the "Primary Product" in each Market

- The most complex

We Review the Primary Product Beginning to End

- Objections on Primary Product
- Objections on other Products only re: Differences

When All Objections Resolved in Primary Product Filing, We Ask You to Conform All the Other Product Filings

- Make all changes consistent with the changes made to the Primary Product filing

Timelines for Objection Responses

- You may see shorter response times than you do for filings without a deadline
- Forms:
 - Preliminary and First Substantive Objection Letters – 5 days
 - Second Objection Letter – 3 days
 - Subsequent Objection Letters – 2 days
- You may request an extension of the respond by date. We will grant reasonable extension requests. If we have a concern, we may communicate with you about the deadline.

GFI and STM (Speed to Market)

Required GFIs vs. Optional Speed to Market Tools and Processes

- Clearly identifies what is necessary to get your filing in the door and what you can do to help your filing get reviewed as quickly as possible
- GFIs get your filing in the door
 - Some modifications to GFIs this year, primarily related to Standardized and Public Option plans
- STM tools and processes get your filing reviewed quicker
 - Minimal modifications to STMs this year
 - Based upon most common and time-consuming review difficulties, and most common objections

GFIs and STM – New for 2021

GFIs for filing Student Health Plans are now located in the **Health** and Disability Forms General Filing Instructions.

STM – New for 2021

STM Tools for Individual and Small Group Filings

Checklists for Forms:

- Individual Forms Analyst Checklists (Disability Company, HCSC, HMO) –for major medical plans
- Small Group Forms Analyst Checklists (Disability Company, HCSC, HMO) –for major medical plans
- Individual Stand-Alone Dental with Pediatric EHB Forms Analyst Checklists (Disability company, HCSC)
- Small Group Stand-Alone Dental with Pediatric EHBs Forms Analyst Checklists
- All Filers Individual Embedded Pediatric Dental with EHBs Forms Analyst Checklists
- All Filers Small Group Embedded Pediatric Dental with EHBs Forms Analyst Checklist
- 2020-2021 School Year Higher Education Student Health Plan Forms Analyst Checklist
- **NEW Standardized Plan Analyst Checklist**
- **NEW Standardized Plan Silver Variant Analyst Checklist**

STM Processes

STM Processes for Individual and Small Group Filings

- Include a Snapshot document in your Binder
- Identify a primary product for review
- Use Section III of the STM Guide to ensure you include only administrative variability
- Include correct page numbers in the Table of Contents

New legislative requirements include:

SHB 2554	Mitigating inequity in the health insurance market and exclusion of mandated benefits	Effective 6/11/2020
ESHB 2642	Removing barriers to accessing substance use disorder treatment services	Effective 01/01/2021
E2SSB 6087	Imposing cost-sharing requirements for coverage of insulin products	Effective 01/01/2021
SHB 2338	Prohibiting discrimination in health care coverage	Effective 01/01/2021
SHB 2464	Protecting patients from excessive prescription medication charges	Effective 01/01/2021
SB 5887	Concerning health carrier requirements for prior authorization standards	Effective 06/11/2020
HB 2390	Replacing references to “handicapped persons” with “individuals with disabilities” and “the elderly” with “the aging”	Effective 06/11/2020
SHB 2473	Revising definition of “domestic violence”	Effective 03/18/2020

#1 Thing You Can Do to Speed Up Review

MAKE SURE YOUR FORM FILING, RATE FILING, NETWORK FILINGS and BINDER MATCH

- Same number of products and plans
- Same cost sharing amounts in binder and forms
 - Including whether before and after deductible
- Same network name(s) in network filings and forms
- Same benefits and cost sharing in rates and forms

We strongly suggest that you do a matching review before submitting your filing to ensure that your forms, rates, networks, and binder all contain the same information.

This is by far our most common objection, and most time-consuming!

Call us when you have a question

- Unclear about a filing instruction?
- Question about an item on a checklist?
- Confused by an objection?
- Not sure what to do in response to an objection?
- Question not addressed in the GFIs or other resources?

CALL US –Analysts are busy but ready to take your call

Your company has an assigned Analyst. To learn who your assigned Analyst is, look in your SERFF filing.

Provider Networks

Jennifer Kreidler, Provider Network Oversight Program Manager

Provider Network Oversight Program

In July 2019 the Network Access Unit became the Provider Network Oversight Program.

The program name is not the only change you will experience. The program includes the addition of 6 new FTE's allowing for the specialization of personnel.

The program consists of 2 specialized units:

- Provider Contract Unit
- Provider Network Unit

Staffing Updates in PNOP

Provider Network Unit – responsible for the review of binder templates (for network access certification) and network access reports.

- Marney Gagnon – Senior Provider Network Analyst
 - Debbie Johnson – Provider Network Analyst
 - Courtney Taylor – Provider Network Analyst
 - Desiree Rosenberg – Network Management Analyst
 - 1 FTE to be filled – Provider Network Analyst

Staffing Updates in PNOP

Provider Contract Unit – responsible for the review of provider contracts.

Darren Dezutter – Senior Provider Contract Analyst

- Joanne Najdzin– Provider Contract Analyst
- Sean Gregory – Provider Contract Analyst
- Mary Tedders Young – Provider Contract Analyst
- 1 FTE to be filled – Provider Contract Analyst

Network Date Timeline

Network Access Portal will open and be ready for upload on April 17, 2020

- Network Access reports must be submitted by May 21st

On the Form, Rate, and Binder approval date

- Network must demonstrate it will support services guaranteed in the health benefit plan

November 1, 2020

- Notification to OIC is required by the network may have an access gap on January 1, 2021

December 31, 2020 through December 31, 2021

- Is your Alternative Access Delivery Request still needed?
- Is your Alternative Access Delivery Request approved?
- Are you monitoring your network through the plan year?

Public Option Networks

- The same network access requirements apply to public option health plans.
- Network access reports are due on May 21st
 - Access Plan
 - GeoNetwork Report

Identify the Network Name

The Network Name must be clearly and consistently identified

- What must match?
 - Provider Agreement and Compensation Exhibits
 - Provider Directory
 - Health benefit plan documents
 - Provider Network Form A
 - Access Plan and Geonetwork reports
 - Binder – Network Template

Provider Contracting and Balanced Billing Protection Act

The OIC has removed filing requirements from the General Filing Instructions in response to comments. The Provider Contracting Analyst Checklist will be updated to outline expectations.

- RCW 48.43.730(7) - Provider contracts filed pursuant to subsection (2) of this section shall identify the network or networks to which the contract applies.
- WAC 284-170-480(7) - Provider contracts and compensation agreements must clearly set forth the carrier provider networks and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.

What to do when I have a question

- Unclear about a filing instruction?
- Question about an item on a checklist?
- Confused by an objection?
- Not sure what to do in response to an objection?
- Question not addressed in the GFIs or other resources?

Use our dedicated mailbox to drop us a question

Analysts are ready to assist you at:

OICNetworkAccess@oic.wa.gov

Rates

Lichiou Lee, Chief Actuary

Rate Filing Instructions

Rate Filing Instructions - What's New?

- All rate filing instructions other than property and casualty are in one document: Washington State SERFF Life, Health and Disability Rate Filing General Instructions (per WAC 284-44A-040(2)(b))
- Clarification: Except for large group health, dental only, or vision only plans, rate and form filings for new plans must be filed concurrently.

PY21 ACA Individual and Small Group Rate Flings

Risk Adjustment Fees and Exchange Carrier Assessment

- Risk Adjustment fees: 0.19 PMPM per HHS Proposed Rule for Notice of Benefit and Payment Parameters for 2021. Subject to change per final rule.
- The Health Benefit Exchange (HBE) finalized the 2021 Exchange carrier assessment on April 2nd. For 2021, HBE is maintaining the same carrier assessment:
 - QHPs: \$3.36 PMPM
 - QDPs: \$0.81 PMPM
 - Pediatric Dental Plans: \$0.58 PMPM

PY 21 ACA Individual Exchange Plans

- At least one standardized gold plan and at least one standardized silver plan must be included for offering coverage through the Exchange. If bronze plans are offered through the Exchange, at least one standardized bronze plan must be included. RCW 43.71.095
- The actuarial value of nonstandardized silver health plans offered on the exchange may not be less than the actuarial value of the standardized silver health plan with the lowest actuarial value (RCW 43.71.095)
- Washington State Health Benefit Exchange (WAHBE) is tasked with developing and publishing the standardized plans and the Actuarial Value (AVs).
- All standardized plan AVs, including those of Silver 73% AV, Silver 87% AV, and Silver 94% AV in the rate and binder filings must match those published by the WAHBE.

Speed to Market Tools (STMs) – Individual

For ACA Individual Health Plan Rate Filings:

- STM - Rate Schedule Format: Format-Rates-2021 Individual NonGF Health Plan Rate Schedule.
 - **New this year:** For “Plan Type” dropdown field, you must select one of the following three plan types for each plan: Non-Standardized, Standardized Non-Public Option, or Standardized Public Option
- STM – Experience Summary Format: Format-Rates-WAC 284-43-6660 Summary
- STM – Filing Checklists and Certifications:
 - Checklist-RF-2021 Ind Med Uniform Product Modification Justification
 - Checklist-Rates – 2021 Individual Nongrandfathered Health Plans
 - Certification-Rates – 2021 Ind Mental Hlth and Subst Use Dis Financial Reqs

<https://www.insurance.wa.gov/filing-instructions>

Speed to Market Tools (STMs)- Small Group

For ACA Small Group Health Plan Rate Filings:

- STM - Rate Schedule Format: Format-Rates-2021 Small Group NonGF Health Plan Rate Schedule.
- STM – Experience Summary Format: Format-Rates-WAC 284-43-6660 Summary
- STM – Filing Checklists and Certifications:
 - Checklist-RF-2021Sm Grp Med Uniform Product Modification Justification
 - Checklist-Rates – 2021 Small Group Nongrandfathered Health Plans
 - Certification-Rates – 2021Sm Grp Mental Hlth and Subst Use Dis Financial Reqs

<https://www.insurance.wa.gov/filing-instructions>

Speed to Market Tools (STMs) – Student Health Plans

STMs for Higher Education Student Health Plan Rate Filings

- For Higher Education Student Health Plan rate filings, issuers are required to submit only one public rate filing and one not-for-public rate filing (if applicable).
- Complete and attach a Checklist-Rates-2020-2021 School Year Higher Education Student Health Plan
- SERFF binders are not required for student health plans
- See information in STM-Rates- Student Health Plan <https://www.insurance.wa.gov/filing-instructions>

Speed to Market Tools (STMs) – Pediatric Dental

STMs for Stand Alone Pediatric Dental Plan Rate Filings

- For stand-alone dental plan rate filings, issuers are required to submit only one public rate filing and one not-for-public rate filing (if applicable) per (individual or small group) market.
- Complete and attach a *Checklist-Rates-2021 EHB Dental Rate Filing* document
- Use the Format - Rates - WAC 284-43-6660 Summary
- See information in STM-Rates-SAPD-Ind and Sm <https://www.insurance.wa.gov/filing-instructions>

CCIIO Reports for 2019 Risk Adjustment Data

- CCIIO normally provides the prior calendar year's Risk Adjustment data on June 30th
- It's being delayed by two week this year – expected July 15th instead of June 30th
- Once CCIIO has published the reports, we will provide direction how issuers can submit updates of applicable documents in SERFF related to Risk Adjustment

SERFF Binder

Rocky Patterson, Actuarial Analyst

Binder Documents

- CMS Templates required in submission
 - No changes from PY2020
 - See WA Exhibit A document for required templates
- Plans and Benefits Template (PBT)
 - CMS PBT Add-in file
 - No changes from PY2020 for WA
 - Use WA Exhibits B and C to correct PBT add-in results for WA EHBs
 - New requirement for standardized plans
 - Standardized plan naming conventions (pending WAHBE)

Binder Documents

- Medical Snapshot Document
 - Added Plan Type field to the Plan Summary Section: This field documents whether the plan is a standardized plan.
 - Selections include
 - Non-Standardized
 - Standardized Non-Public Option
 - Standardized Public Option

Binder Review Changes

- We will review standardized plans for consistency with the WAHBE designs.
 - Includes standardized CSR plan variations

Standardized Plan Information Cross-Section

Content	WAHBE	Binder Filing	Rate Filing	Form Filing
Plan Name	<ul style="list-style-type: none"> Will specify plan naming convention 	<ul style="list-style-type: none"> Plans and Benefits Template (PBT) Snapshot 	<ul style="list-style-type: none"> All documents that state plan name 	<ul style="list-style-type: none"> Plan Name
Plan Type		<ul style="list-style-type: none"> Snapshot, Plan Type Field 	<ul style="list-style-type: none"> Rate Schedule, Plan Type Field 	
Benefits/ Cost-Sharing	<ul style="list-style-type: none"> Specifies plan design and AV 	<ul style="list-style-type: none"> PBT 	<ul style="list-style-type: none"> Benefit Components and AV Screenshots 	<ul style="list-style-type: none"> Statement of Benefits

Next Steps

Molly Nollette

OIC Review Teams (Binder teams)

Every carrier's Individual and Small Group filings are reviewed by a team of 4 reviewers –Actuary, Forms Analyst, Network Analyst, and Binder Analyst (who is an Actuarial Analyst).

SCRUM –weekly status meetings of entire Rates, Forms, and Provider Networks health care team

“Binder meetings” –meetings of team reviewing a particular carrier's filings (meetings are sometimes split between markets as needed)

- First binder meeting is scheduled to occur when the first set of substantive rate and forms objections has been sent and responses received
- After first binder meeting, objections synchronized so rate, form, and binder objections (which include Network objections) all go out same day

#1 Thing You Can Do to Speed Up Review

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We strongly suggest that you do a matching review before submitting your filing to ensure that your forms, rates, networks, and binder all contain the same information.

This is by far our most common objection, and most time-consuming!

Next Steps

Get your filings in on time!

- The filing deadline is May 21st, 2020.
- Please do not wait for the last minute.
- We are all in this together!

Good luck and stay safe.

Questions

If your question was not answered during the presentation, please send it to:

Rfhealthplan@oic.wa.gov

Questions?

Molly Nollette

Deputy Commissioner, Rates, Forms, and Provider Networks

MollyN@oic.wa.gov

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