FLORIDA OFFICE OF INSURANCE REGULATION

TO: All insurers authorized to write life & health insurance products in Florida, including those writing supplemental products

The following information is provided as guidance to insurers about the form and rate filing process in Florida for life and health insurance products, mainly Patient Protection and Affordable Care Act (PPACA) compliant products in the small group and individual markets. This overview is intended to assist industry in understanding the filing process and deadlines, as well as to provide insight into how the Office of Insurance Regulation (Office) will allocate resources to meet federal timeframes.

Although the Office will continue to process other life and health filings unrelated to PPACA (e.g., long-term care, Medicare supplement, annuity products) during the May to August timeframe, companies should delay making any non-essential filings of these types during this period to allow analysts to focus on the PPACA filings.

PPACA Filing Deadlines

Per the final United States Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2017 and guidance within the 2017 Letter to Issuers the Qualified Health Plan (QHP) filing submission deadline for PPACA compliant products (including stand-alone dental plans) in the individual and small group markets is **May 11, 2016**. *This deadline is applicable for products sold both on and off exchange.*

Additionally, the Office must complete its review of filings with QHP in the risk pool by **August 23, 2016**. Filings will be processed in the order they are received, and there will be no "expedited" status granted to any filings.

Review Timeframe

The Office is required by Section 627.410(2), Florida Statutes, to take action on a filing within thirty (30) days of receipt of the form and/or rate filing, with an option to extend this statutory review deadline by another fifteen (15) days. The anticipated filing volume and short review window will likely result in the Office requiring companies to respond very quickly to requests for information or explanations regarding a filing. Providing complete and clear information in a filing and responding quickly to Office requests will facilitate the timely review of all filings. Filings will be processed in the order they are received, and there will be no "expedited" status granted to any filings. *The information requested in this notice should be submitted at the time of filing. Some of the information is not required to be initially submitted to make a complete filing. However, the Office may require it to be submitted after filing pursuant to Section 624.26(2), Florida Statutes and Rule 69O-149.021(6)(c), Florida Administrative Code. In order to streamline the review process, the issuer is encouraged to submit the information at the time of filing.*

Information to be Filed

Pursuant to Rules 69O-149.002 and 69O-191.051(1), Florida Administrative Code, changes made to a form shall be filed with the Office and the filing shall include a rate filing or an actuarial certification that the form change does not require a change of rates. In addition, according to the 2017 Letter to Issuers, an issuer must submit the Unified Rate Review Template for all single risk pool plans, including plans with rate increases, rate decreases, no rate change, and new plans. Therefore, a rate filing will be required for all QHPs.

Templates to be Submitted

An issuer should submit the following templates to the Office as part of an issuer's Florida filing. The templates are not required to be initially submitted to make a complete filing. However, the Office may require templates to be submitted after filing pursuant to Section 624.26(2), Florida Statutes and Rule 69O-149.021(6)(c), Florida Administrative Code. In order to streamline the review process, the issuer is encouraged to submit the templates at the time of filing.

- Plan Data Template*
- Chronic Conditions Template (See Formulary Review for Certain Conditions)
- HIV/AIDS Template (See HIV/AIDS Formulary)
- Drug Attestation (See Drug Formulary Attestation)
- Federal QHP Plans and Benefits Template
- Federal Prescription Drug Template
- Federal Unified Rate Review Template
- Federal Crosswalk Template
- Federal Summary of Benefits and Coverage
- Federal Business Rules Template
- Federal Network ID Template
- Federal Essential Community Providers/Network Adequacy Template
- Federal Rate Data Template
- Federal Service Area Template

*The Plan Data Template will need to be populated during the I-File filing process. The template will be validated in I-File against Federal Templates. When filing, allow yourself sufficient time to correct any errors or issues which might arise during the validation process.

Drug Formulary Attestation

The final Notice of Benefit and Payment Parameters for 2017 continues to charge the Office with the preliminary enforcement authority to monitor a plan's drug formulary and to ensure the plan's benefit design is not unfairly discriminatory. In order to facilitate the Office's review of a plan's drug formulary an officer or director of the issuer may submit an attestation with its filing confirming the policy form's compliance with 45 C.F.R. § 156.122, regulating Prescription Drug Benefits, and 45 C.F.R. § 156.125, Prohibiting Discrimination, as well as an explanation of how the insurer has determined that its coverage of HIV/AIDS medications and medications for other

chronic conditions (see next section below) is substantially similar to the benchmark plan or is otherwise compliant with Florida and federal law.

The Office is prohibited from certifying a plan to be included on the Federal Health Insurance Marketplace if the Office knows that the plan employs a drug formulary discriminatory in benefit design, benefit implementation or medical management techniques.

The attestation referenced above is available on the Office's website by clicking here: Drug Formulary Attestation

HIV/AIDS Formulary

For the 2017 plan year, the Office will continue to monitor the formulary treatment of medications for those living with HIV/AIDS. Sections 627.429 and 641.3007, Florida Statutes, specifically prohibit treating those living with HIV/AIDS less favorably than any other condition. Designing benefits or drug formularies that limit access to drug regimens for HIV or AIDS violates these statutes.

A health plan is required to be substantially similar in its scope of benefits to the state's benchmark plan and may not unfairly discriminate in benefit design, or in the implementation of its benefit design.

The Office will consider a health plan's formulary compliant with these provisions of Florida and federal law if the tiered formulary of HIV/AIDS medications is at least as favorable as the safe harbor plan.

The safe harbor referenced above is available on the Office's website by clicking here:
HIV/AIDS Formulary Instructions
HIV/AIDS Formulary Template

Compliance with the safe harbor guidelines is not mandatory. However, the Office is prohibited from certifying a plan to be included on the Federal Health Insurance Marketplace if the Office knows that the plan employs a drug formulary discriminatory in benefit design, benefit implementation or medical management techniques. Additionally, the Office will disapprove any plan it finds violates Sections 627.429, 641.3007, or 641.31(3)(c)6., Florida Statutes.

Formulary Review for Certain Conditions

According to the 2017 Letter to Issuers, issuers must use the new benchmark plan when designing their plans. CMS also cautioned issuers to avoid discouraging enrollment of individuals with chronic health needs, which may be done if an issuer places most or all drugs that treat a specific condition on the highest cost formulary drug tier. Enforcement of standards related to discriminatory benefit designs are largely conducted by the state. In its letter, CMS identified certain chronic conditions the state should monitor, including Bipolar Disorder, Breast Cancer, Diabetes, Hepatitis C, HIV/AIDS, Multiple Sclerosis, Prostate Cancer, and Rheumatoid Arthritis.

In an effort to streamline the filings and coordinate required information with federal agencies pursuant to Section 624.26, Florida Statutes, the Office has developed a template for use by issuers to complete and submit with each filing. For every QHP formulary, the template has a field for issuers to identify the number of drugs for each formulary tier for the respective chronic condition the drug treats. This information will enable the Office to determine whether it should make a required certification to include the plan on the Federal Health Insurance Marketplace. The Office is prohibited from including a plan on the Federal Health Insurance Marketplace if the Office knows that the plan employs a drug formulary discriminatory in benefit design, benefit implementation or medical management techniques.

The instructions and template for the formulary review referenced above is available on the Office's website by clicking here: Chronic Conditions Template

Interim Risk Adjustment Data

On January 8, 2016, in FAQ ID number 14572, CMS indicated that it would release an issuer-level interim risk adjustment transfer report at the issuer's request in March 2016, in order to provide issuers with information in pricing their 2017 health plans.

Those issuers filing QHP's in Florida should obtain this report from CMS and include it in their initial rate filing. Risk adjustment data may be material information essential to the determination of whether a rate is reasonable in relation to the benefits offered

Experience Pooling

In accordance with Section 627.410(6)(e)3., Florida Statutes, and Rule 69O-149.003(1)(a), Florida Administrative Code, in a rate filing the experience of all non-grandfathered health insurance policy forms providing similar benefits, whether open or closed, shall be combined unless otherwise permitted. This requirement applies to health insurance policies, *including dental policies.*

Taxes and Fees

A moratorium of the Health Insurance Tax set forth in PPACA Section 9010 and 26 C.F.R. § 57 has been enacted for the 2017 year. Therefore, plans affected by this moratorium should not reflect the tax in their rate filings.

Additionally, the Transitional Reinsurance Fee expires at the end of 2016. Therefore, plans affected by the Transitional Reinsurance Fee should not reflect the fee in their rate filings.

Experience Reporting

Please provide historical experience since inception on a *quarterly* basis. All experience exhibits should be in Excel with active formulas for all calculated values and projections. Historical and future Florida experience should be provided in the format outlined in Rule 69O-

149.006(3)(b)23., Florida Administrative Code. An example of the recommended format can be found at: Sample Experience Exhibit. At a minimum, the experience exhibit should include columns for the following:

- Earned premium, incurred claims on an incurral year basis, incurred loss ratios, expected loss ratios and actual to expected loss ratios.
- Risk Adjustment amount payable/receivable, Risk Corridor amount payable/receivable, and Reinsurance amount recoverable.
- Incurred loss ratios net of the federal premium stabilization programs.

Rate Collection System

Last year, the Office made no changes in the rate collection system. This year the Office has added a column for Formulary IDs that will synchronize with the Federal Prescription Drug Template simultaneously with the rate collection system. The Office also added separate copay and coinsurance columns in order to account for more complex plan designs. *The data collection template is generated during the I-File filing process and must be completed before submitting the filing for review. Sufficient time before the deadline should be allocated for this step.*

Guaranteed Renewable Insurance and Uniform Modifications of Coverage

Changes to plans and products may be made only in accordance with the HHS Uniform Modification of Coverage regulations or the state and federal guaranteed renewability regulations. According to federal guidance, if a health insurance issuer changes all of its products in a market such that the changes do not qualify under the uniform modification of coverage rules, the issuer will be considered to have performed a market withdrawal and be subject to a five (5) year prohibition on market reentry.

If a change in coverage is not a Uniform Modification of Coverage, the guaranteed renewable provisions in Sections 627.6425, 627.6571, and 641.31074, Florida Statutes, will apply.

Transitional Policies

On February 29, 2016, CMS extended the transitional policy for non-grandfathered coverage in the small group and individual health insurance markets to policy years beginning on or before October 1, 2017, provided that all transitional policies end by December 31, 2017.

The Office will work with any company that chooses to continue coverage in accordance with the transitional policy to facilitate the continuation of coverage for Floridians in accordance with the February 29th CMS bulletin.

If you have questions about any of the above information you may contact the following people:

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