OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Universal Objections to be made regarding all individual and small group plans for PY 2017

For the last few years, OIC has been sending what we call "universal objections" to all issuers on their individual and small group health plan filings. Universal objections address possible issues that have been identified market-wide, requirements that are too new to have been included in the most recent Analyst Checklist, and other emerging issues. For consistency, we send the objections to all issuers in order to ensure that each issuer reviews its filings for compliance. A particular issuer or filing may or may not need to make corrections. We expect to include these universal objections in the next SERFF form or rate objection letter to each issuer. Issuers should respond to universal objections as they would for any other objection.

We have identified four areas which require universal objections. These objections will be sent to all issuers in the individual and small group market rate or form filings through SERFF:

1. **Updating Risk Adjustment and Reinsurance (Rate Filing):**

   On June 30, the Centers for Medicare and Medicaid Services (CMS) issued the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year. To read the Risk Adjustment & Reinsurance report, you can visit: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

   For all issuers who have submitted individual and small group market major medical plans for plan year 2017, you will be required to update applicable documents and rating information related to Reinsurance and Risk Adjustment in the rate filing. To make our review more efficient, we will require issuers to update the applicable documents related to these items according to the following guidance in SERFF:

   - For issuers with the rate filing currently in "active suspense" (i.e. objections pending for the issuer's response), the OIC will send a "Note to Filer" to the issuer requesting to update all applicable documents related to Reinsurance and Risk Adjustment in the response to the objection letter. Issuers may request an extension to respond to the objection letter due to the additional objection.

- For issuers with the rate filing currently not in active suspense, we will send an objection letter soon. The objection letter will include pending rate filing objections as well as the request to update applicable documents and rating information related to Reinsurance and Risk Adjustment.

Additional actuarial certification: The submission of updated applicable documents in the rate filing must include a separate actuarial certification from the opining actuary indicating that the changes to the rate documents are either to respond to pending objections or to update applicable documents and rating information related to Reinsurance and Risk Adjustment, and there are no other changes to the pricing assumptions. You must name this certification "Certification to Update Reinsurance and Risk Adjustment."

If issuers have any questions, issuers should contact their OIC rate analyst for direction.

2. Final Nondiscrimination Rules (Form Filing):

The federal Department of Health and Human Services (HHS) recently issued its final rules implementing section 1557 of the ACA. These final rules require covered entities to post a nondiscrimination notice and language taglines in their significant publications as of October 18, 2016. The rules specify the contents of the notice, and provide that the taglines must be posted in the top 15 languages used in the state. We have attached PDFs of the list of languages for Washington and the sample translated taglines which you may use.

The rules require that the notice and taglines be posted in a "conspicuously-visible font size" in significant publications and significant communications targeted to beneficiaries, enrollees, applicants, and members of the public. The preamble to the rule states that such "significant publications" may include patient handbooks, outreach publications, or written notices pertaining to rights or benefits or requiring a response from an individual. This would include enrollee plan documents such as those which comprise this filing.

In response, please direct our attention to the location of the required notice and taglines in your filing. If the notice and taglines have not been included in your filing, please amend your form(s) to include them.

If you have any questions, please contact your OIC analyst or Andrea Philhower, Manager of the Health and Disability Unit at AndreaP@oic.wa.gov or (360)725-7119.

3. Screening for Maternal Depression (Form Filing)

As you know, the ACA requires that health plans include the 10 Essential Health Benefits (EHBs), one of which is Preventive Services. Carriers must cover, without cost sharing, all

preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a rating of A or B.

In January, 2016, the USPSTF updated its recommendation regarding depression screening for adults. The USPSTF had previously recommended screening all adults when staff-assisted depression care supports are in place, and selective screening based on professional judgment and patient preferences when such support is not available. The new recommendation is that all adult patients be screened for depression. The USPSTF has said that this change recognizes that staff-assisted depression care supports are now much more widely available and accepted as part of mental health care, and that current clinical practice is to screen all patients. The update also added a specific recommendation of screening for depression in pregnant and postpartum women. The recommendation now reads:

Depression screening: adults
The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

The ACA provides that, when the USPSTF amends it's A and B recommendations, carriers have one year from the time of the amendment to ensure that they comply with the new recommendation. Therefore, depression screening must be a covered preventive benefit for Plan Year 2017.

OIC recognizes that depression screening is usually done as part of a routine preventive care or postpartum visit. For that reason, it has not needed to be specifically stated in health care forms describing benefits. However, because depression screening for all adults, including screening for maternal depression, is now an EHB, it must be called out in the forms.

In response, please direct our attention to the location where depression screening for adults in general, and postpartum women in particular, is listed in your forms as a covered preventive benefit. If this benefit is not listed, please amend your form(s) to include it.

If you have any questions, please contact your OIC analyst or Andrea Philhower, Manager of the Health and Disability Unit at AndreaP@oic.wa.gov or (360)725-7119.

4. Drug Substitution Request Process (Form Filing):

Objection 1: : 45 CFR §155.122(c)(1) requires that each health plan have a process for enrollees or their representatives to request a review of a decision that a drug prescribed for them is not covered by the plan. 45 CFR §155.122(c)(3)(i) further requires that each

health plan have a process for enrollees or their representatives to request that the original exception request, and subsequent denial of such request, be reviewed by an independent review organization.

As a result, the issuer's medication substitution process may not require more than one level of internal appeal before the enrollee is entitled to request external review of a denial of a request for medication substitution.

Please explain how the drug substitution process applicable to this plan complies with this requirement.

Objection 2: 45 CFR §155.122(c)(1)(ii) requires that each health plan must make its determination on a standard medication substitution request, and notify the enrollee or representative and the prescriber of its determination no later than 72 hours following receipt of the request.

Please explain how the drug substitution process applicable to this plan complies with this requirement.

Objection 3: 45 CFR §155.122(c)(2)(iii) requires that each health plan must make its determination on an expedited medication substitution request, and notify the enrollee or representative and the prescriber of its determination no later than 24 hours following receipt of the request.

Please explain how the drug substitution process applicable to this plan complies with this requirement.

Objection 4: 45 CFR §155.122(3)(2) states:

"A health plan must make its determination on the external exception request and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following its receipt of the request, if the original request was a standard exception request under paragraph (c)(1) of this section, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request under paragraph (c)(2) of this section."

Please explain how the drug substitution process applicable to this plan complies with this requirement.

If you have any questions, please contact your OIC analyst or Andrea Philhower, Manager of the Health and Disability Unit at AndreaP@oic.wa.gov or (360)725-7119.