FAQs for Maine Merged ACA Market and Clear Choice Plans

May 6, 2022

Timeline for Form/Rate Review

1. When are form and rate SERFF submissions due? The deadline for initial submissions is June 27 with final approval at the end of August or mid-September depending on the timing of the 1332 announcement. The Bureau Bulletin 463 is posted on the website with the timeline and filing requirements.

2. Should carriers submit form and rate filings for a merged market assuming CMS approval? Yes, if CMS does not approve the 1332 amendment, carriers will be able to resubmit off-Marketplace individual and all small group plans and rates. Marketplace plans will not change but the rates may be revised at that time.

   On March 28, 2022, Maine's waiver amendment application was deemed to be complete. Federal public comments on Maine's waiver amendment request were accepted through April 26, 2022. The Bureau is anticipating approval within the rate review time-period.

3. Will the date of plan preview remain 10/15? Yes, we anticipate that plan preview will begin 10/15, though this date is not final and subject to certification timelines and data validation.

MGARA

4. What assumptions should be used for MGARA? Attachment points to use for rate filings will be announced following the recommendation from the MGARA Board.
5. How will the transition to merged market work for MGARA? The tail of non-calendar-year 2022 small-group plans is expressly excluded by Subsection 6(1) and 24-A M.R.S. § 3958(1)(A-1) – coverage is triggered by issue date under the statute, and status as a "pooled market health plan" under Rule 856. Risk Adjustment is calendar-year rather than policy-year.

Clear Choice Plans

6. May forms may be filed to accommodate small group and individual differences such as applications or certificates? Yes

Rule 851, Paragraph 5(1)(E) states: "differences in the administrative provisions of the policy forms issued to individuals and the coverage documents for the same plan issued to small employers and plan participants, if the variations in contract terms are reasonably related to the differences in the mode of coverage, and do not affect the plan benefits or premium rates except to the extent expressly permitted by this rule or required by controlling law." This might include offering an EAP to employers and a different but comparable wellness program to individuals The Bureau's suggestion for "right to shop" provisions is required to include it in both individual and group HSA plans, but optional in the non-HSA plans. The" right to shop" must be the same in both individual and small group plans.

7. Are there required naming conventions? Carriers may distinguish individual and small group in that version of the plan name. Clear Choice must specifically state "Clear Choice" and not CC. CSR variation plans must be distinguished. For example: [Company Name][Clear Choice Bronze 4500 etc.] [company preferred name/branding][CSR 94/CSR 87/CSR 73/CSR 100/CSR LCS]. On-marketplace plan names should not exceed 80 characters. OHIM strongly encourages carriers to limit names to 50 or fewer characters for display and consumer comprehension. Are carriers allowed to abbreviate their company name ? Yes

8. What adjustments to Clear Choice cost share structure might come later? The Bureau may need to adjust Clear Choice plans to meet AV calculation requirements or other federal limits as they are announced according to Rule 851, Section 5 (B). Also, HSA maximum out of pocket amounts have not been announced by IRS/Treasury so that may lead to those plan limits increasing once those are announced.

9. Are all of the Clear Choice plans for 2023 available for both On/Off the Marketplace? Do the (New) plans apply to Small Group or off-Marketplace only? Yes, this includes the Bronze 5200 and Bronze 6300 HSA intended to be offered off-exchange. Will the Clear Choice 3500 HSA and Clear Choice 4500 HSA be off-Marketplace only? Yes

   Rule 851, Section 5 (2) describes the requirements for Marketplace plans. Carriers must offer a Clear Choice plan in each metal level that they offer coverage. Carriers on the Marketplace must have a Clear Choice Silver plan and also need a Gold plan but the Gold plan may be either Clear Choice or an alternative plan.

   The Silver $6,000 is designated as the Basic Silver Plan. The Basic Silver Plan is designed to yield an actuarial value that is reasonably close to 70%, and it may be offered as a Marketplace plan. That plan has been modified recently from the chart sent out previously by increasing the deductible to bring it closer to the 70% AV needed for a Basic Silver plan. The deductible was changed from $,5000 to $6,000.

   Generally, carriers that participate in the Marketplace have the discretion to decide (subject to approval by the Marketplace) which plans will be offered on the Marketplace and which plans will be Off-Marketplace only. The only exceptions are: (1) No Silver plan with an actuarial value lower than the Basic Silver Plan may be offered on the Marketplace. (2) A carrier's lowest-cost Marketplace Silver plan must be a Clear Choice plan, not one of its Alternative Plans. (3) The Silver $3,500 HSA; $4,000 HSA and $4,500 HSA Plans have been designated as Off-Marketplace Plans and may not be offered on the Marketplace. (4) Federal law requires all individual plans that a carrier offers on the Marketplace to also be available (though not necessarily actively marketed) off the Marketplace, and state law requires all plans a carrier offers to individuals to also be available (though not necessarily actively marketed) to small groups, and *vice versa*.

10. Is our understanding correct that carriers will be filing one portfolio of products that can be sold to either or both Individuals and Small Groups? Plans must be available to both individuals and small groups but marketing can differ.

11. How will existing plans move through a discontinuance process? For instance, because there continues to only be an allowance of 3 alternative plan designs to cover both market segments.

Current 2022 plans may be revised for 2023 and alternate plans might change due to the merged market. Rule 851, Section 4(3) discusses this process.

12. Is there an opportunity to remove dental on any Off Market Only Plans? Yes, as long as compliance with the ACA is maintained.

Prescription Coverage

13. How will prescription coverage be treated across this expanded market? Clear Choice prescription coverage for individual plans in 2022 varies by metal tier whereas a carrier may be currently offering the same prescription coverage cost share across all small group plans. Is there a way to maintain that approach? Carriers can offer up to 3 alternate plans with their specific cost share levels for prescription coverage in addition to Clear Choice plans.

14. For the Clear Choice plans, can the carriers use their own formulary structure for the pharmacy plans or do the carriers follow certain drug types in certain tiers as outlined in the excel spread sheet. Ex. All generics in T1, All Preferred Brand in T2? Any requirements with PDL, Plan Structure, or Pharmacy network with Alternate Plans? No restriction on formulary due to Clear Choice. There is some flexibility on where certain drug types fall into the tiers.

15. May carriers use a "narrow" pharmacy network? Could this be used for the Clear Choice plans or must carriers use a full/broad pharmacy network? Rule 851, Section 5 (5)(E) Other options for mail order or network pharmacies are acceptable as long as the basic coverage in the Clear Choice plan is offered.

Form/Rate Filings

16. For each plan there needs to be a separate form and rate filing with URRT and HIOS IDs for individual and small group that use the single risk pool for the merged market. The purpose is to allow updated quarterly rates to be filed for small group.

17. How will tobacco rating factors be implemented across a merged market? Could tobacco rating continue for individual plans even if it is not used for small group plans?

    "Pure" tobacco rating may not be used for either individuals or small groups. The federal standard prohibits tobacco rating in the small group market unless the carrier waives the rate differential for any covered individuals who participate in an evidence-based tobacco cessation strategy. Maine's rating law has extended the same standard to individual coverage, so tobacco rating, if carriers choose to use it in 2023, should be applied uniformly to both individuals and small employers. The maximum tobacco rating differential in 2023 is a ratio of 1.25 to 1. In 2024, the Legislature's phase-out of tobacco rating will be complete and tobacco rating will not be permitted in Maine's individual and small group market.

18. Do carriers have the ability to create a price differential between these Individual PPO and Small Group PPO market segments to reflect any expectations that the Individual PPO members will be riskier than the SG PPO members? No

19. Can the carriers choose to offer the Clear Choice plans as Gated (referral required) or Open Access or a combination of both? Yes

20. Please confirm carriers must offer all 19 Standard Clear Choice plans? No requirement to offer all plans.

21. Please confirm carriers can offer some plans as HMO, POS, or a combination of both? Example: All 19 HMO and all 19 POS, 10 POS and 9 HMO, or just all 19 HMO or all 19 as POS. Yes, may offer HMO or POS. Carriers may offer each Clear Choice and 3 alternative plans for each product line.

22. If a carrier cannot administer a specific plan design, are they allowed to make the plan richer? Clear Choice plans must keep to the specified cost share structure. If there is a richer benefit that will be reviewed during the form/rate review process.
    Example:
    T1 $5/25 could become just $5
    T2 $50
    T3 30% up to $300
    T4 30% up to $500

    Clear Choice plans should keep to the stipulated cost share structure but small modifications for richer coverage will be reviewed during the form/rate submission process with the Bureau.

23. We current file 1 Schedule for each product with ranges for cost sharing, limits, etc. Will we be able to continue doing this or will we have to file a separate schedule for each plan?

24. Given the requirements of the merged market, will silver metal level high deductible plans (i.e., HSA compatible) have to be offered across the cost share variants? If so, how will they meet parameters of both CSVs and HSAs? HSA plans may be offered on the Marketplace but the CSR variants would not be considered HSA eligible.

URRT

25. For purposes of completing the URRT, will each filing be for the combined market, or will there be an individual market filing and a small group market filing? One URRT for individual and one for small group based on merged market single risk pool.

26. The URR instructions note that the index rate is the same value for all plans for an issuer in a market. How should the index rate be developed? Merged

    a. We assume the index rate is based on combined experience for individual and small group business. Yes

    b. Are the adjustments to the experience component of the index rate (morbidity, demographic shift, benefit plan adjustments, etc) to be based on the combined projected enrollment (individual and small group)? Yes This would allow for the development of a single index rate that would be used in each filing.

27. How is the market adjusted index rate (MAIR) developed? Are market level adjustments (reinsurance, risk adjustment and exchange fees) developed based on the combined enrollment or on separate enrollment for each line of business (individual vs small group)? The URR instructions note the MAIR should be the same for all plans for an issuer in a state and market – this will not be possible if market level adjustments are developed separately by line of business. Combined

    a. How will risk adjustment work? Will it be for combined experience or separate for individual vs small group? Yes, combined

28. Which plan specific factors, if any, are allowed/expected to vary between the filings? None

    a. Must the same plans be offered in each filing? Yes

    b. Are different admin loads allowed between individual and small group? No

29. How should the calibration factors be developed? We assume the factors should be tied to the same pricing enrollment as is used to develop the index rate(s) but would like confirmation. Combined market

Small Group Considerations

30. Is there ME-specific language required for welcome letters in the IVL market (off-exchange)? Are there any advance member notifications that will be required before a carrier may terminate policy if payment not made by the grace period expiration?

Currently in the Individual market, letters are sent to members when proposed rates are filed for the next year's plans. That letter process would continue in a merged market and the same policyholder notice requirements would continue as required by statue, Rule 856 did not impose new requirements. No new requirements for non-payment termination notices. Will the letters sent to policyholders with proposed rates need to go out to Small Groups as well? No

31. Does standard group grace period for premium apply – no special additional allowance for payment periods? Standard is 31 day from premium due date.

32. What happens to SHOP in a merged market scenario? SHOP could continue with plans offered to small groups but individuals must be able to purchase a parallel version of the same plans on request.

33. Renewals will continue to be allowed mid-year.

34. No requirement to actively market all plans to individuals.

35. As a matter of the new law regarding the standard plan offering requirement, can carriers move their remaining grandfathered plans to Clear Choice plans for next year and if not, how should carriers handle? Grandfathered plans continue under guaranteed renewal requirements. There is a process to cross-walk those plans to new coverage that needs justification required by the statute.

36. Currently there's a much higher selling expense for the small group (SG) plans than individual (IND) plans as most of the SG sales are via brokers whereas over 50% of the IND sales are direct sales. Given that our SG plans will be offered Off Exchange only, could we still only charge the SG specific selling expenses to SG plans only as we do in the non-merged market, or is there any recommendations that could avoid allocating the SG selling expenses to IND plans? Costs will need to be built into the merged single risk pool and spread across all plans.

37. Will the compositing rating option still be available to small groups in the merged market? Yes