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2017 IDAHO STANDARDS FOR INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS AND QUALIFIED DENTAL PLANS–REVISED

The Idaho Department of Insurance (DOI) is providing the following guidelines for carriers who wish to have their health benefit plans available for sale in Idaho's Individual or Small Group markets, and dental carriers wishing to participate in the Idaho health insurance exchange. This includes (1) individual and small group health benefit plans seeking exchange certification, known as Qualified Health Plans (QHPs); (2) individual and small group health benefit plans not seeking exchange certification (non-QHPs); and (3) stand-alone dental plans seeking exchange certification, known as Qualified Dental Plans (QDPs). **This document is revised from the February 12, 2016 version, changing certain dates in the Appendix A – Timeline.**

Certain requirements may apply only to plans seeking to be sold through the health insurance exchange, Your Health Idaho (YHI). There are many other requirements that are not directly addressed in this notice, for example the market-wide reforms. DOI expects the carriers to be aware of those requirements with which they must comply.

DOI will review the information that carriers submit and, from the plans seeking certification, recommend QHPs to YHI for certification for 2017. These guidelines provide the criteria DOI will use when performing reviews and ultimately making recommendations for certification. They align with the regulatory requirements of Idaho Code title 41, chapters 21, 22, 47, 52, 61 and 45 C.F.R. Parts 155 and 156.

DOI or YHI will provide additional guidance as needed. Please contact Wes Trexler (208-334-4315 / weston.trexler@doi.idaho.gov) or carriers@yourhealthidaho.org with questions or comments.

Section One: Filing, Review, and Certification Process

Individual and Small Group health benefit plans, both QHPs and non-QHPs, as well as QDPs, follow the same timeline for the review process. Only QHPs and QDPs participate in the certification process. Plans submitted by the U.S. Office of Personnel Management (OPM) as Multi-State Plans are to meet the same filing dates and requirements as other carriers.

1. Timeline

The preliminary timeline for the 2017 review and certification process is shown in Appendix A. The dates are approximate and subject to change. DOI will revise and redistribute Appendix A upon any decision to modify a date.

Carriers can submit their rates, forms, or templates as early as SERFF makes the functionality available for 2017 plans but no later than the dates shown in Appendix A. In the case that SERFF is not ready to accept binder filings by the specified due dates, carriers will still be expected to submit their forms and rates through standard (non-binder) filings. DOI will expect carriers to complete their application by submitting the remaining components in a binder within one week of the SERFF binder functionality becoming available.

In compliance with 45 C.F.R. § 154.220, DOI expects each carrier to submit the uniform rate review template (URRT), actuarial memorandum, and the rate increase justification to CMS on the same date the carrier submits the rate change filing to DOI through SERFF. The carrier has the responsibility to maintain both filings up-to-date throughout the review process.

DOI will post proposed rate increases on the DOI website no later than the date specified in Appendix A. Consumers will be able to submit comments to DOI through its webpage.

Carrier plan preview is expected to be available on the YHI website through the plan management module on the date shown in Appendix A. DOI will transfer the QHP data from SERFF to the YHI plan management module. The carriers will be able to view plan data in the plan preview environment concurrent with DOI's review of the QHP submissions. DOI will work with carriers to resolve objections and transfer updated SERFF data to the plan management module for plan preview in a timely manner. Carriers should attempt to bundle corrections identified through plan preview into periodic requests and submit the requests to make corrections to DOI through email or SERFF.

DOI will allow carriers to make approved corrections to filings through SERFF until the date shown in Appendix A. DOI plans to present the final certification recommendations to the YHI Board of Directors based on that information. YHI expects to send out certification notices shortly after the approval.

No later than the first day of open enrollment, DOI will post all final rate increases on DOI's website.

2. Filing Expectations

For Idaho, the QHP/QDP application for certification refers to a carrier submitting all QHP/QDP related forms, rate manuals, templates, and other requested documents to DOI through SERFF. There is no separate application to complete. Non-QHPs must submit much of the same information, as outlined below.

Carriers should submit all forms for each product in a single filing. The forms of multiple products can be grouped into a single filing as long as all forms fall under the specified "Type of Insurance" (TOI). Carriers currently selling plans are encouraged to submit

changes to the forms as an amendment. Any forms pertaining to new plans must be submitted without amendments.

There must not be more than one rate filing per carrier per market (individual medical, small group medical, individual dental, and small group dental). Supporting documents for rate filings should be in PDF or Excel format; XML data should only be included with the corresponding data also in Excel format.

Carriers should submit no more than one binder per carrier per market. The binder should include the following templates:

- plan and benefits,
- network,
- service area,
- ECP/network adequacy (n/a for non-QHPs),
- rate data,
- rating business rules,
- plan crosswalk,
- unified rate review (n/a for QDPs), and
- prescription drug (n/a for QDPs).

The binder's supporting documentation at a minimum should include:

- compliance plan and organizational chart,
- federal program attestations (n/a for non-QHPs),
- ID-FF certification form,
- network adequacy plan or narrative (n/a for non-QHPs),
- Idaho-specific attestations (QHPs only),
- un-redacted actuarial memorandum,
- written description justifying the rate increase (if applicable),
- QDP actuarial value attestation and justification (QDPs only),
- QDP description of EHB allocation method (QDPs only),
- Quality Improvement Strategy implementation plan (QHPs only), and
- justifications for any potential deficiencies (as needed).

3. Summary of Benefits and Coverage

Carriers must include on the SERFF form schedule a schedule of benefits and the federally mandated Summary of Benefits and Coverage (SBC) corresponding to each Standard Component ID plus variant code included in the carrier's SERFF medical plan binder(s). Carriers are permitted to submit the SBCs up to two weeks after the binder submission, provided that carriers notify DOI of the delay.

The schedule of benefits and SBCs should not include variable language for benefits. DOI requests that carriers include the plan's ID plus variant code on corresponding schedule of benefits and SBCs, to facilitate review. Carriers can file SBCs without a form number printed within the document, but there must be a form number attached to each

SBC within SERFF. The DOI will accept a generic form number (such as SBC2017) to be assigned to each SBC within SERFF.

4. Variable Language in Forms

Policy forms (including SBCs) should not include variable language unless such language is approved by DOI prior to submission. Variable language that the DOI may allow would generally not affect the benefits or cost sharing. The DOI will allow variable language in the following contexts without prior approval:

- Religious exemption for a specific benefit
- Benefits exclusive to eligible tribal members
- Employer choice to offer coverage to spouses, dependents, or domestic partners
- Employer group number
- Employer name
- Internal plan/product identifier

5. Rate Information Considerations

While the URRT, actuarial memorandum, and the rate increase justification should be complete and identical between the Idaho and CMS submissions, DOI supports a carrier providing additional rate development details to DOI through an Idaho-specific addendum to the actuarial memorandum. Being Idaho-specific, the addendum would not need to be submitted to CMS, and therefore limit the potential for federal disclosure of proprietary data.

The written description justifying the rate increase has additional requirements for rate increases effective on or after January 1, 2017. In order to improve transparency and clarity, DOI is providing a template as Appendix B that carriers should utilize when developing their rate increase explanation. The explanation needs to be a consumer-friendly narrative that describes the relevant URRT data, the assumptions used to develop the rate increase, and an explanation of the most significant factors causing the rate increase. DOI will ask carriers to revise any explanations that are missing the information contained in the template.

6. Transparency

Per Idaho Code § 74-107(1) and DOI Bulletin 95-2, DOI generally considers as proprietary or "trade secret" any rating information that is flagged as confidential within a filing. While flagging a document within a filing as confidential does not conclusively resolve the question, it assists DOI in its identification of confidential proprietary information or trade secrets. Consistent with Idaho Code and historical practices, DOI will not treat form filings as confidential.

QHP carriers are required to submit specified information to YHI, CMS and DOI in a timely and accurate manner as required by 45 C.F.R. § 156.220, implementing § 1311(e)(3) of the Affordable Care Act. CMS intends to provide details on the implementation of the transparency in coverage reporting requirements, including what information must be provided and timing of submissions, through future guidance.

Section Two: Health Benefit Plan Requirements

The following requirements apply to all health benefit plans in the individual and small group markets, which include both QHPs and non-QHPs.

1. Fair Health Insurance Premiums

Idaho Code §§ 41-4706 and 41-5206, as well as federal regulation at 45 C.F.R. § 147.102 provide health insurance premium standards that all plans must follow. These standards include the following:

- Rates for a particular plan may vary only by rating area, age (not more than 3:1 for ages above 20), and tobacco use (not more than 1.5:1);
- The uniform age rating curve must be utilized;
- Premiums for coverage of more than one individual must be determined by summing the premiums for each individual covered, with a maximum of three premiums for covered children under age 21;
- Small group composite rating be in accordance with the methodology specified for Idaho on DOI website;
- Rating area factors should only reflect differences in the cost of delivery, not differences in morbidity; and
- Differences in the rates between plans reflect objective differences in plan design and not differences in morbidity or selection.

DOI will review each rate filing against these criteria. In evaluating that the plan adjusted index rate differences reflect only objective differences in plan design, DOI has established specific criteria that should not be exceeded. For the set of plans within the same plan type (Managed Care or PPO) and network, the difference in plan adjusted index rates – considering only the portion attributable to Essential Health Benefits – should not exceed:

- Within the same metal: difference in metal actuarial value (AV) × 110%,
- Silver to Bronze Midpoint rates: difference in metal AV midpoints × 115%,
- Gold to Bronze Midpoint rates: difference in metal AV midpoints × 120%,
- Platinum to Bronze Midpoint rates: difference in metal AV midpoints × 130%.

The test for rate differences between metal levels relies on a “midpoint” rate difference between metals and a metal AV “midpoint”. The midpoint in plan adjusted index rates is calculated for this purpose as the average of the lowest and highest plan adjusted index rates within a metal level. The metal AV “midpoint” is calculated for this purpose as the average of the metal AV for the lowest and highest plan adjusted index rate plans within a metal level.

Carriers should provide an exhibit in the rate filing that demonstrates compliance with these ratios. Appendix C has an example of such a demonstration.

2. Service Area

Consistent with regulations at 45 C.F.R. § 155.1055(a), each service area of a QHP must cover a minimum geographic area that is at least the entire geographic area of a county. The service area of a QHP must be established without regard to racial, ethnic, language,

or health status-related factors as specified under § 2705(a) of the Public Health Service (PHS) Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

DOI will apply the same criteria to the service areas of non-QHPs in the interest of fairness in the marketplace. Carriers that submit new service areas that include partial counties or carriers that wish to modify their current service areas must include justification that explains the need and describes how the service area meets the regulatory standards listed above.

3. Discriminatory Marketing and Benefit Design

The regulation at 45 C.F.R. § 156.200(e) provides that carriers must not, with respect to their QHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. 45 C.F.R. § 156.225(a) requires that in order to have a plan certified as a QHP, a carrier must comply with all applicable state laws on health plan marketing by health insurance carriers. In addition, 45 C.F.R. § 156.225(b) states that a QHP carrier must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. DOI will apply the same criteria to non-QHPs in the interest of fairness in the marketplace.

YHI and DOI recommend that all marketing materials distributed to enrollees or potential enrollees include the following language suggested by CMS:

> [Insert plan's legal or marketing name] does not discriminate on the basis of basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

DOI, with the assistance of YHI, will monitor consumer complaints regarding a carrier's marketing activities and complaints concerning an agent's, broker's, or web-broker's conduct. Determinations of discrimination may result in a QHP decertification and potentially additional enforcement action against the carrier, agent, broker, or web-broker.

Regarding discriminatory benefit designs, 45 C.F.R. § 156.125(a) states that an issuer does not provide Essential Health Benefits (EHB) if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. The Office for Civil Rights, which enforces section 1557 of the ACA, published a notice of proposed rulemaking on September 9, 2015, entitled "Nondiscrimination in Health Programs and Activities" (80 Federal Register 54172). Carriers should review the proposed rule, along with http://www.hhs.gov/ocr/civilrights for additional information.

For purposes of QHP certification, carriers will attest to compliance with the non-discrimination standards. DOI will apply an outlier analysis on benefit cost sharing (similar to the outlier tests explained in the CMS Letter to Issuers). DOI may require changes to certain cost sharing provisions that potentially discourage the enrollment of individuals with significant health needs or specific conditions. DOI will consider an unusually large number of drugs subject to prior authorization and/or step therapy

requirements, as well as unusually high cost sharing requirements in a particular category and class to be potentially discriminatory. Finally, DOI will review the "explanations" and "exclusions" applicable to benefits for discriminatory language.

4. Minimum Participation and Contribution Rates on Small Group Renewals

The guaranteed availability regulation at 45 C.F.R. § 147.104(b)(1) requires that a small employer be allowed to purchase coverage from November 15 through December 15, even if the employer cannot meet the carrier's minimum participation or contribution requirements. Similar to CMS, YHI and DOI conclude it would impose undue burden on employers and their employees for carriers to non-renew coverage under the exception to guaranteed renewability for failure to meet minimum participation or contribution rates and then re-enroll employers under guaranteed availability during this period. Therefore, carriers offering small group plans must not enforce minimum participation or contribution requirements for renewals of policies purchased between November 15 and December 15.

5. Coverage Appeals

QHPs and non-QHPs are required to meet the standards for internal claims and appeals and external review established at 45 § C.F.R. 147.136, which require an effective process for internal claims appeals and external review. DOI will also review all applicable policy forms for compliance with title 41, chapter 59, Idaho Code and IDAPA 18.01.05.

6. Discontinued Plans

Any discontinuation of an individual or small group health benefit plan must be executed in compliance with § 41-4707(1)(g), Idaho Code, for small employer plans, or § 41-5207(1)(e), Idaho Code, for individual plans. Without prior authorization by DOI, a carrier cannot discontinue (1) a product that has been in use for less than thirty-six consecutive months, or (2) more than fifteen percent of the corresponding line of business within a twelve month period.

Upon discontinuing a particular product, carriers must comply with the requirements of Idaho Code cited in the paragraph above as well as 45 C.F.R. §§ 147.106 and 156.270.

Section Three: QHP and QDP Certification Standards

YHI will rely upon DOI to review potential QHPs and QDPs for compliance with the regulatory and other requirements and to recommend QHPs/QDPs to be certified and available for sale through YHI. The standards and processes do not differ between first-time certifications and re-certifications; therefore, in this document we refer to both situations when discussing certification. This section provides the criteria set by YHI in order to meet certain regulatory requirements for QHPs/QDPs pursuant to 45 C.F.R. Parts 155 and 156. DOI will evaluate QHP/QDP applications against these criteria.

1. Licensure and Good Standing

Consistent with 45 C.F.R. § 156.200(b)(4), each carrier offering QHPs/QDPs must be licensed and in good standing in each state in which it applies for the applicable market,

product type, and service area. Carriers must attest that they meet this standard as part of the signed Attestations Document, which carriers will access through SERFF. DOI's Company Activities Bureau maintains the records associated with this requirement. Carriers are therefore not required to submit any supporting documentation of licensure and good standing in Idaho.

2. Network Adequacy

Pursuant to 45 C.F.R. § 156.230(a)(2), carriers offering QHPs or QDPs that have a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

Carriers seeking certification of QHPs/QDPs in Idaho are required to attest that the networks meet this standard. Additionally, carriers must demonstrate that each network associated with QHPs meets or exceeds the Health Plan network adequacy related accreditation standard of the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC) or URAC. Carriers can demonstrate that they meet one of the accreditation standards by providing proof of accreditation or by providing a network access plan showing how the standards are met.

As part of a medical QHP application, carriers must submit detailed network provider data using the EHB/Network Adequacy template. This includes information about the participating physicians, facilities, and pharmacies, including the location and specialty when applicable. As supporting documentation to that data, the carrier must provide a narrative that describes the approach to developing or selecting each network and how the carrier evaluates the availability and accessibility. Additionally, the narrative should distinguish between any narrow and broad networks, provide high-level network composition and provider adequacy criteria, describe monitoring and care coordination efforts, and explain the in-network and out-of-network referral policy. YHI and DOI will review the data and narratives and may request additional information or justification if inadequate.

QDP carriers and any carrier with non-accredited medical QHPs should complete and attach the Network Adequacy Cover Sheet and an accompanying Network Access Plan which demonstrates that each plan meets 45 C.F.R. § 156.230(a)(2), as it applies to QDPs. The following sections of the Cover Sheet apply to QDPs: standards for network composition (excluding references to mental health and substance abuse providers), ongoing monitoring process, plan for addressing needs of special populations, member communication methods, and continuity of care plan (in the event of provider contract termination or corporate insolvency).

The 2017 federal time and distance standard proposed by CMS for measuring network adequacy only applies to Federally facilitated Marketplaces (FFM), and so DOI will not be evaluating carriers against that standard.

3. Essential Community Providers

45 C.F.R. § 156.235 establishes requirements for inclusion of Essential Community Providers (ECPs) in QHP and QDP provider networks and provides an alternate standard

for carriers that provide a majority of covered services through physicians employed by the carrier or a single contracted medical group.

YHI will apply the same criteria regarding the inclusion of ECPs as described in the December 23, 2015 Centers for Medicare & Medicaid Services (CMS) DRAFT 2017 Letter to Issuers in the Federally-facilitated Marketplace (CMS 2017 Letter), chapter 2, section 4. Portions of the criteria are summarized below; however, carriers should reference the CMS 2017 Letter for the full details.

To meet the ECP standard for YHI, a carrier must demonstrate that it:

- Contracts with at least thirty percent (30%) of available ECPs in each plan's service area to participate in the provider network;
- Offers contracts in good faith to all available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, with the terms and conditions referenced in the model QHP Addendum for Indian health providers developed by CMS; and
- Offers contracts in good faith to at least one ECP in each ECP category (includes Federally Qualified Health Centers, Ryan White Providers, Family Planning Providers, Indian Health Providers, Hospitals, and Other ECP Providers) in each county in the service area, where an ECP in that category is available and provides services that are covered by the plan.

If a carrier's network does not satisfy the 30% ECP standard described above, the carrier is required to include as part of its application a satisfactory narrative justification. The justification must describe how the carrier's provider network, as currently designed, provides an adequate level of service for low-income and medically underserved enrollees and how the carrier plans to increase ECP participation in the carrier's provider network in future years, as necessary.

To assist carriers in identifying these providers, CMS published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies. Carriers should use this CMS-developed list to calculate their satisfaction of the 30% ECP standard. Carriers must use the federally designed ECP template to report participating ECPs to DOI.

Carriers may write in ECPs not on the CMS-developed list for consideration as part of the certification review, as long as the issuer arranges that the written-in provider has submitted an ECP petition to CMS by no later than August 22, 2016. Allowable write-ins count toward the satisfaction of the 30% ECP standard and count toward the denominator of available ECPs for the carrier writing in the additional ECPs. Only one ECP, including write-ins, is permitted per address.

QDPs have the same standard, except for the requirement to offer contracts to at least one ECP in each category. If the QDP network does not meet the 30% ECP standard or does not offer contracts in good faith to all Indian health providers in the service area, the carrier must submit a satisfactory narrative justification.

4. Accreditation (not applicable to QDPs)

Requirements at 45 C.F.R. § 155.1045(b) establish the timeline by which QHP carriers offering coverage in a FFM must be accredited. Pursuant to 45 C.F.R. § 156.275 YHI adopted the same phased approach to the accreditation requirement.

Carriers without YHI-certified 2016 QHPs that do not have an existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity (NCQA, AAAHC, or URAC) for Idaho must schedule a review for accreditation from a recognized accrediting entity. The carrier must submit an attestation that they have scheduled a review for accreditation as supporting documentation, which should reference the accrediting entity and the anticipated review date.

Carriers with YHI-certified 2016 QHPs must provide their accreditation information to DOI using the SERFF's company accreditation entries. There is no need to submit the federal accreditation template. Alternatively, a carrier must have Idaho specific commercial or Medicaid health plan accreditation granted by a recognized accrediting entity. The administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHPs.

5. Patient Safety Standards (not applicable to QDPs)

Regulatory requirements at 45 C.F.R. § 156.1110 outline how carriers can demonstrate compliance with the patient safety standards. QHP carriers that contract with a hospital with more than 50 beds are to verify that the hospital, as defined in § 1861(e) of the Social Security Act (SSA), is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:

- A quality assessment and performance improvement program as specified in 42 C.F.R. § 482.21; and
- Discharge planning as specified in 42 C.F.R. § 482.43.

In addition, carriers are required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the application, YHI will require carriers (other than QDP carriers) to demonstrate compliance with these patient safety standards as part of the QHP application with an attestation that they have collected and are maintaining the required documentation from their network hospitals.

There are proposed modifications to this requirement in the 2017 Payment Notice proposed rule. Carriers should review the final rule, and meet the final requirements under 45 C.F.R. § 156.1110.

6. Quality Reporting and Quality Improvement Strategy (n/a to QDPs)

QHP carriers are required to comply with requirements related to quality reporting for QHPs offered on Marketplaces through implementation of the Quality Reporting Standards (QRS) and the QHP Enrollee Survey. QHP carriers will be required to attest that they comply with these requirements as part of certification process for the 2017 plan year.

YHI will publicly display QHP quality rating information during the shopping experience to help consumers compare QHPs. QHP carriers may begin including 2016 QRS and QHP Enrollee Survey results in marketing materials for 2017 plan year coverage.

CMS anticipates issuing technical guidance on an annual basis that will detail requirements for the QRS and QHP Enrollee Survey including the standards related to data collection, validation and submission, as well as the minimum enrollment and other participation criteria.

A Quality Improvement Strategy (QIS) is a requirement for both individual and SHOP carriers. It is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees. QIS must also include:

- Activities for improving health outcomes;
- Activities to prevent hospital readmissions;
- Activities to improve patient safety and reduce medical errors;
- Activities for wellness and health promotion; and
- Activities to reduce health and health care disparities.

Carriers covering more than five hundred (500) enrollees that offered Marketplace coverage during 2014 and 2015 must implement one or more QIS that applies to all of their applicable QHPs; a QIS does not have to address the needs of all enrollees.

Carriers must submit with their QHP application a QIS Implementation Plan that begins no later than January 2017, and then submit a progress report the following year. DOI will review the QIS plan as part of the certification process. The submission should follow the format provided by CMS for the FFM.

7. QHP Agreement

Carriers offering QHPs or QDPs in YHI will be required to sign an agreement with YHI as part of the 2017 plan year certification process. The agreement must be signed prior to the date specified in Appendix A in order to be eligible for certification. The agreement will cover all of the QHPs/QDPs offered by a carrier at the HIOS Issuer ID level, and must be signed by an officer of the carrier who has legal authority to contractually bind the QHP/QDP carrier.

8. Prescription Drug Coverage (not applicable to QDPs)

Regulations at 45 C.F.R. § 156.122 establish that a health plan that provides EHB must cover at least the greater of (1) one drug in every United States Pharmacopeial Convention (USP) category and class or (2) the same number of prescription drugs in each USP category and class as the EHB benchmark plan. The CMS website lists the EHB benchmark prescription drug category and class counts for Idaho.

DOI will use the federal prescription drug template to collect and review compliance with this standard. The drug template allows carriers to demonstrate that a plan's formulary is sufficiently broad to meet the 2017 Idaho benchmark formulary drug count by USP category and class. Carriers are to provide reasonable justification for any deficiencies in drug lists compared to the Idaho benchmark.

For plan years beginning on or after January 1, 2017, there are new requirements for QHPs regarding prescription drug coverage. QHP carriers must verify their pharmacy and therapeutics committee meets the various requirements of 45 C.F.R. § 156.122(a)(3). Pursuant to 45 C.F.R. 156.122(e), carriers must allow enrollees access to prescription drug benefits at in-network retail pharmacies except in the specific cases enumerated in that section.

As part of the QHP application, carriers must provide a URL to their formulary and provide information regarding their formulary to consumers, pursuant to 45 C.F.R. § 147.200(a)(2)(i)(K). YHI expects the URL link to direct consumers to an up-to-date formulary from which they can view the list of covered drugs along with the corresponding tiers and cost sharing applicable to the QHP of interest, as required by 45 C.F.R. 156.122(d)(1). The URL provided to YHI as part of the QHP application should link directly to the formulary, such that consumers do not have to log on, enter a policy number or otherwise navigate the carrier's website before locating it. If a carrier has multiple formularies, it should be clear to consumers which directory applies to the selected QHP. While the drugs covered only under a plan's medical benefit can be used in demonstrating compliance with the Idaho benchmark drug count, carriers are not required to include those drugs on the formulary that is accessible to consumers.

YHI and DOI encourage carriers to closely monitor requests for non-formulary medications and utilize this information, along with market factors, when reviewing medications for formulary coverage, especially regarding new drugs that enter the pharmacy market. Requests during at least the first thirty (30) days of coverage for medications requiring prior authorization or step therapy should be reviewed promptly with the goal to limit disruptions in ongoing treatment for new enrollees. YHI recommends carriers ensure their exceptions and appeals processes for prescription drugs meet the requirements of 45 C.F.R. § 156.122(c) and do not result in treatment delays. YHI will consider stricter guidelines if the needs of enrollees are not being met in a timely manner.

9. Meaningful Difference (not applicable to QDPs)

CMS has recommended at 45 C.F.R. § 156.298 an approach to assess whether all benefit packages proposed to be offered by potential QHP carriers are meaningfully different from another. YHI plans to apply the criteria to identify potential QHPs for additional review, and YHI may consider additional criteria if deemed necessary.

The meaningful difference criteria is applied to each carrier's QHPs matching a subgroup of the same plan type, metal level, child-only plan status, and overlapping service areas. DOI may not recommend certification of a carrier's plan, and YHI may not certify a carrier's plan, if within a subgroup, plans do not differ from each other by at least one of the following criteria:

- Different network;
- Different cost-sharing tier levels;
- $100 or more difference in both individual and family in-network deductibles;
- $200 or more difference in both individual and family in-network annual limit on cost sharing; and
- Difference in covered benefits.

DOI may ask carriers with plans identified as potentially not meaningfully different to modify or withdraw one or more of the identified plans to meet this requirement. Alternatively, DOI will review a carrier's justification to how the identified plans are meaningfully different and add to meaningful consumer choice.

10. Third Party Payment of Premiums and Cost-sharing

Carriers of individual market QHPs/QDPs are required under 45 C.F.R. § 156.1250 to accept third party premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program; Indian tribes, tribal organizations, and urban Indian organizations; and other federal, state, and local government programs. Payments from grantees or sub-grantees of the allowed third party payers must also be accepted. Violations of 45 C.F.R. § 156.1250 may result in the decertification of corresponding QHPs.

11. Cost Sharing Reduction Plan Variation Reviews (not applicable to QDPs)

Regulations at 45 C.F.R. § 156.420 generally require QHP carriers to submit three plan variations for each silver level QHP in the individual market as well as zero and limited cost sharing plan variations for all QHPs in the individual market. YHI expects QHP applications to comply with 45 C.F.R. part 156, subpart E.

12. Oversight of Agents/Brokers (Producers)

YHI and DOI will not allow agents and brokers (licensed as producers) to use "YHI," "Your Health Idaho," "Marketplace," or "Exchange" in the names of their businesses or names of their websites. Agents and brokers should also be careful in representations that might tend to mislead or confuse consumers. As required by 45 C.F.R. § 155.220(c)(3), if a producer assists a qualified individual with QHP selection through the agent, broker, or web-broker's website, a standardized disclaimer must be prominently displayed on each page to indicate that the site is not Your Health Idaho, the Idaho Health Insurance Exchange, and it must also include a link to the YHI website. Failure to comply with the preceding may result in the loss of an agent or broker's Exchange certification and may constitute a violation of Idaho Code §§ 41-1016(1)(h) or 41-1321, resulting in a potential administrative action against the producer that could affect the producer's license.

13. Idaho's Small Employer Health Options Program

Idaho will have a state-based Small Employer Health Options Program (SHOP) in 2017. YHI will provide the details of Idaho's 2017 SHOP.

Regarding the definition of a small employer in the Idaho small group market, the definitions of "eligible employee" and "small employer" found in Idaho Code §§ 41-4703(13) and 41-4703(28) are not categorically preempted by federal regulations. Therefore, there is no change in the size or employee counting method in Idaho's small group market as a whole.

Note that, however, for purposes of SHOP enrollment and the Small Business Tax Credit, group size is determined using the federal full-time equivalent (FTE) method of counting employees. Under the FTE method, sole proprietors and their spouses or other family members are not counted as employees. Therefore, although a small employer consisting

of only a business owner and spouse who is an eligible employee or business partner are eligible to enroll in a small group plan, the group may not be able to enroll through the SHOP or qualify for the Small Business Tax Credit.

14. Meaningful Access

Pursuant to 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, QHP/QDP carriers must ensure meaningful access by limited-English proficient (LEP) speakers and by individuals with disabilities.

The 2016 Payment Notice final rule added obligations regarding oral interpretation and critical document translations to LEP speakers, as well as a new requirement beginning with the start of the 2017 enrollment period for specific taglines on websites, website content, and critical documents. Carriers should review the above referenced regulatory requirements and the details provided in chapter 7, section 3 of the DRAFT CMS 2017 Letter, as the same requirements apply to Idaho QHPs/QDPs.

15. Provider Directory

Pursuant to 45 C.F.R. § 156.230(b), YHI requires QHPs to make their provider directories available for publication online by providing the URL link as part of the QHP Application and by having the directory openly accessible from the carrier's website. The URL that carriers provide to YHI as part of the QHP application should link directly to an up-to-date provider directory corresponding to the selected QHP. Consumers should not have to log on, enter a policy number, or otherwise navigate the carrier's website in order to view the directory. If a carrier has multiple provider directories, it should be clear to consumers which directory applies to the QHP of interest. Further, YHI expects the directory to include location, contact information, specialty, medical group, and any institutional affiliations for each provider, and whether the provider is accepting new patients. YHI encourages carriers to include languages spoken, provider credentials, and whether the provider is an Indian health provider.

Carriers should submit a PDF of their provider directory as supporting documentation with each form filing in SERFF. While carriers are not required to submit updates to the provider directory to DOI during the year, carriers should update the directory available through their website at least monthly to be considered current. In the case of provider directory changes that have a substantial negative impact to consumers, DOI expects carriers to notify DOI of the changes by submitting a new directory and a description of the impact to consumers.

16. QDP Considerations

The annual limitation on cost sharing for the pediatric dental EHB offered by QDPs is not to exceed the limitations expressed in the 2017 Payment Notice final rule. Carriers submitting QDPs to YHI for certification are expected to meet the applicable standards such as demonstrating that the plan meets either the 70% (low) actuarial value or the 85% (high) actuarial value.

Beginning with the 2016 plans, QDPs that are not to be sold through YHI cannot be "exchange-certified." The DOI bulletin 14-02 provides the process in Idaho for carriers to be reasonably assured that individuals and employers are made aware of their option to purchase a QDP that covers the pediatric dental EHB. Individuals and employers are then

able to choose from among QDPs that are sold through YHI and dental plans that are not sold through YHI to find the plan that best meets their needs.

17. Tribal Relations and Support

The Affordable Care Act (ACA) at Subtitle K, section 2901, of Title II includes Protections for American Indian and Alaska Natives (AI/AN), which extends special benefits and protections to AI/AN, including limits on cost sharing and clarifies payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations and urban Indian organizations.

In coordination with the leadership of the five federally recognized tribes in Idaho, YHI developed a tribal consultation policy that outlines YHI's commitment to achieving culturally appropriate interactions between YHI and Indian Tribes and greater access to the services that will be provided by the YHI Insurance Exchange for AI/AN. Among the goals of the policy are to:

- Maximize participation by AI/AN in QHPs offered by YHI
- Assure that AI/AN receive the benefits and protections provided under federal law
- Assure that AI/AN can choose to receive their health care from the Indian Health Services, a tribally-operated program, or an urban Indian program

As noted in the Essential Community Providers section above, YHI strongly encourages QHP carriers to engage with Indian health care providers, through which a significant portion of American Indians access care. When offering contracts in good faith, YHI recommends QHPs include considerations for culturally specific terms. To promote contracting between carriers and Indian health care providers, YHI expects carriers to offer contracts to Indian health care providers and use the CMS Model QHP Addendum.

Per the Cost Sharing Reduction Plan Variation Reviews section above, QHPs in the individual market are required to offer two plan variations specifically for tribal communities: the zero cost sharing and the limited cost sharing plan variations, as defined at 45 CFR § 156.420(b).

The ACA also allows members of federally recognized tribes to purchase and enroll in Exchange individual or SHOP health insurance coverage monthly rather than just during the annual open enrollment period. QHPs must accept and support tribal members in accordance with this special enrollment option.

Regulations at 45 C.F.R. § 155.240(b) provide YHI with flexibility to permit Indian tribes, tribal organizations, and urban Indian organizations to pay QHP premiums—including aggregated payment—on behalf of members who are qualified individuals, subject to terms and conditions determined by YHI. During YHI consultations with tribal governments, tribal leaders indicated the importance of tribes having the ability to pay premiums on behalf of their members. Since YHI does not collect premiums from individuals, YHI has determined it will rely on the carriers to work directly with each of the five federally recognized tribes to enable tribal premium sponsorship, as required at 45 C.F.R § 156.1250.

Appendix A – Timeline

The dates are approximate, subject to change, and occur during 2016.

Carriers to notify DOI of their intent to offer 2017 QHPs	March 4
QHP rates and forms filings due in SERFF, CMS filings due in HIOS; YHI to provide 2017 carrier participation agreement	May 2
QHP binder filings due in SERFF	May 11
Proposed rate increases posted on DOI website	June 13
Carrier plan preview begins; renewal notice development begins	July 1
Signed carrier participation agreement due to YHI	July 29
Final day for carriers to submit corrections and objection responses	July 29
Carrier filings in "final" status in CMS's Unified Rate Review System	August 23
DOI to provide final QHP recommendations to YHI	September 16
QHP certification notices provided	September 19
Anonymous plan browsing available to the public through YHI	October 1
All final rate increases posted on DOI website	November 1
Open enrollment begins	November 1
Open enrollment ends	January 31

Appendix B – Rate Increase Justification Template

[Company Name]

Preliminary Rate Increase Justification for [2017]

[Individual/Small Group] Health Benefit Plans

Rate Change

[In narrative form, provide the percentage rate change overall for the market. Also provide the percentage rate changes for any major groupings, if significantly different from the overall, for example, metal levels or geographic areas. If the percentages here do not match the percentages in the URRT, the differences must be explained.]

Most Significant Factors

The rate change described above is driven by the following factors:

- [Most significant factor description]: [Most significant factor percentage]
- [2nd most significant factor description]: [2nd most significant factor percentage]
- [3rd most significant factor description]: [3rd most significant factor percentage]
- [4th most significant factor description]: [4th most significant factor percentage]
- [etc.]

[Explanation of factors. Any minor factors can be grouped together into an "other" factor, which is then explained here. The sum of the factor percentages should match the overall rate change listed in the first section.]

Financial Experience

[Include a narrative explanation of the 2015 financial experience. This section must show the total paid claims after subtracting CSR reimbursements and total premium including APTC payments. All amounts should be based on best estimates of 2015 incurred, aligning with data used in URRT, or describe how they differ.]

Key Assumptions

The annual cost trends used in developing the 2017 rates:

- Medical: [percentage]
- Drug: [percentage]
- [Other]: [percentage]

[Explanation of trends]

The 2017 rates are made up of the following components:

- Claims: [percentage]
- Administrative costs: [percentage]
- Federal taxes and fees: [percentage]
- State taxes and fees: [percentage]
- Commissions: [percentage]
- Contribution to surplus, profit, and risk margin: [percentage]

[Explanation of percentages, which should add up to 100%.]

Appendix C – Sample Exhibit Testing Plan Adjusted Index Rate Ratios

All Plans Offered in a Given Network

HIOS Plan ID	Plan Type	Metal Level	Metal AV	Plan Name	Plan Adjusted Index Rate	Plan Rank For Testing
12345ID0010001	PPO	Bronze	60.0%	Plan 1 - PPO	$244.00	
12345ID0010002	PPO	Bronze	60.6%	Plan 2 - PPO	$247.00	High Bronze
12345ID0010003	PPO	Bronze	61.5%	Plan 3 - PPO	$228.00	Low Bronze
12345ID0010004	PPO	Silver	68.1%	Plan 4 - PPO	$272.00	
12345ID0010005	PPO	Silver	68.5%	Plan 5 - PPO	$261.00	Low Silver
12345ID0010006	PPO	Silver	71.9%	Plan 6 - PPO	$299.00	High Silver
12345ID0010007	PPO	Gold	81.5%	Plan 7 - PPO	$379.00	Only Gold
12345ID0050051	HMO	Bronze	59.0%	Plan 51 - HMO	$210.00	Low Bronze
12345ID0050052	HMO	Bronze	61.4%	Plan 52 - HMO	$229.00	High Bronze
12345ID0050053	HMO	Silver	68.6%	Plan 53 - HMO	$250.00	Low Silver
12345ID0050054	HMO	Silver	71.0%	Plan 54 - HMO	$283.00	High Silver
12345ID0050055	HMO	Silver	70.5%	Plan 55 - HMO	$278.00	
12345ID0050056	HMO	Gold	79.0%	Plan 56 - HMO	$323.00	Low Gold
12345ID0050057	HMO	Gold	80.5%	Plan 57 - HMO	$361.00	High Gold

Plan Adjusted Index Rate Ratios Compared to Maximum Allowable

PPO	Plan Adjusted Index Rate			Metal Actuarial Value			Rate / AV	Maximum
	High	Low	Ratio	High	Low	Ratio	Ratios	Allowable
Bronze/Bronze	$247.00	$228.00	1.083	60.6%	61.5%	0.985	**1.099**	1.10
Silver/Silver	$299.00	$261.00	1.146	71.9%	68.5%	1.050	**1.091**	1.10
Gold/Gold	$379.00	$379.00	1.000	81.5%	81.5%	1.000	**1.000**	1.10
	Plan Adjusted Index Rate			**Metal Actuarial Value**				
	Higher Metal Midpoint	Bronze Midpoint	Ratio	Higher Metal Midpoint	Bronze Midpoint	Ratio	Rate / AV Ratios	Maximum Allowable
Silver/Bronze	$280.00	$237.50	1.179	70.2%	61.1%	1.150	**1.025**	1.15
Gold/Bronze	$379.00	$237.50	1.596	81.5%	61.1%	1.335	**1.195**	1.20

HMO	Plan Adjusted Index Rate			Metal Actuarial Value			Rate / AV	Maximum
	High	Low	Ratio	High	Low	Ratio	Ratios	Allowable
Bronze/Bronze	$229.00	$210.00	1.090	61.4%	59.0%	1.041	**1.048**	1.10
Silver/Silver	$283.00	$250.00	1.132	71.0%	68.6%	1.035	**1.094**	1.10
Gold/Gold	$361.00	$323.00	1.118	80.5%	79.0%	1.019	**1.097**	1.10
	Plan Adjusted Index Rate			**Metal Actuarial Value**				
	Higher Metal Midpoint	Bronze Midpoint	Ratio	Higher Metal Midpoint	Bronze Midpoint	Ratio	Rate / AV Ratios	Maximum Allowable
Silver/Bronze	$266.50	$219.50	1.214	69.8%	60.2%	1.159	**1.047**	1.15
Gold/Bronze	$342.00	$219.50	1.558	79.8%	60.2%	1.325	**1.176**	1.20