TOP STORY

CMS Releases “Mega Reg” for Medicaid and CHIP Health Plans

The Centers for Medicare & Medicaid Services (CMS) issued a pre-publication version of a final rule addressing a broad range of health plan issues under Medicaid and the Children’s Health Insurance Program (CHIP). The official Federal Register version will be published on May 6, 2016.

In the final rule, the agency finalizes the basic structure and many of the provisions in the proposed rule published May 26, 2015. When implemented, the rule will affect the full range of Medicaid health plan operations and achieve greater alignment of regulatory standards for plans that operate in Medicaid, Medicare Advantage, and the Exchange Markets. However, in response to comments, CMS has made a number of changes in the final rule, has decided not to finalize certain proposals, and has adopted a range of implementation dates for different provisions.

We have released the following AHIP statement: “Modernization of the Medicaid program is critical to meet the health needs of an increasingly diverse beneficiary population. While we are still reviewing the many provisions of this comprehensive final rule, it’s critically important that health plans and states have the flexibility to structure their programs and benefits to care for the millions who depend on Medicaid managed care. We will be evaluating these final policies against this guiding principle.”

Elements of the final rule include the following:

- **Actuarial Soundness**: The rule includes a variety of new Federal standards for actuarially sound capitation rates, including the documentation states must submit to CMS for rate reviews. As proposed, only withhold arrangements with reasonably achievable targets are counted for actuarial soundness purposes. The rule also retains the proposal allowing states to require plans to adopt a minimum fee schedule for network providers.

- **Medical Loss Ratio (MLR)**: The rule requires each Medicaid health plan to calculate and report an MLR for contracts starting on or after July 1, 2017. (For multi-year contracts that do not start in 2017, the reporting is required for rate periods that begin in 2017.) The minimum federal standard is 85 percent, although states can establish a higher MLR. States must establish capitated rates such that plans would be reasonably expected to achieve an MLR of 85 percent no later than the rating period for contracts starting on or
after July 1, 2019. CMS decided not to move forward with its proposal to include costs of fraud prevention activities in the numerator of the MLR calculation, until a similar change is made for the private market.

- **Network Adequacy**: The rule requires states to develop time and distance standards for primary and specialty care providers and assess the adequacy of the provider network at least annually. Under the rule states retain the flexibility to establish specific standards.

- **Quality Ratings**: The rule gives CMS the authority to implement a Medicaid health plan quality rating system similar to that in the Marketplace.

- **Enrollment Period**: CMS has decided not to adopt a proposal that would have required a new 14-day period during which beneficiaries residing in areas implementing managed care programs must remain in the FFS program while considering plan options. States however retain the option to mandate such period.

- **Supplemental Payments**: Under the final rule, states will be permitted to pass-through supplemental payments in a plan’s capitated rate, but the pass-through will be phased out over a period of years.

- **Provider Screening and Enrollment**: The rule requires states to screen and enroll all plan network providers, including those not otherwise enrolled with the state to provide services to FFS Medicaid beneficiaries. However, plans may execute provider agreements for up to 120 days pending the outcome of the state screening and enrollment process.

- **Payments for Patients in Institutions for Mental Disease (IMD)**: The rule allows states to make capitated payments to Medicaid health plans in certain circumstances for enrollees who are patients in IMDs. For example, an institution must meet certain conditions and the enrollee’s length of stay cannot exceed 15 days in the payment month.

The proposed rule also addresses a number of other issues including codifying standards for Medicaid health plan managed long term services and supports programs and adopting new grievance and appeals requirements intended to align with Medicare requirements. The following are links to a CMS press release and a CMS blog post. CMS summaries of key provisions of the final rule can be found at this webpage by clicking on the “Final Rule” arrow.

**NEWS BY STATE**

**Arkansas Works Becomes Law After Line Item Veto**

On April 21, Arkansas Governor Asa Hutchinson (R) signed SB 121, the Department of Human Services appropriations bill that creates the Arkansas Works program, a modified version of the state’s “private option” approach to Medicaid expansion. Before signing the bill, though, the governor line item vetoed a provision that would have ended funding for the program on December 31 of this year. This provision was added to the bill with the governor’s blessing as part of a strategy to overcome opposition from 10 Senators.
SB 121 will, among other things, grant spending authority for $8.4 billion in state and federal funds for various Medicaid programs, including Arkansas Works that was passed during the special session that preceded this fiscal session. The Arkansas Works Act of 2016 allows the state to continue to receive federal Medicaid funding to subsidize private health insurance for low-income residents with incomes between 100 and 138 percent of the Federal Poverty Level while instituting, among other provisions, job-training requirements for enrollees.

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Indiana Department of Insurance Seeking Comments on NAIC Network Adequacy Model Act as Basis for 2017 Legislation

The Indiana Department of Insurance (DOI) has announced by email that it anticipates a bill in the 2017 legislative session concerning network adequacy. According to the DOI, the NAIC Network Adequacy Model Act is likely to form the basis for the bill.

The DOI is asking for written comments on the NAIC Model Act to be sent to compliance@idoi.IN.gov with the subject title Network Adequacy Comments. The DOI will be accepting comments/questions until close of business on May 6.

Leanne Gassaway at (562) 429-7493 and David Kennedy at (202) 380-8514

Idaho Department of Insurance Releases Bulletin on Extension of Transitional Plans

The Idaho Department of Insurance has released Bulletin 16-03, Extension of Transitional Plans through December 31, 2017 to announce that grandfathered transitional plans in the individual and small group markets will be extended through December 31, 2017 in compliance with the February 29 CMS guidance.

The DOI’s bulletin lays out the following carrier requirements for the extension:

- For renewals of transitional policies on or after August 1, 2016, the carrier must renew policies until December 31, 2017 with no premium increase after that renewal.
- For transitional plans with deductibles and out-of-pocket maximums by plan year, prohibits carrier from apply accumulation periods of fewer than 12 months, even when the policy is less than 12 months. The bulletin lays out two options for this scenario.
- The plans must continue to comply with ACA provisions, such as the elimination of EHB annual dollar limits, mental health parity rules (individual plans) and waiting periods limitations and prohibition on pre-existing condition exclusions for small group plans.
- Carriers must provide a DOI notice (Individual Transitional Plan and Small Group Transitional Plan) without modification at renewal explaining the option to renew or enroll in a new plan and include information on the inclusion of limited ACA market reforms.

Grace Campbell at (971) 599-5379 and Rosemary Englert at (202) 778-1154
Kentucky Legislature Adjourns

The Kentucky Legislature adjourned earlier this month and the governor has signed several bills of interest. Enacted legislation includes topics such as telehealth (HB 95), an autism liaison (HB 100) mandate, an acid-based elemental formula mandate (HB 193), PBM licensure and MAC pricing (SB 117), and biosimilars (SB 134). Additionally, SB 20, which requires a provider that has exhausted an internal appeals process of a Medicaid MCO be granted an administrative appeals hearing, was enacted. A bill regarding provider contracting (SB 18), which also includes a mitochondrial disease therapeutic food coverage mandate, is awaiting the governor’s signature.

Legislation that did not pass includes topics such as prescription drug cost sharing limits (HB 321/ SB 268), abuse-deterrent opioids (HB 330), mail-order pharmacy (HB 226), air ambulance providers (HB 273), and chiropractor parity (HB 288). In addition, two bills failed that were introduced in response to Governor Matt Bevin’s (R) plans to rethink Medicaid expansion (HB 6) and the state-based Exchange (HB 5).

Brian Quigley at (860) 533-9393 and David Kennedy at (202) 380-8514

Maine Bureau of Insurance Finalizes Adoption of Amendments to Rate Filing and Data Reporting Rule

The Maine Bureau of Insurance (BOI) has adopted a revised Rule Chapter 940, Requirements for Health Insurance Rate Filings and Data Reporting, which became effective April 19, 2016. The rule has been updated for consistency with various ACA requirements and procedures. This includes revised definitions, updated formatting and content requirements for rate filings, and modified annual data collection requirements.

Proposed revisions were first announced in October 2015, and following a public comment period, were further revised based on stakeholder input. The BOI has provided both an accompanying Basis Statement and tracked changes version of the subsequently revised rule detailing the comments it received and the corresponding revisions the Bureau chose to adopt.

Brian Quigley at (860) 533-9393 and Tom Palumbo at (202) 861-1461

Minnesota Legislative Update

Since the deadline passed for committees in the Minnesota legislature to act favorably on bills that originated in the opposite chamber, many of the more than 4,000 bills introduced this session have died; however several other bills of interest are still alive because, in most cases, they have been amended onto either the Omnibus Finance bills in either the House or the Senate.

Active legislation includes topics such as 90-day dispensing of a prescription drug after an initial 30-day supply (HF 2512) and continuation of coverage (HF 3285 and SF 3047). Additionally, the legislature is considering two bills requiring the state to seek a Section 1332 waiver (SF 2541).
and HF 2405). Key amendments in the Senate Finance Omnibus bill include new procedures for quality of care complaints for HMOs and new prior authorization and step therapy restrictions.

Bills that have died include prescription drugs measures covering topics such as cost transparency (HF 2526, HF 2525, and SF 2947) and acquisition of discounted prescription drugs from Canadian pharmacies (HF 2430 and SF 2239). Other legislation that has died includes provider payment reform (HF 2725, HF 2768, HF 3291/SF 3046), rating areas (HF 3225/SF 3118, HF 3040/SF 2506), and risk-base capital (SF 3079).

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Mississippi Legislature Adjourns

The Mississippi Legislature adjourned the 2016 regular session on April 22. Several bills of interest have already been enacted, covering topics such as assignment of benefits (HB 93), access to investigational drugs (SB 2527), regulation of PBMs (HB 462), and changes to risk-based capital requirements to align with the NAIC model (SB 2189). A bill relating to prompt payment requirements for PBMs awaits the governor’s signature (HB 456).

Legislation that failed to pass includes topics such as any willing provider (HB 1207/SB 2819), any willing laboratory (SB 2142), rate review (SB 2335), balance billing (HB 1212, HB 1172, HB 1175), rental networks (HB 89), and a number of mandates (HB 88, HB 152, HB 836, HB 1163, HB 1171, SB 2613).

Mara Osman at (202) 861-1474 and David Kennedy at (202) 380-8514

Nebraska Legislature Adjourns

The Nebraska Unicameral legislature ended its 60-day, 2016 session on April 20. Governor Pete Ricketts (R) has already signed several pieces of legislation related to health care. Enacted bills include topics such as data breach (LB 835), external review (LB 840), and direct primary care (LB 817). New market regulation laws adopt the latest changes to the NAIC Insurance Holding Company System Regulatory Model Act and the NAIC Corporate Governance Annual Disclosure Act (LB 772) and prohibit limited liability companies from operating as insurers (LB 758). Other signed legislation includes topics such as the establishment of a prescription drug monitoring database (LB 471), prescription requirements for dispensing of contact lenses or glasses (LB 235), Medicaid behavioral health contracting (LB 1011), and prescription transfers between pharmacies (LB 567).

Failed legislation includes topics such as biosimilars (LB 979), pharmacy benefit manager regulation (LB 1060), and several pieces of Medicaid legislation including expansion (LB 472) and access to treatment for opioid abuse (LB 696).

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Nevada Division of Insurance Issues Bulletin on Provider Directory Standards for Individual and Small Employer Plans


The DOI’s recently adopted network adequacy regulations include a requirement that carriers update their provider directories at least once a month and include providers whom are no longer in-network or whom have stopped accepting new patients. The DOI will require carriers issuing or renewing individual or small group plans on or after January 1, 2017 to have a provider directory system in place prior to November 1, 2016 and provide accurate and complete provider directories for all 2017 network plans.

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New Jersey Department of Banking and Insurance Releases Student Health Plan Rate and Form Filing Requirements

The New Jersey Department of Banking and Insurance (DOBI) has issued an Order No. A16-106 detailing rate and form filing requirements and deadlines for fully-insured student health benefit plans (SHPs).

The Department is requiring carriers offering SHPs to comply with existing regulations governing information and rate filing requirements for individual health benefit plans.

Specifically, the Order requires:

- All carriers offering SHPs in New Jersey effective on or after July 1, 2016 must submit separate rate and policy form filings in SERFF for each SHP offered;
- Carriers must submit policy form filings at least 90 days prior to the policy's effective date, or 30 days after the Order date, whichever is later, and must include a certification that the form complies with EHBs set forth in the state's benchmark plan. Alternatively, carriers may submit in SERFF a certification that a previously filed form complies with the EHBs found in the state's benchmark plan;
- SHP rate filings must be submitted 90 days before the effective date of the rates, or 30 days from the Order's effective date;
- New Jersey SHP rate filings must be submitted for all rate changes and must include Parts I, II, and III of the CMS Rate Review Justifications (updated April 1, 2015); and
- Carriers must confirm in the actuarial certification submitted with Part III of the Rate Review Justification that the New Jersey rates do not subsidize a carrier's SHPs in other states, as well as specify a number of additional supporting and explanatory details and data points.

Brian Quigley at (860) 533-9393 and Tom Palumbo at (202) 861-1461
Ohio Department of Insurance Issues Bulletin Concerning Extension of Transitional Policies

The Ohio Department of Insurance has issued Bulletin 2016-01 to announce that insurers in Ohio may offer their insureds the ability to continue/renew non-ACA compliant individual and small group coverage, at the insured’s option.

According to the bulletin, insurers wishing to extend coverage shall follow CCIIO’s transitional policy, including federal notice requirements, offering reenrollment or extended coverage to impacted policyholders in the individual and/or small group market in a uniform and non-discriminatory manner in accordance with Ohio law.

The bulletin outlines filing requirements that must be met for insurers to take advantage of the transitional policy extension.

Grace Campbell at (971) 599-5379 and David Kennedy at (202) 380-8514

Tennessee Legislature Adjourns

The Tennessee Legislature adjourned the 2016 regular session on April 22. Governor Bill Haslam (R) must sign or veto legislation within 10 days of transmittal (excluding Sunday), or it becomes law without his signature. Legislation awaiting the governor’s signature includes the following topics: data security (SB 2005), direct primary care (SB 2443), telemedicine (SB 2373), teledentistry (SB 1214), and MAC pricing (SB 1789). The governor has signed a bill (SB 1619) requiring any new mandates to apply not only to private health insurance issuers but also to any managed care organization contracting with the state to provide insurance through the TennCare program and state or local insurance program.

Prescription drug proposals that died include oral chemotherapy parity (HB 2239/SB 2091), biosimilars (HB 2262/SB 1802), abuse-deterrent opioids (HB 746/SB 601), drug price transparency (HB 2206/SB 2442), and pharmacy audits (HB 121/SB 152). Bills regarding provider networks that have died include balance billing (HB 2005/SB 2232), network adequacy (HB 1745/SB 2237), and provider contracting (HB 1910/SB 2031, HB 963/SB 973). Mandate proposals that died include autism (HB 1017/SB 960), proton therapy (HB 1441/SB 1773, HB 1006), contraceptives (HB 1847/SB 1958/HB 1723, HB 1823/SB 1677), and telemedicine (HB 2331/SB 2373).

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ADDITIONAL INFORMATION

CSRxP Announces Policy Options to Address Transparency, Competition, and Value in Prescription Drug Pricing

The Campaign for Sustainable Rx Pricing (CSRxP) announced a package of market-based policy solutions to address soaring prescription drug prices. The proposals were unveiled at an event in
Washington, D.C. that included remarks by CSRxP Executive Director John Rother and additional speakers from the American Hospital Association, AARP, the American College of Physicians, and Kaiser Permanente.

AHIP has been working closely with the CSRxP over the past two years to focus public attention on unsustainable prescription drug costs, and to promote solutions that improve choice and value for consumers. The policy options announced today include the following:

- To increase transparency, the CSRxP’s proposals address: (1) releasing details of a drug’s unit price, cost of treatment, and projection on federal spending before FDA approval; (2) annually reporting increases in a drug’s list price; and (3) disclosing true research and development costs for drugs.

- To promote competition, the CSRxP’s proposals address: (1) speeding FDA approval of generic drug applications, especially for lifesaving drugs; (2) reducing drug monopolies by incentivizing competition for additional market entrants; (3) strengthening post-market clinical trials and surveillance; (4) targeting exclusivity protections to truly innovative products; (5) curbing the misuse of Risk Evaluation and Mitigation Strategies; and (6) promoting the uptake of biosimilars.

- To enhance value, the CSRxP’s proposals address: (1) increasing funding for public and private research on drug pricing and value; (2) requiring drug manufacturers to compare cost and outcomes of new versus existing drugs; and (3) expanding value-based pricing in public programs.

The following are links to a summary and the full text of the CSRxP policy proposals.

**AHIP Comment Letter on Risk Adjustment for ACA-Compliant Coverage**

AHIP submitted comments to the Centers for Medicare & Medicaid Services (CMS) on their white paper outlining potential changes to their risk adjustment model for ACA-compliant coverage in the individual and small group markets. Based on feedback from member plans, our comments generally recommend targeted changes to the model that will improve overall accuracy and stability, including:

- Adopting a durational factor into the risk adjustment model to better capture the risk of partial year enrollment;

- Supporting the inclusion of prescription drug data to improve payment accuracy under the risk adjustment model;

- Supporting CMS’ decision to maintain the concurrent model for risk adjustment;

- Safeguarding consumer privacy while preventing the disclosure of plan proprietary and confidential business information under any new data recalibration approaches to update the risk adjustment model—including the proposed re-calibration for the 2019 benefit year that would be based on edge server data submitted by plans;
Recommending that CMS not go forward with the high-risk pooling approach described in the discussion paper; and

Recommending that CMS not adopt changes at this time to the risk adjustment payment transfer formula that are considered in the discussion paper—such as excluding fixed administrative costs in the statewide average premium.