NCDOI – Life & Health Division

Q&A on Implementation of the Federal Transitional Policy in North Carolina
December 4, 2013

1. **Benefit Plans. Do benefit plans need to be updated for ACA-compliant features such as:**

   a) **Actuarial Values satisfying metal level requirements.**
   b) **OOP maximum of no more than $6350, and all medical copays must count against it. We are assuming that Rx cost sharing can still not count toward the OOP max, or can count towards a separate OOP max, if that is how it worked in 2013.**
   c) **Maximum allowable deductible of $2000.**
   d) **All EHBs are covered (e.g., pediatric dental).**
   e) **All inside benefit limits are removed, other than those consistent with the EHB benchmarks plan.**

   NCDOI Response: Per the guidance issued by CMS/CCIIO on Thursday, November 14, CMS/CCIIO will not enforce the standards of Section 2707 of the Public Health Service Act which includes the standards of EHB (other than the 10 broad categories found in Section 1302(b) of the ACA.) This includes all provisions which are found in the EHB final regulations including the topics outlined in the subsections of this question. For health benefit plans operating under the federal transitional policy, state regulatory issues will be handled in accordance with the federal transitional policy and in a manner which permits insurers to accomplish the goal of allowing policyholders to reenroll in their 2013 policy.

2. **Manual Rates. What manual premium rates will we use? Do we need to file new rates? Suggestions for rate filings are discussed below under "Suggestions for How it Could Work".**

   NCDOI Response: Per the guidance issued by CMS/CCIIO on Thursday, November 14, CMS/CCIIO will not enforce the standards of Section 2701 of the Public Health Service Act which includes standards relating to fair health insurance premiums. Additionally, CMS/CCIIO has indicated to state regulators that transitional policies are not required to be included in the single risk pool, and therefore the URRT will not apply to them.

   Under NC law, an insurer may only use approved rates in the individual and small group markets, and therefore must obtain approval of rates for the transitional policy period if the insurer does not have an approved rate for the period.

3. **Rating & Underwriting Rules. What rating and underwriting rules will apply?**
   a) **Can we continue to apply underwriting loads of up to +/- 25% around the manual rates?**
   b) **Must we use the State's new small group geographic rating regions? If yes, what if our current area factors vary within those regions?**
   c) **Must we use the State's new small group age rating factors, and rate all groups using exact member censuses rather than employee censuses?**
   d) **Can pre-existing conditions still be excluded for a period of time, consistent with the rules in effect in 2013?**
   e) **Can we continue to cover groups with 1 employee as small groups?**

NCDOI Response: Per the guidance issued by CMS/CCIIO on Thursday, November 14, CMS/CCIIO will not enforce the standards of Section 2701 of the Public Health Service Act which includes the standards relating to fair health insurance premiums. This would include federal provisions relating to a single risk pool, geographic area, etc. Additionally, NCDOI expects that premium rates for reenrolled plans should comply with all applicable Chapter 58 statutes or regulations. For small groups, NCDOI expects that premium rates for transitional policies will comply with NCGS 58-50-131 and all of the applicable subsections of NCGS 58-50-130 as those subsections existed before the enactment of HB 649.

With regard to d), pursuant to the Department's response in 1), Section 2704 of the Public Health Service Act which prohibits pre-existing condition exclusions in health insurance coverage, for both children up to age 19 **and adults**, will apply to transitional small group policies effective for plan or policy years beginning on or after 1/1/14.

With regard to e), the current definition of small employer found in NCGS 58-50-110(22) includes a self-employed individual as part of that definition. Therefore, in order to be consistent with the Department's stated objective of handling state regulatory issues in a manner which permits insurers to accomplish the goal of allowing policyholders to reenroll in their policy, self-employed individuals with small employer group health plans which are subject to the federal Transitional Policy should also be afforded the opportunity to reenroll in their small employer group health plan to the degree that an insurer chooses to provide the transitional relief in the small group market.

Of course, new sales of comprehensive health insurance coverage with effective dates of January 1, 2014 or later must comply with all applicable provisions of the 2014 market reforms.

4. **Filings. What needs to be filed and approved?**
   a) **All forms?**
   b) **Premium rates?**
   c) **Other documentation, benefits templates, premium rate development documentation, etc?**
   d) **What needs to be filed with the federal government, versus with NCDOI?**

NCDOI Response: As indicated in the Department's Advisory Memorandum of November 15, 2013, all filings to accommodate reenrollment in existing health insurance plans subject to the federal Transitional Policy must provide all of the traditionally required supplemental or supporting documentation normally required for a regulatory submission to the Life & Health Division. Additionally, All Chapter 58 statutes will continue to apply, including prior approval requirements, but for health benefit plans operating under the federal transitional policy, state regulatory issues will be handled in accordance with the federal transitional policy and in a manner which permits insurers to accomplish the goal of allowing policyholders to reenroll in their policy. In the interim, NCDOI will process rate change requests under the expedited review process and will work with insurers as necessary to assure compliance with federal reporting once it is clear from CMS/CCIIO guidance that reporting is necessary.

Additionally, CMS/CCIIO has indicated to state regulators that transitional policies are not required to be included in the single risk pool, and therefore the URRT will not apply to them. CMS/CCIIO is continuing to research the issue of rate increases subject to reporting (10% or greater) and how that requirement relates to transitional policies. NCDOI will convey to insurers any information we receive relating to the reporting issue.

5. **The 3 Rs. Will the "extended plans" participate in the federal risk adjustment and risk corridors programs? Small group will not participate in payouts from the federal reinsurance program for individual insurance.**

NCDOI Response: These issues were not addressed in the federal guidance that has been issued in writing to date, except that the CMS/CCIIO guidance indicated:

"Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance."

 # 5 (continued)

Additionally, CMS/CCIIO has verbally provided the following to state regulators in regulatory only calls (the following was prepared by the NAIC):

Reinsurance Program - Transitional plans must pay into the reinsurance program, but may not receive payments.

Risk Corridor - CMS/CCIIO is exploring ways to adjust the risk corridor formula to ameliorate the impact of this federal Transitional Policy. CMS/CCIO expects to issue more guidance in the future.

Non-QHPs may not participate in the risk corridor program, therefore any adjustment to the Risk Corridor program will only impact QHPs (inside and outside the Exchange).

Payments in the risk corridor program are not limited by appropriations or budget neutrality. Payments must be made under the statutes.

Risk Adjustment - Transitional plans do not participate in the risk adjustment program

Reinsurance and Risk Corridor – These temporary programs will end on the date stated in the statute, and CMS/CCIIO has no authority to extend that time period.

6. Can carriers keep all 2013 benefit plans "as is" in 2014, with no benefit changes.

NCDOI Response: CMS/CCIIO has indicated to states regulators that the following sections of the Public Health Service Act will be enforced on transitional policies. NCDOI expects that insurers will make the necessary changes to insurance policy forms and/or rates to accommodate these provisions. Additionally, 2013 plans that are not part of the transitional policy cohort will be subject to ALL of the 2014 market reforms upon the plans' anniversaries in 2014.

Section 2711 – No lifetime or annual limits – can no longer use the $2M annual limit on essential health benefits (i.e., the 10 broad categories described in Section 1302(b)(1)) of the ACA) that had been permitted under a previous CMS/CCIIO policy permitting the continued use of annual limits until plan or policy years beginning on or after 1/1/14.

Section 2726 – Parity in mental health and substance use disorder benefits - compliance with the Mental Health Parity and Addiction Equity Act (applicable to grandfathered and non-grandfathered individual and large group health insurance coverage with plan or policy years beginning on or after 7/1/14 if the plan provides any mental health or substance abuse benefits in addition to medical or surgical benefits.)

 # 6 (continued)

Section 2708 – Prohibition on excessive waiting periods – cannot exceed 90 days (applicable to group health insurance coverage and effective on plan or policy years beginning on or after 1/1/14).

Section 2704 – Prohibition of preexisting condition exclusions – cannot apply the exclusion to adults (applicable to group health insurance coverage and effective on plan or policy years beginning on or after 1/1/14).

7. **Require no changes in rating and underwriting rules. Carriers can continue to rate +/- 25% around the manual rate, consistent with the 2013 rules. Carriers can continue to use their 2013 geographic area rating factors and age/sex/tier factors.**

   NCDOI Response: This would be consistent with how NCDOI views the issue of reenrollment and with the response to question #3 above. However, insurers are still required to receive NCDOI's prior approval of rates for use with these transitional policies to the degree that the insurer does not have an approval from NCDOI extending through the end date of the transitional policy. If an insurer has the necessary approvals, NCDOI would still request the insurer inform the Department of its decision to permit the reenrollment in the existing health benefit plans that were facing cancellation.

8. **Keep the extended plans out of the statewide risk adjustment program. Allowing them to participate would be very complicated.**

   NCDOI Response: This issue is beyond NCDOI's control as it is purely a mechanism of the federal government, but refer to 5) above for some related information.

9. **Allow carriers to update their premium rates from 2013 to 2014 using one of the following approaches, at the carrier's discretion:**
   a) **Notify DOI that they will simply trend up their premium rates using previously filed trend rates that have been used for quotes effective in months after January 2013. No other filing documents required.**
   b) **Submit updated trend factors to DOI, and apply those to the most recently filed 2013 premium rates. No other filing documents required. Trend factors could be developed to capture normal trend, changes in administrative expenses (e.g., new ACA taxes and fees), and any other expected cost increases, which could all be itemized in the notification to DOI in a simplified format that facilitates easy review for reasonableness.**
   c) **Submit a full premium rate filing to DOI, using a format, approach, and documentation consistent with 2013 premium rate filings.**

 # 9 (continued)

NCDOI Response: The Department intends to use the third option and for all insurers that elect to follow the President's transitional guidance/request – subject to the submission of the usual data and supporting exhibits - NCDOI's expedited review of rate filings is described below. If the Department is satisfied on these points, approval of the rate filing can be issued. The federal MLR requirements and potential for refund will be the ultimate standard for companies to meet at year end.

The Department's expedited review process:

- Highest priority given to these rate filings
- Actuary will check the work of the company to ensure no errors are found and there are no obvious inflation of rates or factors
- Very limited time frame – Actuary will scrutinize assumptions but within a limited timeframe… insufficient time to request more detailed data, dig deeper into details or further detail on reasons for patterns in the data
- Actuary will perform analysis of medical loss ratios and trend using state analysis (pre-ACA) similar to Grandfathered rate filings
- Will generally rely on the 80% Federal rebate calculation to catch any "overpricing" on the back end, i.e. assume the 20% or less is not unreasonable for administrative costs and margin and will not require any explicit reductions to margins or subsidization from surplus

10. May an insurer extend the renewal option to all of its current members, including those who have recently purchased coverage that went into effect after 10/1/13? Will this be permitted by the Department?

NCDOI Response: Pursuant to the CMS/CCIIO Letter to Commissioners, the Federal Transitional Policy applies only to individuals and small groups with coverage that was in effect on October 1, 2013 and that is set to renew between January 1, 2014 and October 1, 2014. Plans that went in effect after 10/1/13 would not appear to meet these requirements, and therefore are not eligible for the transitional relief.

11. What is the definition of a market? Is it possible for an issuer to have subdivisions within the under 65-market itself?

NCDOI Response: In order to assure that all policyholders are offered the same opportunities and choices, the Department will interpret "market" to mean all health benefit plans issued in the individual health insurance market or the small employer group health insurance market as those terms are defined in NCGS 58-68-25(a)(9) and (a)(17).

12. **Is it feasible for an insurer to provide transitional policy relief in the small group market on a delayed implementation date because of an inability given the short time frames to implement on January 1, 2014?**

    NCDOI Response: Please refer to the additional guidance issued on December 4, 2013 by NCDOI relating to the small group market.

13. **Would the Department allow an insurer to provide the transitional relief option to only those plans that are over $2,000 deductible or sub-bronze to give small group customers most greatly impacted by the ACA market reforms, financial relief?**

    NCDOI Response: Please refer to 11) above and note that an insurer who chooses to offer transitional relief must offer the reenrollment opportunity on a market-wide basis to all existing policyholders whose policies are in the Transitional Policy cohort.

14. **With regard to the pending changes from HB649, what will be the definition of small employer applicable to plans under the transitional policy?**

    NCDOI Response: Since the advisory memo addresses plans open for reenrollment that were issued under the definition of small employer that was in effect prior to the enactment of HB 649, plans under the transitional policy should comply with the definition of small employer that is found in NCGS 58-50-110(22) as it existed before the enactment of HB 649. Note that this means that self-employed individuals who have small employer health plans that are within the transitional policy cohort shall be provided the same option to reenroll as other small employer groups.

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