Plan Year 2023 Filing Webinar

Rates, Forms, and Provider Networks Division
Introduction / Overview

Molly Nollette, Deputy Commissioner RFPN
Agenda

• Welcome / Overview – Molly Nollette, Deputy Commissioner
• Product & Plan – Ned Gaines, Forms Compliance Manager
• Provider Networks – Jennifer Kreitler, Provider Network Oversight Program Manager
• Forms – Kim Tocco, Health Forms Program Manager
• Rates – Lichiou Lee, Chief Actuary
• SERFF Binders – Rocky Patterson, Actuarial Analyst III
• Questions – All
• Closing – Molly Nollette
Housekeeping

The PowerPoint deck will be posted after the presentation.

Questions:
• Use the Q&A feature to ask questions
• We will pause for questions after each section
• We will answer what we can on the fly
• If we don’t answer your question, send it to Rfhealthplan@oic.wa.gov
PY23 review plan

We have a vigorous market! If we have a repeat of PY22, we’ll be busy:

• 15 individual market carriers – 12 on-Exchange
• 12 small group market carriers
• 3 higher education student health plans
• 9 standalone dental carriers

One OIC review team

We have a lot of work to get done together!
PY23 review plan cont.

Order of priority for review:

1. **Higher education student health plans**
   - Plan year is the academic year, starting in August

2. **Individual market health and standalone dental plans for Exchange**
   - Deadline for QHP/QDP Certification to offer on Healthplanfinder

3. **Individual market health and standalone dental plans for off-Exchange only AND small group market health plans**
PY23 review plan cont.

**May 2022:** preliminary review of all health plans

**June:** focus on higher education student health plans and Exchange-bound individual market

**July:** approve higher education student health plans, maintain focus on Exchange individual market

**August:** finish up Exchange individual market, turn to off-Exchange individual and small group markets

**September/October:** finish up off-Exchange individual and small group markets

* Standalone dental plans are reviewed alongside health plans by market
Cascade Select “Public Option” RFP

Issuers that are not selected as Apparently Successful Vendors in HCA’s RFP for Cascade Select (Public Option) will be allowed either to:

1. withdraw Cascade Select plans; or,
2. amend Cascade Select plans to become Cascade Care plans.

- The withdrawal or amendments related to not being selected to participate in Cascade Select must be filed with OIC in SERFF no later than June 30, 2022.
- Issuers must ask OIC permission to withdraw or amend Cascade Select health plans
- OIC will provide direction to issuers on how to withdraw or amend plans due to not being selected for the RFP
- HCA will confirm RFP results to OIC when publicly announced
PY23 key dates

May 19\textsuperscript{th} – Filing deadline

June 30\textsuperscript{th} – last date for changes related to Cascade Select RFP

\textbf{September 8\textsuperscript{th}} – last day for guaranteed presentation at WAHBE Board Certification meeting

\textbf{September 15\textsuperscript{th}} – WAHBE Board Certification meeting

\textbf{November 1\textsuperscript{st}} – Open Enrollment
Market rules reminder

Individual market:
• If an issuer does not offer all its individual market health plans for every day of Open Enrollment, then they are required to offer open enrollment for the entire plan year.

Small group:
• If an issuer does not offer its small group plans for every day of OE, then the issuer cannot enforce participation requirements during the plan year.

Get approved on time or face adverse selection.
GFIs and STMs

**General Filing 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.**
- STMs are **not required** to get your filings accepted in SERFF for review
- Using STMs helps get your filing to approval faster
- We will prioritize filings with completed STMs
Questions?
Product & Plan

Ned Gaines, Forms Compliance 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 cont.

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 01/21/2021
- Copy of slides available on RegTAP or upon request
- 45 CFR §144.103
As part of Federal requirements, a “discrete set of health coverage benefits” includes the formulary.

In PY 2023, OIC will continue to enforce the federal requirement that all plans within a product share the same drug formulary.

OIC formally asked CMS what are allowable formulary changes within one product for purposes of maintaining that product status.

As per CMS, a product formulary must have the same list of drugs and same drugs in each cost-sharing tier, though cost-sharing may differ between plans.

“Formulary ID” as used in the CMS QHP templates does **not** automatically indicate a different drug formulary for the purpose of defining separate products.

- For plans within the same product, plans may have different formulary IDs if such differences are only due to variations in cost-sharing requirements of the plans.
Product, Plan and Formulary

- If an issuer makes changes to its drug formulary upon renewal or mid-plan year, these changes must comply with the (UPMJ) criteria under 45 CFR §147.106(e)(3), including the allowable plan-adjusted rate index variation of +/- two percentage points.
  - For existing products, changes in the covered drug list may be considered a product discontinuation.
  - We will not expect a new UPMJ submission with a mid-year formulary change.
Product, Plan and Formulary - Resources

- OIC GovDelivery emails of 2/09/21 and 3/10/21*
- OIC future GovDelivery emails as we receive guidance from CMS-CCIIO

*See appendix for GovDelivery emails
Questions?
Provider Networks

Jennifer Kreitler, Provider Network Oversight Program Manager
Does your network match?

PNOP will review the following:

- Network name(s) listed in approved provider contracts
- Registered network maintenance information:
  - Name,
  - Type of network (single or tiered),
  - Market (outside, Exchange or both)
  - Line of Business
- Service Area template
- ECP and Network Adequacy Template
- Network Template
- Plans and Benefits Template
- GeoNetwork Report
- Access Plan
- Provider Network Form A report
Network Template

New PY2023:

• Health carriers must create separate network IDs for your Individual Market networks and Small Group Market networks.

• Washington State is a SERFF filing state.
  • Health carriers must use the same Network Template across all binders or ensure that no network IDs repeat across binders.
Essential Community Provider (ECP)

Notice Benefit Payment Parameter proposed (NBPP) rule:

• Increases the federal ECP participation standard from 20% to **35%**
• Washington state currently requires carriers to meet a 30% standard
• Carriers will be required to meet highest participation standard
ECP continued

“Description and Purpose of the Final CMS Essential Community Providers List for 2023 Plan Year” document

Updates to CMS List of ECPs documentation:
- Updated provider contact information
- Modifying health services displayed at specific provider facilities,
- Removing provider practices no longer in business
- Removing provider practices that no longer accept plans purchased through an Exchange.

CMS ECP list for PY2023 reflects ECP petitions received between December 9, 2015, and August 18, 2021

Clean up efforts resulted in reduction of list from 12,420 providers to 12,099 providers

ECP petition will only be accepted from a provider
- Third-party entities can not petition for a provider to be included on the list
ECP continued

- **Qualified Health Plans:**
  - Include at least 1 ECP in each of the ECP categories in each county in the service area where an ECP in that category is available. [45 CFR 156.235(2)(ii)]

- **ECP Categories:**
  - Federally Qualified Health Centers
  - Ryan White Providers
  - Family Planning Providers
  - Indian Health Care Providers

- **Hospitals**
  - At least 1 ECP hospital per county in the service area in each network. [WAC 284-170-310(3)(g)]
  - A carrier may have more than 1 hospital in a county but at least 1 must comply with the ECP requirement.

- **Other ECP Providers**
Tiered Network

- Tiered network means a network that identifies and groups providers and facilities into specific groups to:
  - Reimburse providers differently, or
  - Establish different enrollee cost-sharing levels, or
  - Establish provider access requirements, or
  - Any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

- Only tier one providers will be counted to determine essential community provider threshold standards.

- **CAUTION**: Benefit design changes may change your network structure and require development of a new network.
OIC Rulemaking R2021-16

• Implementation of E2SHB 1477 and consolidated health care rulemaking
  • Public hearing held on March 24, 2022
  • If adopted by commissioner:
    • Access plans –
      • Adds new requirements for gender affirming treatment [WAC 284-170-280(3)(g)(i)(J)(K) and (M)]
      • Updated Access Plans to be due no later than July 1, 2022.
    • New “988 Crisis Hotline Appointment Form D Report”
      • Working group coming early summer
      • Please send carrier contact to Jennifer.Kreitler@oic.wa.gov
Provider Network Form A update

Telemedicine Services

- Current requirement populate field 4.12 with value 1 = true, 0 = false
- PY2023 when reporting a practitioner provides telemedicine services a carrier will additionally report:
  - Audio Only services,
  - Virtual only services, or
  - Both audio and virtual services
- Look for more information early Fall 2022
Balance Billing Protection Act

- Amended AADR [E2SHB1688, Section 18]
  - New request form to open Network Access Portal.
  - New network access report that will:
    - Describe request, and
    - Outline the health carrier’s new evidence of good faith efforts to contract for 3 months
  - Coming Soon: draft templates to share with industry
Questions?
Welcome!
PRIORITY OF FORMS REVIEW BY MARKET

- Student Health Plans
- Individual Exchange Health Plans & On-Exchange Stand-Alone Dental
- Individual Off-Exchange Health Plans
- Small Group Health Plans & Off-Exchange Stand-Alone Dental
PRELIMINARY FORMS REVIEW

Purpose: Identify threshold issues that may prevent or delay substantive review of your filing

Preliminary Review of ALL Filings

✓ Are “products” and “plans” correctly sorted and identified?

✓ Are HIOS IDs correct?

✓ Have you filed the same number of products and plans in your form, rate, and binder filings?
PRELIMINARY FORMS REVIEW (cont’d)

✓ Have you filed at least one renewal product?

✓ Have you submitted redline versions of all “revised” forms under the Supporting Documentation tab?

✓ Do Cascade Care plan names meet WAHBE naming conventions?

✓ Have you submitted electronic review tool results with your binder filing?
SUBSTANTIVE REVIEW

✓ Begins when preliminary objections are resolved

✓ Uses applicable analyst checklist

✓ Analyst may “group” filings for review based on similarity across products

✓ On- and off-Exchange typically reviewed together
Substantive Review (cont’d)

✓ Communicate with your analyst!

✓ Remember: All communications that relate to the OIC’s review of a specific filing **must** occur in SERFF

✓ “Primary product” reviewed beginning to end
“Primary Product”

✓ Product with the most complex or “richest” benefit design in each market

✓ Designated in the analyst checklist and binder snapshot document

✓ If your individual market products include both standardized (Cascade or Cascade Select) and non-standardized plans, please designate your most complex non-standardized plan as primary
“Primary Product” (cont’d)

 ✓ All first-round substantive objections are made within primary product filing

 ✓ Objections to secondary product filings will be based on differences/variation from primary

 ✓ When all objections are resolved within primary product filing, you will be asked to conform all other product filings in accordance with these changes
MATCHING INFORMATION ACROSS FILINGS

BINDER

RATES

NETWORKS

FORMS
COMMON FORM “MATCHING” OBJECTIONS

Cost-share amounts
✓ Forms: Schedule of Benefits/Summary of Costs
✓ Binder: PBT
✓ Binder: Prescription Drug Template

Network names
✓ Forms content
✓ Binder: Network Template
✓ Provider Networks: Filed networks

Service Area - Counties
✓ Forms content
✓ Binder: Service Area Template counties
Timelines for Response to Form Objections

Preliminary and 1st Substantive Objection Letters: 5 business days

2nd Objection Letter: 3 business days

Subsequent Objection Letters: 2 business days

- All timelines subject to OIC and/or WAHBE deadlines for plan approval and certification
- You may request an extension of the “respond by” date; reasonable requests will be granted
What’s new for PY2023?

**E2SHB 1688**: aligns state BBPA with federal NSA

- Effective upon Governor’s signature

- Expect a GovDelivery communication that will address required endorsements of current forms and expectations for PY23 forms

- Universal form objection to be issued
What’s new for PY23? (cont’d)

Effective 01/01/2023:

**ESHB 1689**: Biomarker testing and prior authorization

**ESHB 1821**: Changes the definition of "established relationship" for purposes of reimbursement for audio-only telemedicine

**SSB 5546**: Temporarily requires health plans to cap the amount an enrollee is required to pay for a 30-day supply of insulin at $35
What’s new for PY23? (cont’d)

Effective 01/01/2023

**SSB 5610**: Requires certain third-party payments to count towards an enrollee's cost-sharing obligation or out-of-pocket maximum for prescription drugs

**E2SSB 5702**: Donor human milk coverage – LG Group only

**SHB 1052**: Applicable performance standards must be explained in the contract filed with the OIC – LG Group only
What’s new for PY23? (cont’d)

Women’s Preventive Services Guidelines (HRSA)

U.S. Preventive Services Task Force A & B Recommendations
“Flipping the Forms”

✓ When all objections are resolved within primary product filing, you will be asked to conform all other product filings in accordance with these changes.

✓ 5-day turnaround time, subject to OIC and WAHBE deadlines.

✓ Required certification of changes.
TIPS FOR SUCCESS: HELP US HELP YOU!

- REVIEW YOUR FILINGS FOR CONSISTENCY AND MATCHING INFORMATION
- BE PROACTIVE
- COMMUNICATE WITH YOUR ANALYST
Questions?
Rates

Lichiou Lee, Chief Actuary
Proposed PY23 NBPP Related to AV

Changes to AV in the Notice of Benefit and Payment Parameters (NBPP) 2023 Proposed Rule

- The de minimis ranges for the standard bronze, gold, and platinum levels of coverage will change from +2%/-4% to +/-2%.
- The de minimis range for expanded bronze plans will change from +5%/-4% to +5%/-2%.
- The de minimis range for individual market silver CSR variations will change from +1%/-1% to +1%/0%. For the Silver QHP and its 73% variation, the AVs still must differ by at least 2 %.
What’s new in SERFF?

For plan year filings starting 2023, there is a new separate URRT tab between the Rate/Rule schedule and the Supporting Documentation tab that is applicable to Unified Rate Review (URR) submissions.

• The first item on the new URRT tab is a question asking if the filing which is being created is applicable to URR submissions. Carriers need to select “Yes” for all ACA non-grandfathered individual and small group health plan rate filings.

• Load Part I (URRT), Part II, and Part III (Actuarial Memorandum) on this new tab.

• A document is required to be loaded under “Actuarial Memorandum” section and “Actuarial Memorandum – Redacted” section of the URRT tab. You must load the same (un-redacted) Actuarial Memorandum in both sections. Per RCW 48.02.120, all individual and small group health plan rate filings must be public. Issuers are not allowed to redact any information in these rate filings. (Note: SERFF will require different file names for redacted and un-redacted versions.)

• See General Rate Filing Instructions for submission requirements.
ARP subsidies

• Issuers should price their 2023 rates in line with the current law, which (as of the writing of this) includes the expiration (aka sunsetting) of the American Rescue Plan (ARP) subsidies for 2023 and the return to the pre-ARP federal and state subsidies.
• We will not request two sets of rate filings.
• We will continue to monitor the development of ARP subsidies.
• If there are changes to the status before we approve any individual rate filings, we will allow all issuers to change assumptions and update their rate filings if time permitted.
PY23 Exchange User Fees

• The Exchange Board has approved PY23 Exchange User Fees the same as those of PY22.
  • Qualified Health Plans: $3.00 PMPM
  • Qualified Dental Plans: $0.81 PMPM
  • Pediatric Dental Plans: $0.58 PMPM
General Filing Instructions (GFIs) and Speed to Market Tools (STMs)

- For OIC to accept your initial submission through SERFF, issuers must comply with GFIs (WAC 284-58-025).
- STMs are not required for initial submission. Using STMs helps get your filing to approval faster.
- The General Rate Filing Instructions states: If you prepared the filing with the intent to follow the STMs, please state this in the Filing Description field.
- We will prioritize filings with completed STMs. If you do not follow the STMs in your initial SERFF submission, we will send the first objection letter requesting the STMs – this might delay the review of your filing.
General Filing Instructions (GFIs) and Speed to Market Tools (STMs)

- Updated Rate Filing Instructions related to the new URR Tab submission requirements.
- Updated some STM tool documents, including the checklist for Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity Calculation. We added a sheet to address data used and a sheet to address mapping of services to testing categories.
Questions?
New and Important

Binder GFIs - Waiting for CMS final QHP Templates and Review Tools
- Final binder GFIs are pending release of CMS final documents
- We do not expect any additional changes to the binder GFIs regarding CMS templates
- We have no info about changes to CMS review tools, but do not expect material changes

Network IDs
- Use unique network IDs for the individual and small group markets
- Submit the same network template in both of your individual and small group market binder filings (if applicable)

Plans and Benefits Template (PBT) Add-In Files
- We have been working with CMS to get the PBT Add-In file updated for WA so fewer modifications are needed when setting up the PBT.
- CMS expects to have at least some of these changes finalized soon.
- Regardless of the add-in file version used, your PBT benefit package tabs should match Exhibit C except where deviations are allowed (see details in Exhibits B and C)

CMS’s Standardized Plans Add-In File
- Do not use CMS’s add-in files for standardized plans to prepare WA binder filings
Binder Review Process (High Level)

Step 1
Preliminary Review:
- We check fundamental components of the filing.
- Tasks include:
  - Correct Documents Included
  - Product and Plan Counts
  - Renewing Product and Plan Changes
  - Service Area Offering Requirements

Step 2
Substantive Review:
- We check the remaining details
- Analysts compare the binder to the form, networks, and rate filings.
- Generally, this is where the majority of review and objection letters occur.

Step 3
Cleanup:
- We prepare the filing for final disposition and reporting in this step.
- We make sure the documents are consistent with the final versions in the rate, form and binder filings.

Notes:
- Steps are recursive and dependent on filing specific circumstances.
- Overlap may occur based on timing of the review.
“EHB Variance Reason” is a field in the PBT Benefit Package tab

• Do **NOT** use “Substituted,” “Substantially Equal,” or “Using Alternate Benchmark” reasons, these are not allowed in WA

• See Exhibit B and C provided by the OIC for details about the right reasons to use
  • There will be no changes to Exhibit C
Unique Plan Design Issues

**Is my plan design unique? You have a unique plan design if your plan design...**
- Cannot accurately fit into the PBT; or
- Is not consistent with the standard translation of plan designs from the PBT to the AV Calculator (AVC); or
- Is not consistent with the AVC functionality and calculation assumptions.

**Why does unique plan design matter?**
- If you have a unique plan design, you must submit additional supporting documentation for the plan’s metal actuarial value (AV).
  - See the binder GFls and rate filing checklist for details
- If you do not identify your plan design as unique, we may identify it later in the review and that may require you to change your plan designs to meet federal AV requirements.
Unique Plan Design Issues Continued

**Unique plan design estimates/adjustments must balance explainability and accuracy**

- Problem: It is unclear whether the final AV of a unique plan design is within the required metal AV range without a custom AV calculation or support.

- Solution Requirements
  - Use an actuarially justifiable method of estimating the plan's final AV
  - Provide support with enough detail for the reviewer to determine whether the methods used are appropriate and the results are reasonable

- Solution Selection Guidance

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<tr>
<th>Explainability</th>
<th>Accuracy</th>
<th>Model</th>
<th>Model Examples</th>
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| High           | Low      | This is **NOT a good** model for the task because it doesn’t address the problem with objective evidence that supports the final AV. | - Gut feeling  
|                |          |       | - Intuition     |
| Low            | High     | This **is NOT a good** model for addressing the problem because the result cannot be verified or evaluated for reasonableness using the information provided. | - Neural network  
|                |          |       | - A program that is too complicated to reasonably review |
| High           | Reasonably High | This **is a good model** because it is accurate enough to address the problem useful and explainable enough for the reviewer to verify. | - Using AVC data to calculate estimate (AVC data should be used when possible) |
Questions?
Next Steps

Make the best filing you can.

Don’t wait until that last minute to submit it!

Watch the calendar and respond to objections quickly and completely.

Filing Deadline is May 19, 2022.
Use your resources

• Review General Filing Instructions and Speed-to-Market tools
• Contact the analyst assigned to your filing in SERFF or your assigned network analyst
• Email the RFHealthPlan@oic.wa.gov inbox
Questions?

Molly Nollette
Deputy Commissioner, Rates, Forms, and Provider Networks
Molly.Nollette@oic.wa.gov / 360.725.7117

Connect with us!
• Facebook: https://www.facebook.com/WSOIC
• Twitter: https://twitter.com/WA_OIC
• www.insurance.wa.gov
Greetings,
As part of the Office of the Insurance Commissioner’s (OIC) plan year 2022 individual and small group filing review process, the OIC will be enforcing the federal requirement that all plans within a product share the same drug formulary (also referred to as “covered drug list”).

Under 45 CFR § 144.103, a set of plans that share a discrete package of benefits and network type within a service area are considered a single product. An issuer’s drug formulary is a feature of the product’s “discrete package of benefits” offered to the consumer. Any limits on the scope of covered benefits, including the drug formulary, are considered product-level differences and all plans offered within each product must use the same drug formulary (within allowable rate variations as described below). For example:

- Product A offers identical benefits to the state’s EHB benchmark plan through a preferred provider organization network. Product B is identical to Product A except for the drug formulary. Product A and Product B offer different prescription drug benefits and are therefore two different products.

If an issuer makes changes to its drug formulary on renewal, these changes must comply with the uniform product modification justification (UPMJ) criteria under 45 CFR §147.106(e)(3), including the allowable plan-adjusted rate index variation of +/- two percentage points. For existing products, changes in the covered drug list may be considered a product discontinuation.

For purposes of explanation, we provide the following four scenarios:

**Scenario 1: A New Carrier in the Marketplace**
A new carrier offers two products and the only difference between the two products are their prescription drug formularies. These must be two distinct products with separate HIOS product IDs. To be considered the same product, covered items and services must be identical.

**Scenario 2: Existing Carrier in Year 2; in Year 1, Product A had five plans and all five plans had the same drug formulary.**
In year 2, the carrier changes only the drug formulary in each plan, everything else being the same except for the changes to the drug formulary. For all five plans, the impacts to the plan-adjusted index rate due to the changes to the drug formulary are still within an allowable variation of +/- 2 percentage points (not including changes pursuant to applicable Federal or State requirements) under 45 CFR §147.106(e)(3) (v). In this case, Product A is still a renewal Product with five renewal plans as long as changes to the drug formulary are the same for all plans within the product (so all five plans would still have the same drug formulary) regardless of the variation to the plan-adjusted index rate.
Scenario 3: Existing Carrier in Year 2; in Year 1, Product A had five plans and all five plans had the same drug formulary.
In year 2, the carrier changes only the drug formulary in each plan, everything being the same except for the changes to the drug formulary. For four plans, the impacts to the plan-adjusted index rate due to the changes to the drug formulary are still within an allowable variation of +/- 2 percentage points (not including changes pursuant to applicable Federal or State requirements) under 45 CFR §147.106(e)(3) (v). One plan, Plan 5, falls outside of an allowable variation of +/- 2 percentage points. In this case, Plan 5 no longer belongs to the same product and is discontinued. The carrier maintains the Product as a renewal product with four renewal plans. Issuers can only change the drug formulary at the product level and the change must be made uniformly for all plans within that product in the individual and small group markets. The four renewal plans under that product would still need to use the same drug formulary.

Scenario 4: Existing Carrier in Plan Year 2022; in Plan Year 2021, Product A had seven plans, five of which had the same drug formulary and two of which had different drug formularies.
In order to keep Product A as a renewal product in Plan Year 2022, the carrier must first determine which plans have the same drug formulary. In this scenario, the carrier can start with picking the five plans that had the same drug formulary in Plan Year 2021 and then go through the exercises in Scenarios 2 and 3 above. If it is difficult to determine your renewal plans due to variations in drug formularies, we recommend picking the plans with more membership as your renewal plans.

Issuers are encouraged to carefully review federal guidance addressing prescription drug formularies as a feature of a product’s “discrete package of benefits” and the federal definitions of “plan” and “product” at 45 CFR § 144.103. This guidance may have substantial impacts on some issuers when building plan binders, completing associated templates and justifications, and determining product renewals and discontinuations. For additional information, see https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08017.pdf, pages 17460-17463; see also Centers for Medicare & Medicaid Services (Qualified Health Plan Series Webinar), February 6, 2020, Federal Definitions for Health Insurance Products and Plans. Presentation slides available at REGTAP: https://www.regtap.info/.

We understand that issuers may have additional questions and concerns specific to their plan year 2022 portfolios. Please submit additional questions to RFHealthPlan@oic.wa.gov. In your email, please use “questions related to product and drug formulary” in your subject line.
Greetings,

As explained in the Office of the Insurance Commissioner’s (OIC) prior message on February 9, 2021, for plan year 2022 (PY22), OIC will be enforcing the federal requirement that all plans within a product share the same drug formulary (also referred to as “covered drug list”).

Under 45 CFR § 144.103, a set of plans that share a discrete package of benefits and network type within a service area are considered a single product. An issuer’s drug formulary is a feature of the product’s “discrete package of benefits” offered to the consumer. Any limits on the scope of covered benefits, including the drug formulary, are considered product-level differences and all plans offered within each product must use the same drug formulary (within allowable rate variations).

After further discussion with CMS-CCIIO, OIC has learned additional information that we believe is important to share with issuers as you continue to develop your PY22 filings. OIC has learned that the designation “formulary ID” as used in the CMS QHP templates does not automatically indicate a different drug formulary for the purpose of defining separate products.

This message is to clarify that for plans within the same product, plans may have different formulary IDs if such differences are only due to variations in cost-sharing requirements of the plans. In other words, different formulary IDs associated with your plans in the QHP Prescription Drug and Plans & Benefits templates do not necessarily trigger different products.

The OIC is still working with CMS-CCIIO to clarify which formulary features could trigger a separate product. We will provide additional guidance when we have more information.