Filing for Plan Year 2025

Rates, Forms, and Provider Networks

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

WELCOME TO PY25, THE 12TH PLAN YEAR!

Housekeeping:

- This PowerPoint Deck will be posted on the OIC website after the presentation.
- A link will be sent out via a GovDelivery email
- Ask questions using the Q&A link on the Zoom task bar.
    - We will post Questions and Answers as the webinar progresses.
- If we don't answer your question, email it to Rfhealthplan@oic.wa.gov

Overview

Ned Gaines, Deputy Commissioner

AGENDA

- Overview
- Forms
- Provider Networks
- Rates
- SERFF Binders
- Recap

IMPORTANT DATES

- **May 16, 2024** – Filing deadline
- **June 28, 2024** – PY25 Service Area Changes deadline
- **September 5, 2024** – On Exchange Individual Market approval due date
- ~~**Sept 13, 2024**~~ – WAHBE Board meeting to certify QHPs and QDPs **Correction: Board meeting is September 12, 2024**
- **Oct 15, 2024** – CMS's approval deadline for all off-Exchange individual and small group health plans.

SIGN UP TO RECEIVE GOVDELIVERY EMAILS

How to sign up for GovDelivery emails

- Subscribe to OIC news through our GovDelivery system by entering your email address at the following location https://public.govdelivery.com/accounts/WAOIC/subscriber/new

- Under industry information choose topic “Health care filing information” to receive updates on webinars, changes related to our filing instructions, and general news related to PY25

And sign up for any other topics you want to receive information on, such as rulemaking.

THE DIFFERENCE BETWEEN GFIs AND STMs

General Filing Instructions (GFIs) are required.

- Compliance with GFIs is required to get your filing through the door in SERFF
- Following GFIs does not mean your filing will be approved

Speed To Market (STMs) tools, processes, documents are optional.

- STMs are not required to get your filings accepted in SERFF for review
- Using STMs helps get your filing to approval faster
- We will prioritize filings with completed STMs

Website link to Filing Instructions and Speed to Market (STM) Tools:
https://www.insurance.wa.gov/health-care-and-disability-filings

NO MPMS FOR WASHINGTON STATE

CMS/CCIIO has created a new HIOS Marketplace Plan Management System (MPMS) Module for states that use the federal platform.

This does not impact Washington state because we have a State-Based Exchange (Marketplace) that does not use the federal platform.

Forms

Heather Shimoji, Health Forms Compliance Manager

DEFINITIONS OF PRODUCT AND PLAN

Product:

- Discrete package of health coverage benefits that uses a particular provider network type (HMO, PPO, EPO, POS or indemnity) within a service area

- Differences in the scope of benefits = different products
  - i.e., limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the amount, scope or duration of treatment
- Differences in "cost-sharing structure" ≠ different products
  - i.e., deductibles, coinsurance, copayments, or similar charges
- A product can be modified in some ways yet remain the same product.
  - "Uniform Modification": 45 CFR §146.152(f), 45 CFR §147.106(e), or 45 CFR §148.122(g).

DEFINITIONS OF PRODUCT AND PLAN (cont'd)

Plan:

- Pairing of health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area
- All service areas of the plans offered within a product constitutes the service area of the product

- Product and plan defined in 45 CFR § 144.103

PRODUCT, PLAN, AND FORMULARY

- As part of Federal requirements, a "discrete set of health coverage benefits" includes the formulary.
- In PY 2025, OIC will continue to enforce the federal requirement that all plans within a product share the same drug formulary.
- OIC formally asked CMS what are allowable formulary changes within one product for purposes of maintaining that product status
    - According to CMS, a product formulary must have same list of drugs and same drugs in each cost-sharing tier, though cost-sharing may differ between plans
- "Formulary ID" as used in the CMS QHP templates does **not** automatically indicate a different drug formulary for the purpose of defining separate products.
    - For plans within the same product, plans may have different formulary IDs if differences are only due to variations in cost-sharing.

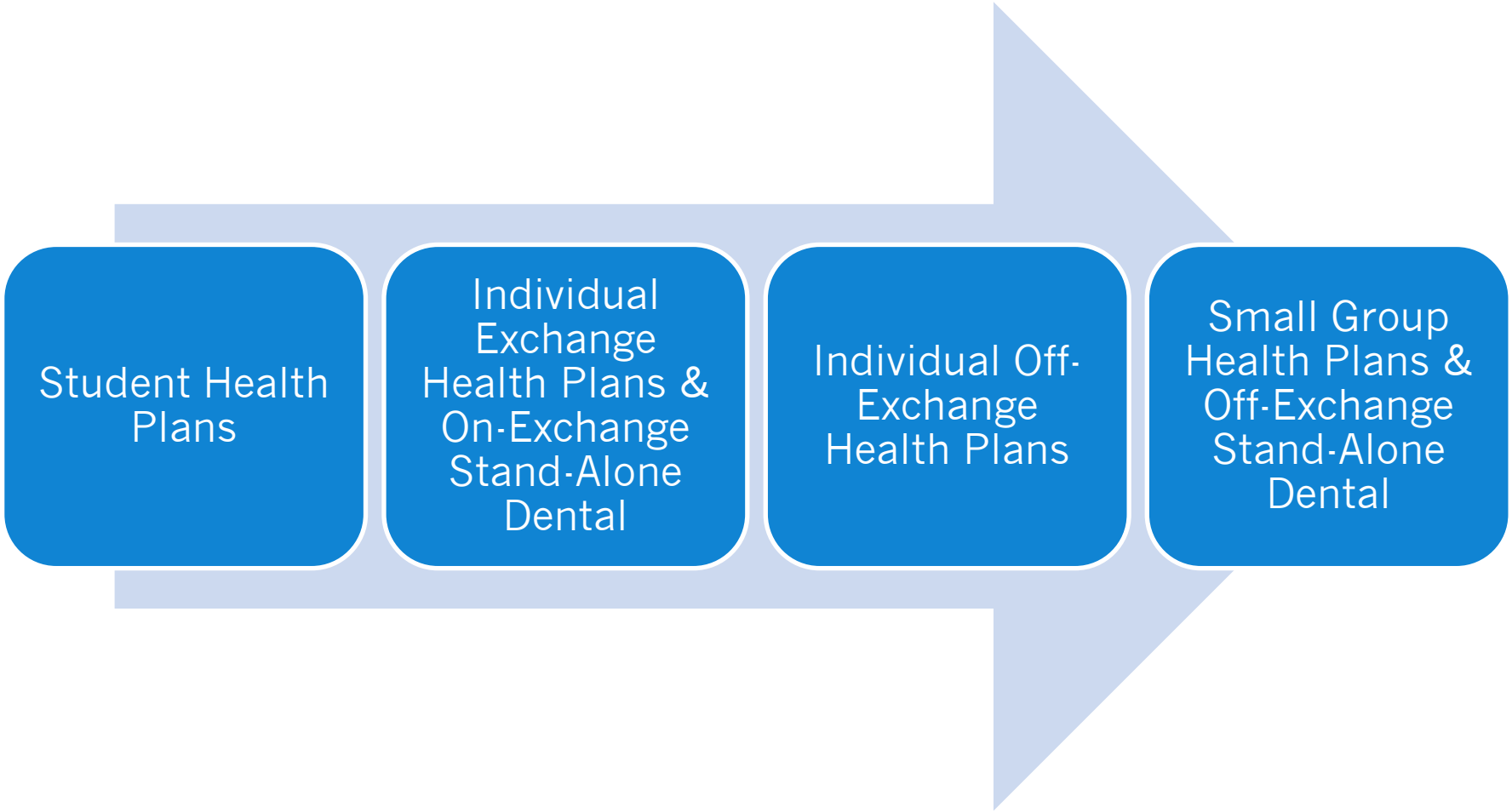
PRODUCT, PLAN AND FORMULARY (cont'd)

- If an issuer makes changes to its drug formulary upon renewal or mid-plan year, these changes must comply with the Uniform Product Modification Justification (UPMJ) criteria under 45 CFR §147.106(e)(3), including the allowable plan-adjusted rate index variation of +/- 2%.
    - For existing products, changes in the covered drug list may be considered a product discontinuation.
    - We will not expect a new UPMJ submission with a mid-year formulary change

"PRIMARY PRODUCT"

- ✓ Product with the most complex or "richest" benefit design in each market
- ✓ Designated in the analyst checklist and binder snapshot document
- ✓ If your individual market products include both standardized (Cascade or Cascade Select) and non-standardized plans, please designate your *most complex non-standardized plan* as primary

PRIORITY OF FORMS REVIEW BY MARKET



PRELIMINARY FORMS REVIEW

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

Preliminary Review of ALL Filings:

- ✓ Are "products" and "plans" correctly sorted and identified?
- ✓ Are HIOS IDs correct?
- ✓ Have you filed the same number of products and plans in your form, rate, and binder filings?

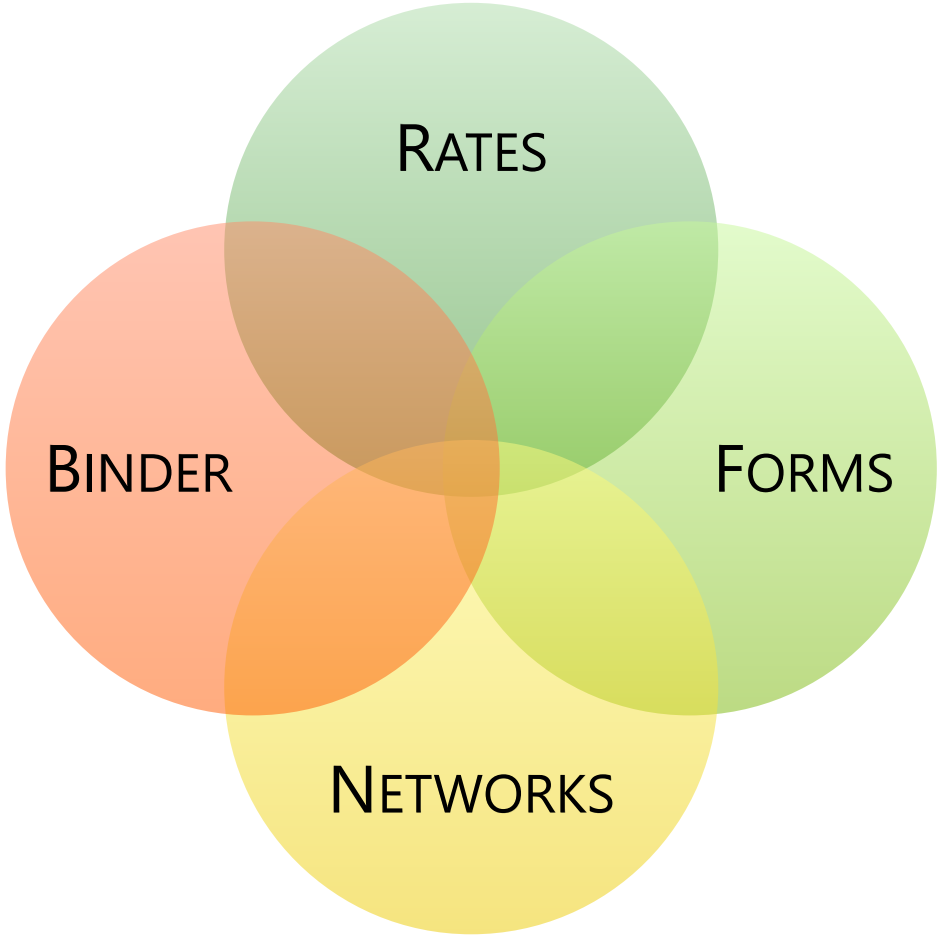
PRELIMINARY FORMS REVIEW (cont'd)

- ✓ Have you filed at least one renewal product?
- ✓ Have you submitted redline versions of all "revised" forms under the Supporting Documentation tab?
- ✓ Do Cascade Care plan names meet WAHBE naming conventions?
- ✓ Have you submitted electronic review tool results with your binder filing?

SUBSTANTIVE REVIEW

- ✓ Begins when preliminary objections are resolved
- ✓ Uses applicable analyst checklist
- ✓ Analyst may “group” filings for review based on similarity across products
- ✓ "Primary product" reviewed beginning to end

MATCHING INFORMATION ACROSS FILINGS



COMMON FORM "MATCHING" OBJECTIONS

Cost-share amounts

- ✓ Forms: Schedule of Benefits/Summary of Costs
- ✓ Binder: Plan & Benefits Template
- ✓ Binder: Prescription Drug Template

Network names

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

Service Area - Counties

- ✓ Forms content
- ✓ Binder: Service Area Template counties

TIMELINES FOR RESPONSE TO FORM OBJECTIONS

	Preliminary & Substantive Objection Letters		
	1st	2nd	Subsequent
# of Business Days	5	3	2

- All timelines subject to OIC and/or WAHBE deadlines for plan approval and certification
- You may request an extension of the "respond by" date
  - Reasonable requests will be granted
- Reminder: All communications that relate to the OIC's review of a specific filing **must** occur in SERFF

"PRIMARY PRODUCT" OBJECTIONS

- ✓ All first-round substantive objections are made within primary product filing
- ✓ Objections to secondary product filings will be based on differences/variation from primary

AMENDING FORMS ("FLIPPING" PROCESS)

- ✓ When all objections are resolved within primary product filing, you will be asked to amend all other product filings in accordance with these changes
- ✓ 5-day turnaround time, subject to OIC and WAHBE deadlines
- ✓ Required certification of changes

WHAT'S NEW FOR PY2025?

Health Plan Maximum Out of Pocket*:

- $9,200 for self only coverage
- $18,400 for other than self only coverage

Pediatric Dental Annual Limit on Cost Sharing:**

- $425 for one child
- $850 for multiple children

* Source: 2025 PAPI Guidance

** Source: 2025 Draft Letter to Issuers in the Federally-Facilitated Exchanges

WHAT'S NEW FOR PY2025? (cont'd)

SSB 5986

- Protecting consumers from out-of-network health care services (ground ambulance).

ESSB 6127

- Increasing access to human immunodeficiency virus postexposure prophylaxis drugs or therapies.

2SSB 6228

- Concerning treatment of substance use disorders.

ESHB 1957

- Preserving coverage of preventive services without cost sharing.

WHAT'S NEW FOR PY2025?

SHB 1979

- Reducing the cost of inhalers and epinephrine autoinjectors.

E2SSB 5213

- Concerning health care benefit managers (Sections 5 and 7 through 9 take effect 1/1/2026).

SB 5821

- Establishing a uniform standard for creating an established relationship for the purpose of coverage of audio-only telemedicine services.

ADDITIONAL RESOURCES

Women's Preventive Services Guidelines (HRSA)

- https://www.hrsa.gov/womens-guidelines/index.html

U.S. Preventive Services Task Force A & B Recommendations

- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations?SORT=D&DESC=1

TIPS FOR SUCCESS: HELP US HELP YOU!

- ✓ REVIEW YOUR FILINGS FOR CONSISTENCY AND MATCHING INFORMATION
  - ✓ Highly recommend submitting STM checklist with form filing
- ✓ BE PROACTIVE
- ✓ COMMUNICATE WITH YOUR ANALYST
  - ✓ All communications that relate to the OIC's review of a specific filing **must** occur in SERFF

Provider Networks

Jennifer Kreitler, Provider Network Oversight Program Manager

DOES YOUR NETWORK MATCH?

PNOP will review the following:

- Network name(s) listed in approved provider contracts
- Registered network maintenance information:
  - Name,
  - Type of network (single or tiered),
  - Market (outside, Exchange or both)
  - Line of Business
  - ***New PY2025*** *– HCBM licensure and subnetwork names*
- Service Area template
- ECP and Network Adequacy Template
- Network ID Template
- **GeoNetwork Report – *NAR Portal opening 4/25/2024***
- **Access Plan – *NAR Portal opening 4/25/2024***
- Provider Network Form A report

NETWORK ID TEMPLATE

- Health carriers must create separate network IDs for your Individual Market networks and Small Group Market networks.
- Washington State is a SERFF filing state.
    - Health carriers must use the same Network Template across all binders or ensure that no network IDs repeat across binders

CMS and State Marketplace Changes

- Washington state **will not** be imposing quantitative time and distance standards.
  - Do not file justification documents.
- Washington state **will not** be imposing appointment wait time standards.
  - OIC proposal for rule making regarding appointment wait times is postponed for additional federal guidance.
- Washington state **will be** collecting information about access to Telehealth services.
  - Information will be collected in the Provider Network Form A report.

ESSENTIAL COMMUNITY PROVIDER (ECP)

The approach for review will remain the same for PY2025 as PY2024.

- Overall participation threshold is **35%** of available ECPs in the plan's service area
- Washington state rule currently requires carriers to meet a 30% standard
- Carriers will be required to meet highest participation standard

ECP/NA Template

- Washington state **does not** use the network adequacy data side on the ECP/NA Template
  - Provider Network Form A report is used to collect network access data

ECP/NA TEMPLATE (cont'd)

Provider reporting requirements by location:

- Washington state network access standards
  - The Provider Network Form A report should include **all** contracted in-network providers
  - Meeting network access standards may include access to providers in nearby states
- ECP standards
  - The ECP side of the ECP/NA template may only include providers located in the state corresponding to the carrier's service area for the respective plan ID and network ID combination
  - ECPs reported outside Washington state will not count towards meeting threshold requirements

ECP/NA TEMPLATE (cont'd)

- Washington state uses the alternate access delivery request (AADR) process to report
  - Carrier issues meeting the ECP threshold standards
  - Network access issues:
    - SADPs [WAC 284-170-200(14)] or
    - Health benefit plans [WAC 284-170-200(15)]
- Washington state **does not** use the ECP and Network Adequacy Justification Form.

TIERED NETWORK

- Tiered network means a network that identifies and groups providers and facilities into specific groups to:
    - Reimburse providers differently, or
    - Establish different enrollee cost-sharing levels, or
    - Establish provider access requirements, or
    - Any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.
- Only tier one providers will be counted to determine essential community provider threshold standards.
- **CAUTION**: Benefit design changes may change your network structure and require development of a new network.

Rates

Rocky Patterson, Actuary

Compressed Review Timeline

Significant timeline changes:

- **Late Risk Adjustment Data**
  - CMS announced that risk adjustment data will be released about a month later than last year (on July 22, 2024).
- **Earlier approval deadlines from the Exchange and CMS.**

Expected results:

- Expect shorter turnaround times for responses to objection letters
- Expect objections in your small group filings earlier than last year.

Rate Filing Review Process Highlights

- **Preliminary reviews of all rate filings within the first couple of weeks.**

- **Rate filing review priority (after preliminary reviews):**
    - On-exchange rate filings first
    - Off-exchange rate filings second

How to Expedite the Review Process

- **Submit the final STMs in the rate filing**
- **Submit complete responses to rate filing objections.**
- **If you need clarification of an objection, contact the reviewer before you respond.**

GENERAL FILING INSTRUCTIONS (GFIs) AND SPEED TO MARKET TOOLS (STMs)

- STM update highlights
  - Updates to individual market supplemental checklist for 1332 Waiver report.
  - Update to MHSUD financial parity testing document to clarify the meaning of "same as" in testing selections.
  - Updates to Benefit Components related to virtual visits.

PY 25 Individual Supplemental Checklist for 1332 Waiver Reporting

- This supplemental checklist is per Washington Health Benefit Exchange (HBE) request regarding the 1332 waiver reporting requirements.
- This supplement checklist applies to all individual health plan market carriers regardless of whether the carrier markets on-Exchange or not.
- OIC will review this checklist as part of the rate filing review.
- See the supplemental checklist for detailed instructions.

PY25 USER FEES

- The Exchange Board approved the PY25 Exchange User Fees on March 28, 2024.
  - Qualified Health Plans: $5.11 PMPM
  - Qualified Dental Plans: $0.94 PMPM
  - Pediatric Dental Plans: $0.67 PMPM

- The Risk Adjustment User Fee for PY25 is $0.18 PMPM.

URRT/SERFF PROCEDURE

- Rate filings are essentially locked down forever after the state determination is entered on the URR tab in SERFF and the final action in SERFF is submitted. The state cannot re-open the rate filing (same as PY23-24).

SERFF Binders

Ben Driver, Actuarial Analyst 3

BINDER REVIEW PROCESS (HIGH LEVEL)

Step 1

Preliminary Review:

- Basic consistency and compliance checks:
  - Correct documents included?
  - HIOS IDs, plan names, etc., are consistent across documents?
  - Data Integrity Tool results?
  - Service area requirements are met?

Step 2

Substantive Review:

- Detailed checks are performed.
- Analysts compare the binder, form, network, and rate filings for consistency.
- Generally, this is step represents the majority of review and results in the majority of objections.

Step 3

Cleanup:

- Check consistency with final versions of rate and form documents.
- Prepare filing for final disposition and reporting.

Notes:

- The process is not always linear. Preliminary checks are rerun throughout the process.
- Cleaner filings receive fewer objections and permit later review stages to begin earlier.

IMPORTANT REMINDERS

Binder Filing General Instructions and Templates

- Final filing instructions and templates are pending release of CMS's final QHP documents.

Service Area Template and Network ID Template

- Submit the same Service Area and Network ID Template across both coverage types (medical and dental) and both markets (individual and small group).
- Do NOT reuse service area IDs or network IDs across coverage types (medical and dental) or markets (individual and small group).

Plans and Benefits Template (PBT) Add-In File & Benefits Package Worksheets

- The benefit information tables in your PBT Benefits Package worksheets should match Exhibit C, except where deviations are allowed (see Exhibits B and C for details).
- EHB Variance Reason: Do NOT use "Substituted," "Substantially Equal," or "Using Alternate Benchmark." See Exhibit B and C for allowable reasons.

CMS's Standardized Plans Add-In File

- Do NOT use CMS's add-in file for standardized plans to prepare WA binder filings.
- Use "Not Applicable" for the Design Type field in the Plans and Benefits Template.

PLANS AND BENEFITS TEMPLATE – EXCHANGE STATUS

QHP/Non-QHP Field in the PBT (Benefits Package worksheets)

- Page 2G-5 of the "Qualified Health Plan Issuer Application Instructions: Plan Year 2024"

QHP/Non-QHP*	Indicate whether the plan will be offered only on the Exchange, only off the Exchange, or both on and off the Exchange. Choose from the following: • **On the Exchange**—if the plan will be offered only on the Exchange. Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered on the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan off the Exchange. If you offer a plan on the Exchange, select **Both** unless an exception to guaranteed availability applies. • **Off the Exchange**—if the plan will be offered only off the Exchange. This includes non-QHPs and plans that are substantially the same as a QHP offered on the Exchange as part of the risk corridor program (see 45 CFR 153.500 for more details). • **Both**—if the plan will be offered both on and off the Exchange. Such plans must have the same premium, provider network, cost-sharing structure, service area, and benefits, regardless of where they are offered. Selecting this option creates two separate plan variations when the Cost Share Variances worksheet is created: one on-Exchange plan and one off-Exchange plan.

- Enter "Both" for plans (other than catastrophic plans) that are offered on the exchange.
- Enter "On the Exchange" for catastrophic plans.
- Enter "Off the Exchange" for plans not offered on the exchange.

OIC Templates (including Benefit Components, Snapshot, and Rate Schedules)

- Enter based on **marketing intentions** instead.

CONNECTING THE RATE, FORM, AND BINDER FILINGS

Use the same entries across documents:

- Plan names.
- HIOS IDs.
- Metal actuarial values (Metal AVs).
- Metal levels.
- Exchange marketing intentions.
- New or Existing Plan.

Ensure consistency between documents:

- Schedule of Benefits (form filing) vs. Plans and Benefits Template (binder filing).
- Benefit Components Template (rate filing) vs. Plans and Benefits Template (binder filing).
- Rate Schedules (rate filing) vs. Rate Data Template (binder filing).
- Rate Schedules (rate filing) vs. Service Area Template (binder filing).
- Unified Rate Review Template (rate filing) vs. Rate Data Template (binder filing).

NEWS AND IMPORTANT UPDATES

Stand-Alone Pediatric Dental Plans

- In the Plans and Benefits Template (PBT), if the coverage level (i.e., "High" or "Low") changes from year to year, the HIOS Plan ID must change.
- CMS mentioned that this requirement was due to their data validation system.
- While coverage levels are no longer defined under 45 CFR § 156.150, the "Level of Coverage" field is still indicated to be a required in the PBT, so please make the most appropriate selection possible for each plan.

Medical Benefit Components Template (submitted in the rate filing)

- It is assumed that your plan designs cover virtual visits at the same cost shares as in-person visits. If this is not the case for one or more categories of services, add rows to the table as necessary to reflect the differing cost shares.
- The dedicated virtual visits row has been removed from the table.

Recap

Ned Gaines, Deputy Commissioner

NEXT STEPS

We are still waiting on:

- Final Payment Rule (NBBP) for 2025
- PBT instructions to finalize Binder GFIs

We will update GFIs/STMs as necessary.

COMMUNICATION

If you have a question, contact us.

- Start with the OIC analyst assigned to your filing in SERFF.
- If you get the same objection a second time and you don't understand why, contact us.
- Remember that there is one OIC and many carriers.
- Please organize your questions.

If you asked a question today that we didn't answer, email it to Rfhealthplan@oic.wa.gov

FILING DEADLINE

The Filing deadline is May 16th, 2024.

Please do not wait until the last minute to submit your filings.

Thank you for attending our PY25 filing webinar!

Any questions?

QUESTIONS?

Ned Gaines

Deputy Commissioner, RFPN

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