NOTICE TO ALL CARRIERS WRITING ACA INDIVIDUAL AND SMALL GROUP MAJOR MEDICAL AND STAND ALONE DENTAL FILINGS FOR PLAN YEAR 2019

Timeline For Plan Year 2019

- QHP application submission deadline-6/20/2018
    - Filings need to be concurrent into **BOTH** HIOS and SERFF
    - Filings must include all forms and rates
    - Refer to plan management instruction in SERFF
    - IDOI completes review of QHP filings 9/11/2018
- Non-QHP application submission deadline-7/25/2018
    - Filings need to be concurrent into **BOTH** HIOS and SERFF
    - Filings must include all forms and rates
    - Refer to plan management instruction in SERFF
    - IDOI completes review of non-QHP filings 9/30/2018

Essential Health Benefits 2019

- Indiana will be retaining the current 2017 essential health benefit benchmark plan for the 2019 calendar year:
    - Anthem BCBS Blue 5 Blue Access PPO Medical Option 6 Rx Option G
    - Pediatric Oral (FEDVIP)
    - Pediatric Vision (FEDVIP)
- Additional information may be obtained by visiting http://www.in.gov/idoi/2812.htm

SERFF Plan Management Instructions

- Binder submissions and form/rate filing submissions are required by Indiana for all ACA compliant non-grandfathered plans that are part of the single risk pool as well as Stand Alone Dental Plans (SADPs)
    - Additional information on submission requirements can be found by visiting http://www.in.gov/idoi/2812.htm

Formulary Review Updates

- The IDOI has updated our approach to reviewing for clinical appropriateness
    - Please refer to the Power Point presentation and excel document which can be found by visiting http://www.in.gov/idoi/2813.htm

SADP Changes 2019

- Actuarial value requirements have been removed for the 2019 benefit year
- The annual limitation on cost-sharing will remain at $350 for one child and $700 for two or more children

Maximum Annual Limit on Cost-Sharing 2019

- The maximum limitation on cost-sharing for 2019 is $7,900 for self-only coverage and $15,800 for other than self-only coverage.
    - The amounts are reduced by the cost-sharing reductions to $2,600 for self-only coverage and $5,200 for other than self-only coverage for individuals with incomes below 200 percent FPL and to $6,300 and $12,600 for individuals and families between 200 and 250 percent FPL

MHPAEA

- The IDOI will be implementing a more focused review on MHPAEA. As such, part of the review process will entail review of non-quantitative treatment limitations
- Additional information on MHPAEA can be found via the Mental Health Parity Final Rule

Legislative Changes

- HEA 1007 Mental Health Access
    - Effective July 1, 2018
    - Requires certain plans of accident and sickness to provide coverage for substance abuse or chemical dependency treatment provided by an addiction counselor or a marriage and family therapist.
    - Insurers that issue or administer policies that provide coverage for basic health care services and HMOs must provide provisional credentialing to a provider if the credentialing determination is not completed in 30 days and if the provider meets certain requirements.
    - Provides that once an insurer or HMO fully credentials a provider holding

provisional credentialing, that reimbursement payments under the contract between the provider and either the insurer or HMO are retroactive to the date of the provisional credentialing.

- Urges the Legislative Council to assign to an appropriate interim study committee the task of studying the impact that opioid treatment programs have on the neighborhoods and communities in the immediate area of the opioid treatment programs.

- HEA 1017 Newborn Screenings
  - Effective April 1, 2018
  - Adds spinal muscular atrophy and severe combined immunodeficiency to the list of disorders in the newborn screening requirements.
- HEA 1143 Prior Authorization for Health Care Services
  - Effective July 1, 2018
  - Specifies requirements for prior authorization of health plan coverage and claim payment, including provisions requiring electronic transmission of prior authorization requests and responses or, in certain circumstances, use of a standard prior authorization form established by the Department of Insurance.
- HEA 1287 Newborn Screenings
  - Effective July 1, 2018
  - Establishes that a newborn infant's blood sample testing for certain disorders must be taken not earlier than 24 hours from birth.
  - Provides that the time requirement for taking a blood sample does not apply to preterm infants or newborn infants who receive a total exchange blood transfusion.
- HEA 1301 Insurance Matters
  - Effective July 1, 2018
  - Updates names of health care provider billing forms.
  - Permits the Department of Insurance and Governor to apply for a 1332 waiver.
- HEA 1317 Health Matters
  - Effective July 1, 2018
  - Prohibits an insurer, HMO, or LSHMO that provide coverage for drugs, or an administrator of drug benefits on behalf of an insurer, HMO, or LSHMO, from including a provision that requires an insured to make a payment for a

prescription drug in an amount that exceeds the less of either the contracted copayment amount, or the amount of the total approved charges by the insurer, LSHMO, or HMO at the time of sale.

- Allows a pharmacist or pharmacy to provide an insured with information about the amount of the insured's cost chare for the prescription drug.

Transitional Health Plans

- Insurers may determine at their discretion whether to renew transitional policies that have been continually renewed since 2014, so long as the determination is made on a non-discriminatory basis. If insurers choose to renew its transitional policies, the policies may be renewed for no longer than 12 months. Insurers may choose from the following renewal options:
  - All individual and small group transitional policies;
  - Only individual transitional policies; *or*
  - Only small group transitional policies.
- Further information can be found by visiting http://www.in.gov/idoi/2591.htm under Bulletin 243

Product Discontinuance

- Notification must be sent to policyholders at least 90 calendar days in advance before the date the coverage will be discontinued
  - Carriers should also send written notice of the product discontinuance to the Commissioner
  - Notification to policyholders should be approved by the IDOI prior to sending to policyholders
- Notification requirements are applicable for both grandfathered and non-grandfathered coverage in the large group, small group and individual market on and off Marketplace
- Additional information regarding notice requirements may be found at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-090216.pdf

Reference Documents

- The IDOI Rate and Form Review will encompass information contained within

the following reference documents/rules:

- 2019 Notice of Benefit and Payment Parameters
  http://www.in.gov/idoi/2812.htm
- 2019 Final Letter to Issuers-

  http://www.in.gov/idoi/2812.htm
- 2019 Plan Management/CMS Templates-
  https://www.qhpcertification.cms.gov/s/Application%20Materials