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2020 IDAHO STANDARDS FOR AFFORDABLE CARE ACT COMPLIANT INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS AND QUALIFIED DENTAL PLANS

The Idaho Department of Insurance (DOI) is providing the following guidelines for carriers who wish to sell health benefit plans complying with the Affordable Care Act (ACA) 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) ACA-compliant 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).

Certain requirements addressed in this notice may apply only to plans intended 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, and DOI expects the carriers to be aware of, and to comply with, those additional requirements.

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

Items of Note

Carriers should pay particular attention to the following items, many of which may differ slightly from prior years:

- Various 2019 legislative and rule changes may impact HBPs and QDPs, some of which are discussed within this document.
- Managed care plans (including non-QHPs) must provide acceptable out-of-network coverage, which DOI has defined as no greater than 60% member coinsurance. Going forward, acceptable out-of-network deductibles and out-of-pocket limits are capped at a multiple of the indexed federal in-network cost sharing limitation.
- Although the meaningful difference standard for QHPs was eliminated as mandatory under federal law for 2019 onward, DOI will continue to apply the same standard as prior years.
- QDPs are no longer required to meet the “high” or “low” actuarial value as previously defined. Carriers of QDPs still must provide the actuarial value of each plan as certified by a member of the American Academy of Actuaries and should assign each plan either a “high” or “low” label within the template in order to pass federal template validations.
- Commission schedules must be included in the rate filing and must not vary between special enrollments or open enrollments or any other factor that may indicate health status such as metal level, age, family size, etc.
- Carriers should submit silver rates that account for the anticipated lack of cost sharing reduction payments and must include the non-loaded silver rates as supplementary information.
- The rate increase justification, following the Appendix B template, must be submitted to DOI for each health benefit plan rate filing even if the increase is below the federal threshold.
- The network adequacy template is required for all health benefit plans, while the essential community provider portion of the template only needs to be completed for QHPs.
- The network narrative required for QHPs must explain how each of the carrier’s networks will meet Idaho’s any willing provider laws.
- QHP carriers must make available up-to-date machine-readable data files of the QHP provider directories and prescription drug formularies. The SERFF filing should indicate the publicly accessible location of such datasets.
- Quarterly small group index rate adjustments must be filed no later than 105 days prior to the effective date.

Contents

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 2020 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 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 Centers for Medicare & Medicaid Services (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 dates specified in Appendix A. Consumers will be able to submit comments to DOI through the website.

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 concerning QHPs and QDPs to the YHI Board of Directors based on the finalized information provided by the carriers by the date shown in Appendix A. 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.

After open enrollment, DOI will allow a carrier to adjust its small group quarterly index rates, which affect the rates of all of the carrier's small group plans by a similar percentage, as long as the rate adjustment is filed with the DOI at least 105 days prior to the effective date. The rate adjustment needs to be justified by submitting an updated URRT, actuarial memorandum, and the rate template as part of the rate filing. The carrier should also request the DOI reopen the corresponding binder to replace the binder's rate template once the rate filing is accepted and closed. DOI will not allow rate adjustments to individual health plans during the calendar year.

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 should be grouped into a single filing if all forms fall under the specified "Type of Insurance" (TOI). Carriers currently selling plans can submit changes, other than changes to cost sharing amounts, to the forms as an amendment. Any forms pertaining to new plans must be submitted without amendments.

There must be only 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 files should be accompanied by the same data 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 ID,
- service area,
- ECP/network adequacy (just the network provider portion for non-QHPs),
- rates tables,
- rating business rules,
- plan crosswalk,
- unified rate review (n/a to QDPs), and
- prescription drug (n/a to QDPs).

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

- compliance plan and organizational chart (QHPs/QDPs only),
- federal program attestations (n/a to non-QHPs),
- ID-FF certification form,
- network adequacy plan or narrative (QHPs/QDPs only),
- Idaho-specific attestations (QHPs/QDPs only),

- un-redacted actuarial memorandum,
- written description justifying the rate increase (see Appendix B, n/a to QDPs),
- QDP actuarial value certification (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 SBC2020) 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

The carrier must maintain consistent submissions of the URRT, actuarial memorandum, and the rate increase justification in both the Idaho and CMS filing systems. 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, thereby limiting the potential for federal disclosure of proprietary data.

While CMS requires the rate increase justification only for increases above a threshold, DOI requires carriers to submit the justification for all rate filings. In order to improve transparency and clarity, DOI is providing a template as Appendix B that carriers should utilize when developing their written description justifying any rate increase. 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 change. DOI will ask carriers to revise any explanations that are missing the information contained in the template.

Within the rate filing, carriers must delineate their broker commission schedules for the upcoming calendar year. The schedules must not distinguish between special enrollments or open enrollments or any other factor that could be related to health status such as metal level, age, family size, etc. As commissions are a key component of the rate development, changes to the schedules for individual and small group health benefit plans should largely align with the calendar year rate setting process. Commission schedule changes must be submitted to the DOI for review at least 90 days prior to implementation and may not be accepted without clear justification as to why the change cannot be postponed until the next calendar year.

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, which implements § 1311(e)(3) of the Affordable Care Act.

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 (ACA-compliant plans only offered off-exchange).

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 the 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. To evaluate if 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 and assuming CSR payments – should not exceed:

- Within the same metal: difference in metal actuarial value (AV) × 115%,
- Silver to bronze Midpoint rates: difference in metal AV midpoints × 115%,
- Gold to bronze Midpoint rates: difference in metal AV midpoints × 125%,
- Platinum to bronze Midpoint rates: difference in metal AV midpoints × 140%.

The test for rate differences between metal levels relies on a *rate midpoint* and a *metal AV midpoint*. The *rate midpoint* 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 AVs for the lowest and highest plan adjusted index rate plans within a metal level. Extended bronze plans should be included as additional bronze plans in this testing. Carriers should provide an exhibit in the rate filing that demonstrates compliance with these ratios. Appendix C has an example of such a demonstration.

The actuarial memorandum or addendum to the memorandum should include a comparison table indicating what the carrier's silver rates would be at a given age if cost sharing reduction payments were made, how the offsetting rate load is justified, and what the final silver rates are after accounting for the anticipated lack of the payments. The rates for non-silver plans must not vary between the two scenarios. If at some point prior to open enrollment the cost sharing reduction payments are restored, carriers will be required to submit modified rate templates containing the non-loaded silver rates already communicated within the rate filing.

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 final rule on May 18, 2016, entitled "Nondiscrimination in Health Programs and Activities" (81 Federal Register 31375). Carriers should review the 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.

Under Idaho Code, the allowable network types for health benefit plans are: managed care, preferred provider organization, and indemnity. Carriers should designate managed care plans as "HMO" or "POS" in the federal templates, as the federal templates do not include a "managed care" designation. Idaho law does not recognize "EPO" or "Exclusive Provider Organizations." Therefore, such designation or label, even if only for marketing purposes, will not be accepted.

As discussed with carriers in 2018, managed care plans must provide substantive coverage of out-of-network services (see § 41-3905(3), Idaho Code). Beginning with plan year 2020, DOI will consider health plans with out-of-network member coinsurance that exceeds 60% not to meet that standard. Pursuant to IDAPA 18.01.30.018.01, all major medical plans must not exceed 50% member coinsurance for in-network care, and non-managed care (e.g. PPO) plans must not exceed 50% member coinsurance on covered services received out-of-network.

Out-of-network deductibles and out-of-network out-of-pocket limits must similarly not be excessive. DOI will consider out-of-network deductibles in excess of twice the federal in-network annual limitation to be excessive, and DOI will consider out-of-network out-of-pocket limits in excess of ten times the federal in-network annual limitation to be excessive. The federal maximum annual limitation on cost sharing for 2020 is $8,150 for self-only coverage and $16,300 for other than self-only coverage.

We expect carriers with cost sharing in excess of the thresholds provided above will make any needed modification in their 2020 filings. Since these thresholds were not previously provided to carriers, DOI is amenable to discussions with carriers regarding modifications to out-of-network cost sharing beyond what is more generally described in Section 6 of this document (Discontinued Plans) as allowable cost sharing changes.

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 health benefit plan that has been in use for less than thirty-six consecutive months, or (2) more than fifteen percent of a line of business within a twelve-month period.

When applying the federal discontinuation criteria at 45 C.F.R § 147.106, the federal definitions at 45 C.F.R § 144.103 of *plan* and *product* apply. As explained in those definitions, a *plan* consists of a certain package of health insurance benefits with a particular cost sharing structure, provider network, and service area; and a *product* comprises all a carrier's plans with the same package of health insurance benefits and with a particular network type (such as preferred provider organization), within the product's service area (defined as the combined service area of all plans constituting that product).

A carrier may make certain changes to a product without being considered a new product. The changes must meet the criteria of a uniform modification of coverage, as provided at 45 C.F.R. §§ 146.152(f), 147.106(e), 148.122(g). The carrier requesting a uniform modification must demonstrate to DOI that:

- The product is offered by the same health insurance issuer;
- The product is offered as the same product network type;
- The product continues to cover at least a majority of the same service area;
- Within the product, each plan must have the same cost sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier; and
- The product provides the same covered benefits, except for changes that cumulatively impact any plan-adjusted index rate within the allowable variation of 2 percentage points.

In order to assist DOI with the evaluation of changes to a plan's cost sharing structure, each carrier making cost sharing changes to a plan must submit with the binder an exhibit showing how each cost sharing change (for both in-network and out-of-network) meets at least one of the two permitted conditions: "solely related to changes in cost and utilization of medical care" or "to maintain the same metal tier." Cost sharing changes beyond those two conditions will need DOI approval to be considered the same plan or product.

Upon discontinuing a particular health benefit plan, carriers must comply with the requirements of Idaho Code and federal rule cited above as well as 45 C.F.R. § 156.270.

7. Relevant 2019 Legislative Actions

During 2018, DOI discussed various proposed rules with carriers. Those rule changes are now final and effective for individual and small employer HBPs and QDPs. In particular, carriers should review IDAPA 18.01.30 and 18.01.70 regarding the hearing aid exclusion. The changes to the rules did not broadly eliminate the permissible exclusion for hearing aids; instead, the changes added a clarification as to when the exclusion must not apply.

Additionally, carriers should track all legislation that may impact the plans subject to this guidance. For example, SB 1204aa modified the expanded Medicaid within Idaho, pending the Departments of Health and Welfare and Insurance working toward approval of a federal waiver to permit consumer choice to stay on YHI with APTC. HB 275 defines a short-term type of health benefit plan with limited renewability that will likely be available in the individual market by 2020. SB 1069 revised the contractual reimbursement applicability on dental plans. SB 1097 requires certain coverage for persons enrolled in approved clinical trials.

Carriers should assess their filed policy language against these and any other federal or state law and rule changes. Any rate impact should be clearly identified and justified within the rate filing. DOI may facilitate meetings during the year regarding these topics as they more fully develop.

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 can 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 /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 of care. 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. The narrative must explain how the carrier meets Idaho's any willing provider laws (see Idaho Code §§ 41-2872 and 41-3927) for each network, including who decides the terms and conditions of participation and who providers should contact to obtain the requirements to participate. 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).

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 16, 2016 Centers for Medicare & Medicaid Services (CMS) 2018 Letter to Issuers in the Federally-facilitated Marketplace (CMS 2018 Letter), chapter 2, section 4. Portions of the criteria are summarized below; however, carriers should reference the CMS 2018 Letter for the full details.

DOI will continue to require a minimum thirty percent (30%) participation standard, as has been the requirement for the past several years.

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

- Contracts with at least (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 not write in ECPs not on the CMS-developed list for consideration. Only one ECP is permitted per physical 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 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 QHPs must provide their accreditation information to DOI using the SERFF's company accreditation entries. 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.

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.

Once it is required by CMS, YHI will publicly display QHP quality rating information during the shopping experience to help consumers compare QHPs. QHP carriers may include QRS and QHP Enrollee Survey results in marketing materials.

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 Small Employer Health Options Program (SHOP) carriers. A QIS is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees. A 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 meeting the applicable minimum enrollment threshold as defined by CMS must implement one or more QIS that applies to all of their QHPs; a QIS does not have to address the needs of all enrollees.

Carriers must submit with their QHP application a QIS Implementation Plan and a progress report form. 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 /QDPs in YHI will be required to sign an agreement with YHI as part of the plan year certification process. The agreement must be signed prior to the date specified in Appendix A to be eligible for certification. The agreement will cover all of the QHPs/QDPs offered by a carrier at the Health Insurance Oversight System (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 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.

QHP carriers must also 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 to access 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.

QHP carriers must make available machine-readable files containing the formularies in the same manner prescribed by the federal marketplace.

9. Meaningful Difference (not applicable to QDPs)

Although meaningful difference standards for QHPs were eliminated as mandatory under federal law, YHI will continue to apply the same standard as prior years.

The meaningful difference criteria is applied to each carrier's QHPs matching a subgroup of the same plan type, metal level, 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;
- $250 or more difference in both individual and family in-network deductibles;
- $500 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.

The final HHS Notice of Benefit and Payment Parameters for 2020 allows for the exclusion of drug manufacturer coupons from the annual limitation on cost sharing when a generic drug is available, if consistent with state practice. Idaho carriers were provided similar guidance in DOI Bulletin 16-04, which is still in effect. That bulletin, among other things, requires carriers to apply payments from third parties that are meet certain criteria, including not being “financially interested,” toward deductibles and out-of-pocket maximums as if the insured made the payment directly. Payments from other third party payers, including drug manufacturers, need not apply toward an enrollee’s deductible or out-of-pocket maximum, regardless of the availability of a generic drug equivalent. Such application continues to be consistent with the intent of deductibles and out-of-pocket maximums to equitably require and reflect only amounts truly paid by an enrollee or a non-financially interested party on behalf of the enrollee.

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 continue the state-based SHOP through YHI. YHI will provide carriers with the details needed to allow small employers access to the federal tax credit through Idaho’s 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 CMS 2018 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.

QHP carriers must make available machine-readable files containing the provider directories in the same manner prescribed by the federal marketplace.

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 2020 Payment Notice final rule: $350.00 for one child and $700.00 for two or more children. Carriers submitting QDPs to YHI for certification are expected to meet the applicable standards. As federal regulations no longer mandate QDPs to meet specific actuarial values, DOI will no longer require carriers offering these plans to demonstrate that a plan meets either the 70% (low) actuarial value or the 85% (high) actuarial value. Carriers of QDPs still must submit the actuarial value of each plan as certified by a member of the American Academy of Actuaries.

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 2019.

Carriers to notify DOI of their intent to offer 2020 QHPs	March 20
QHP forms filings due in SERFF	May 22
QHP rates and binder filings due in SERFF and HIOS; YHI to provide 2020 carrier participation agreement	June 3
Carrier plan preview begins	July 3
Final day for carriers to submit corrections and objection responses	July 26
Proposed rate increases posted on DOI website	August 1
Signed carrier participation agreement due to YHI	August 2
Carrier filings in "final" status in CMS's Unified Rate Review System	August 21
DOI to provide final QHP recommendations to YHI	September 19
QHP certification notices provided	September 25
Anonymous plan browsing publicly available	October 1
All final rate increases posted on DOI website	October 1
Open enrollment begins	November 1
Open enrollment ends	December 15

Appendix B – Rate Increase Justification Template

[Company Name]
Preliminary Rate Increase Justification for 2020
[Individual/Small Group] Health Benefit Plans

Rate Change

[In narrative form, provide the percentage rate change overall for the market and the number of individuals impacted. Also provide the percentage rate changes for any major groupings that differ from the overall, for example, by metal level, network, or geographic area. 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 2018 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 2018 incurred, aligning with data used in URRT, or describe how they differ.]

Key Assumptions

The annual cost trends used in developing the 2020 rates:

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

[Explanation of trends]

The 2020 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**	1.15
Silver/Silver	$299.00	$261.00	1.146	71.9%	68.5%	1.050	**1.091**	1.15
Gold/Gold	$379.00	$379.00	1.000	81.5%	81.5%	1.000	**1.000**	1.15
	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**	1.25

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**	1.15
Silver/Silver	$283.00	$250.00	1.132	71.0%	68.6%	1.035	**1.094**	1.15
Gold/Gold	$361.00	$323.00	1.118	80.5%	79.0%	1.019	**1.097**	1.15
	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**	1.25