COMMISSIONER OF SECURITIES AND INSURANCE

Troy Downing
Commissioner

Office of the
Montana State Auditor

ADVISORY MEMORANDUM

To: ALL INTERESTED PERSONS

From: TROY DOWNING
Commissioner of Securities and Insurance, Office of the Montana State Auditor

Date: April 14, 2022

2023 Form, Rate, & Network Adequacy Filing Requirements Including Qualified Health Plan Certification

The Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), will continue to perform the plan management functions required for issuers choosing to participate in the Federally Facilitated Marketplace (FFM) in 2023.

This Memorandum provides instructions for filing both on-exchange and off-exchange health plans. Center for Medicare & Medicaid Services (CMS) has issued a 2023 Draft Notice of Benefit Payment Parameters (Proposed Rule), which proposes changes to the payment parameters as described below in the "Items of Note for 2023." (*See* www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023.) This Memorandum's description of the form, rate, & network adequacy filing requirements does not include the changes proposed in the Proposed Rule. To the extent that the finalized 2023 Notice of Benefit and Payment Parameters changes the form, rate, & network adequacy filing requirements described herein, CSI will issue an addendum as needed.

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Due to federal requirements, the timeline for filing plans and rates for 2023 is the same for both qualified health issuers (QHP issuers) and health issuers with no QHPs (non-QHP issuers).

Filing Requirements for Montana	Due Date
Binder, Form, & Network Info Due	May 20, 2022
Rate Filings Due	May 20-June 6, 2022
Initial Rate Transfer to CMS	June 15, 2022
Final day for Issuers to make changes to Binder, Form, and Rates	August 5,2022
CMS Binder Final Deadline	August 17, 2022

ITEMS OF NOTE FOR 2023

1) **System for Electronic Rate and Form Filing (SERFF Required).** All filings must be submitted through the System for Electronic Rate and Form Filing (SERFF). SERFF has made updates to the Unified Rate Review (URR) transfer process. Going forward, all Unified Rate Review Template (URRT) submissions should be completed within SERFF and not directly in the Health Insurance Oversight System (HIOS) URR module. All new filings need to be submitted using the new SERFF to URR Transfer Process. This is done by using the new URRT Tab in SERFF. If an issuer enters their rate submission incorrectly through HIOS instead of SERFF, CMS will be deactivating that submission and notifying the issuer and the state that it must be entered through the SERFF Transfer Process.

2) **Risk Adjustment Transfer Elements Extract (RATEE) File.** As with previous years, the CSI will again be requesting that issuers provide their final RATEE file. The CSI will notify issuers via email with further details.

3) **URRT.** The updated URRT and corresponding URR instructions have been released by CMS and are required for 2023 rate filings. Please see:

   https://www.qhpcertification.cms.gov/s/Unified%20Rate%20Review

4) **Silver Loading Guidance Clarified**. Cost-Sharing Reduction (CSR) plan designs are required by federal law, however, that additional cost is not required be paid with federal funds. If the unfunded cost is distributed to all plans, the CSI agrees the load is unfairly forced upon the insured members who are not eligible for the CSR plans through increased premiums for the non-CSR eligible plan designs. The Commissioner prioritizes consumer protection. Charging unfairly high rates on the non-CSR-eligible plan designs conflicts with the responsibility to ensure that rates are neither excessive nor unfairly discriminatory. As such, the Commissioner expects that issuers will develop rates for Affordable Care Act (ACA) plans that distribute the cost of CSRs only to CSR-eligible plans. Since CSR eligibility requires that a policy be exchange-sold, issuers may consider distributing the burden only to plans that are available on the exchange. Note, however, that all plans sold on the exchange must be sold off-exchange at the same premium rate.

5) **New Actuarial Value (AV) Calculator.** CMS has released a new **AV Calculator** and methodology for 2023 that can be found here:

   https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2023-AV-Calculator-Methodology.pdf

   https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2023-AV-Calculator.xlsm

6) **Reinsurance Program Rate Requirement.** Issuers must include in their filing a report detailing premium amounts with and without taking the reinsurance program into consideration. See Medical Rate Filings Section for more details for 2023.

7) **Defrayal of State Mandated benefits**. The State of Montana is required to defray benefits from HB 291 that added a state mandate requiring coverage for children with hearing loss. The issuers will be required to submit the relevant claims incurred and paid in 2022 to the CSI for review. The CSI will provide additional guidance to the issuers on the process to submit the claims. This applies to issuers in both the individual and small employer market.

   For the 2023 plan year the rate filing will need to reflect the defrayal cost estimated as they did for the 2022 plan year. The Actuarial Memorandum should state the amount the issuer anticipates the state will defray and issuers should follow instructions in URRT on how to annotate benefits in addition to essential health benefits (EHB). This applies to issuers in both individual and small employer market.

8) **CMS Proposed Rule on Discrimination of Benefit Design.** Currently, CMS proposed rule provide that an issuer does not provide a EHB "if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." 45 CFR § 156.125 ("EHB nondiscrimination provision"). With the Draft 2023 NBPP, CMS has proposed to add sexual orientation and gender identity to the list of protected classes in the EHB nondiscrimination provision, as well as other nondiscrimination requirements, including, in part, regulations related to guaranteed availability of coverage under § 147.104; and Exchange standards under § 155.120; and standards of conduct for agents, brokers and web-brokers under § 155.220.

   In addition, CMS identified a number of presumptively discriminatory benefit designs that will not be considered EHBs under § 156.125, including but not limited to limitations on coverage for hearing aids for children 18 and under, routine foot care for diabetics or any other health condition, autism spectrum disorder for children 18 and under, limitation of an EHB for gender-affirming therapy, and adverse tiering related to access to prescription drugs for chronic health conditions. The CSI interprets that the proposed rule allows for issuers to provide justification on why a benefit design may not be discriminatory.

9) **Prescription Drug Tearing.** CMS noted that adverse tiering of prescription drugs has the potential to be in conflict with the EHB nondiscriminatory provision in § 156.125. According to CMS, placing all drugs for a high-cost chronic condition on the highest

formulary tier is a presumed discriminatory design, even when those drugs are costly. Plans and issuers should expect to demonstrate that neutral principles were used assigning tiers to such drugs and that those principles were consistently applied across types of drugs.

10) **Standardized QHP Options.** CMS proposes to require issuers of QHPs in FFM to offer standardized QHP options at every product network type, metal level, and throughout every service area that a non-standardized option is offered. For example, if an FFMF issuer offers a non-standardized gold Health Maintenance Organization (HMO) QHP in a particular service area, that same issuer must also offer a standardized gold HMO QHP throughout that same service area.

11) Changes to Network Adequacy. CMS proposes to evaluate QHPs for compliance with network adequacy standards based on time and distance standards and appointment wait time standards. In addition, for plans that use tiered networks, to count toward the issuer's satisfaction of network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. CMS is collecting from QHPs information on whether providers participating in their network offer telehealth services. For plan year (PY) 2023, this data is for informational purposes only. This does not mean that telehealth services can be counted in place of in-person service access for the purpose of satisfying network adequacy standards. CMS is increasing the ECP (Essential Community Providers) threshold from 20% to 35%, and ECPs have to be contracted within the network tier that results in the lowest cost-sharing obligation for the respective plan's enrollees to count toward the issuer's satisfaction of each element of the ECP standard.

FORM FILINGS

All major-medical health issuers that wish to issue or renew small employer group, individual health insurance coverage, or standalone dental plans must file with the CSI their network information, forms, and binders – including all required documents for policies, certificates or membership contracts and their plan binders containing all required templates for coverage that will be issued on or after January 1, 2023, no later than **5:00 PM MDT on May 20, 2022**. The opportunity for all required filing submissions will open as soon as SERFF allows Binder submissions. **Late filings will not be accepted**.

If a policy form to be used in 2023 has no changes from the approved form for 2022, the issuer may file an attestation certifying that there are no changes in the form. However, any changes to cost-sharing will require a new filing for the Summary of Benefits (SBC), Outline of Coverage (OOC), and Schedule of Benefits (SOB) documents. **Note: new templates must be filed every year, even if there are no changes in the policy language.**

All SBCs and OOCs must be filed at the same time as the policy forms. See CSI's bulletin on SBC's and OOC's, entitled "Federal and State Consumer Disclosures", dated July 6, 2012 here: https://csimt.gov/wp-content/uploads/07062012_FedStateConsumerDisclosures.pdf. All required corrections to forms and templates must be made by the issuer on a continuous basis. The CSI will not use "correction windows." Center Consumer Information and Insurance Oversight (CCIIO) will send all substantive corrections to the CSI BEFORE sending those requested corrections to the health issuer. Please do not make corrections without first receiving approval from the CSI.

Corrections to all rate, network information, form, and binder filings must be finalized by 5:00 PM MDT on August 5, 2022. No exceptions will be permitted.

Prescription Drug Coverage

QHP issuers must comply with the final PY 2023 EHB Crosswalk in setting formulary design. The effective Crosswalk was updated in 2022, to contain 8359 Clinical Drug Components (RXCUIs), representing 1531 chemically distinct drugs, 47 categories and 156 classes for a combination of 169 unique category/class combinations. Additional information is available here:

https://www.qhpcertification.cms.gov/s/Review%20Tools

An issuer's formulary drug list must be displayed on the issuer's website and updated regularly as required by state and federal laws. Formulary lists will be reviewed to ensure assignment of drugs to tiers does not discriminate, as defined in Section 1557 of the ACA.

Issuers may not require that prescription be obtained through a mail order pharmacy, as members must have access to retail pharmacy services.

Issuers must provide for a drug formulary exception process that complies with the federal regulation (see 45 CFR 156.122) and provides for a decision within 72 hours, or 24 hours if an expedited exception request is received. In addition, issuers must follow state law (see Mont. Code Ann. Title 33, Chapter 32) regarding internal and external appeals if the member requests an appeal of an adverse benefit determination on a drug claim.

CMS noted that adverse tiering of prescription drugs has the potential to be in conflict with the EHB nondiscriminatory provision in § 156.125. In order not to discriminate under § 156.125, the issuer's EHB prescription drug benefit design must be clinically based. According to CMS, placing all drugs for a high-cost chronic condition on the highest formulary tier is a presumed discriminatory design, even when those drugs are costly. Plans and issuers should expect to demonstrate that neutral principles were used when assigning tiers to such drugs and that those principles were consistently applied across types of drugs.

Product Withdrawals

If an issuer is discontinuing any products in the individual, small group or large group markets, the issuer must provide the CSI with a list of withdrawn products and the number of members affected by that withdrawal. In addition, the issuer must specify how each of those plans will be "mapped" to a 2023 plan when "auto-renewal" occurs. The CSI will not allow mapping to a lower metal tier without the express written permission of the Commissioner. The mapping information submitted must include a detailed plan comparison between the old plan and the new plan. The detailed plan comparison must be included in the renewal notice to the insured.

Healthcare Co-Ops, Student Health Plans, and Multi-State Plans

While healthcare co-op plans are "deemed" certified as described in the CCIIO/CMS 2023 Letter to Issuers, the CSI will review co-op health plan forms in the same manner as all other health issuers' plan forms are reviewed. All timelines and instructions contained in this Advisory Memorandum apply equally to healthcare co-ops.

Similarly, the CSI will review multi-state plans (MSPs) under contract with the Office of Personnel Management according to the same instructions and timelines outlined in this Advisory Memorandum. MSP issuers are treated as a separate issuer.

Pursuant to federal law, student health plan forms and rates must be filed and reviewed as individual health insurance products. The only distinctions from the individual market allowed are those identified in federal regulations that apply specifically to student health plans. Student health plans must be filed and reviewed by the CSI at least 60 days before they are offered for sale. The student health plan forms and rate filings do not need to follow the URR filing requirements; therefore, a binder filing is no longer required. The submission of forms and rates with supporting documentation are the only documents required to be submitted in SERFF. For more detailed instructions, please contact the CSI.

Stand-Alone Dental Plans

Qualified Stand-alone Dental Plans (SADPs) must file their forms, plan binders and network lists according to the same timelines and instructions that apply to all QHP issuers. Rates should be filed in conjunction with the form and binder filings. Montana's PPO network adequacy laws apply to dental plans. The benefits template will be modified for dental plans as described in the CCIIO/CMS 2023 Letter to Issuers. Each SADPs issuer must specify whether the rates contained in the templates are guaranteed to consumers or will be subject to underwriting.

SADP forms, rates and binders must be filed separately from QHP filings. Dental rates may use geographic rating factors that differ from those used for the medical rates, however, the geographic rating areas used must be the same as those identified for health plans. Dental binders/filings should include all SADPs sold on and off the exchange.

Large Employer Group Insurance

Large employer group insurance issuers must follow the instructions regarding network lists required to be filed annually as well as instructions regarding product withdrawal. Policy forms must be updated as needed to comply with state and federal regulations.

Filing Fee

If you are a health service corporation required to pay a filing fee, please make sure to submit the filing fee for each binder.

MEDICAL RATE FILINGS

Rate filings will only be accepted from May 20-June 6, 2022 and are due by 5:00 PM MDT June 6, 2022. Proposed rate increases will be published on or before CMS' August 17th deadline.

All issuers operating in the Individual and Small Group major medical market must submit the federal Rate Data Template (RDT) (filed in the plan binder) and the URRT, even if issuers do not intend to sell on the FFM.

Reinsurance Program Rate Requirement: Montana has received a Section 1332 State Innovation Waiver allowing the state to implement a reinsurance program (Program) in the

individual market. For all years that the Program is in place (January 1, 2020 through December 31, 2024), and for federal pass-through funding calculation purposes:

- Issuers must include in their filing a report detailing premium amounts with and without taking the reinsurance program into consideration.
- Issuers must submit the “without reinsurance” RDT under a user-created Rate/Rule Schedule Item in the rate filing (the "with reinsurance” RDT will continue to be submitted under the binder filing as required by CMS).
- A separate “without reinsurance” URRT must be submitted under a user-created component on the Supporting Documents tab in the SERFF rate filing. The “with reinsurance” URRT must be submitted under the URRT tab in the SERFF rate filing.

A rate filing that contains the URRT and is separate from the form filing and the plan binder must be filed. Do not duplicate templates submitted in the plan binder (RDT) in the rate filing. Part I (Unified Rate Review Template), Part II (consumer justification narrative) and Part III (actuarial memorandum) of the Rate Filing Justification and all supporting documentation for the rates should be submitted in a separate SERFF rate filing. These files are not part of the plan binder.

There is no required format for Part II. However, for consistency, the document should adhere to the URR instructions including all sections in the order listed (scope and range of the rate increase, financial experience of the product, changes in medical service costs, changes in benefits, and administrative costs and anticipated margins). If there are additional material components of the rate change that do not fit into any of the above sections, please add sections at the end to address them.

Part II serves two purposes – it will be posted in PDF format to the CSI’s website regardless of average or plan-level rate impact (as noted elsewhere in this document), and it will also be posted in PDF in HIOS if any renewing plan within a product has a rate increase of 15% or more.

Although there are not specific CSI instructions for Part II, since the PDF is posted to the CSI website, Part II should discuss not only the HIOS-required change derived by the URRT, but also the actuary’s best estimate of the impact of the rate change on the current insured members as reported in SERFF (note – Part III’s discussion of rate impact should also address both perspectives). Part II should include a header containing the following identifying information:

- Title – Part II Justification for Proposed Rate Increase;
- Issuers name;
- Market segment (individual or small group); and
- Rate effective date.

Additional instructions related to rate filings:

- Geographic rating factor support must include documentation regarding how utilization was removed from the development of the proposed rating factors

- Parts I, II and III of the Rate Filing Justification for ALL individual and small employer group health plans must be completed and submitted in SERFF.

- All filings need to be submitted using the new SERFF to URR Transfer Process. This is done by using the new URRT Tab in SERFF.

- The Company Rate Information and the Rate Review Detail on the Rate/Rule Schedule tab in SERFF must be completed for all filings. The values for rate impact generally should agree with those reported in the URR Parts II and III. Although no determination method of the rate impact is mandated, the CSI requires that support be provided in the rate filing. Please submit this support in SERFF separately from the URR components.

- The URRT, Part II Consumer Justification and Part III Actuarial Memorandum are required to be included in SERFF under the URRT tab in the rate filing. Please do **not** include them as attachments as notes to reviewers, under the Rate/Rule Schedule items tab or under the Supporting Documents tab.

- Tobacco use rating is not allowed for anyone under the age of 21. This applies to policies sold both on and off the exchange.

- Individual Market health plan rates, both on and off the exchange, must be guaranteed for the calendar year beginning January 1, 2023. No interim rate revisions will be permitted.

- Rates for the Small Group Market, both on and off the exchange, must be filed for the entire 2023 calendar year. The initial rates for 2023 may be submitted with quarterly trend factors for the entire year. Subsequent quarterly rate revisions will be accepted but as outlined in the URR instructions, must be submitted at least 105 days prior to the effective date of the rate change and finalized at least 45 days prior to the effective date.

- Small group rates are allowed to be composite billed in Montana. Issuers must indicate this for each plan on the Benefit Package tabs in the Plan and Benefit template. CMS has given the CSI authorization to require accurate responses on the Plan and Benefit template. An indication of to which plans composite billing applies should also be included in Part III under the Effective Rate Review Information section. When quoting for dual options, the composite rates for each plan should be calculated using the entire census.

- Rates entered into the RDT should have no more than 2 decimal places in order to avoid validation errors later in the review.

- As in past years, the components of the AV Pricing Values, as described in 45 CFR 156.80(d)(2), must be documented, and supported in the filing. No template will be provided for this information; it is recommended that these components be summarized in a table in Part III.

- Based on the CMS instructions for Parts I & III, there are two distinct subcomponents to the AV and cost-sharing design component described in §156.80(d)(2)(i) – cost-sharing design and utilization differences as a result of the

design. Attention will be paid to thejustification for the assumed utilization differences.

- The Market-Wide Adjusted Index Rate (MAIR) must be fully supported in the Part III and equal to that reported on the URRT.

- Plan Adjusted Index Rate (PAIR) components need to be supported in Part III. Issuers must report Administrative Expenses, Taxes and Fees, and Profit and Risk Load and detailed support must be provided in Part III. Additionally, issuers are required to provide an explanation of how these modifiers are developed and applied to the MAIR to derive the PAIR.

- The CSI requires documentation of the MLR development, including support for each component (including plan-level variation), with the specific requirement of reconciliation of the MLR Exchange User Fees with that on the URRT.

- As noted in the CMS Part III instructions, the actuary may qualify his or her opinion to state that Part I does not demonstrate the process used to develop the rates, but this does not negate the requirement that the assumptions used to develop the rates be accurately captured in Part I and thoroughly documented and supported in Part III.

If an issuer wishes to identify any part of the rate filing as confidential, it must first be identified as a "trade secret." Do not mark the entire filing as a "trade secret." Reasons for a trade secret determination must be specific for each item of information in the rate filing. Each item that properly deserves trade secret status must be clearly identified and accompanied by an affidavit from an authorized company representative identifying specific reasons under Montana law that legally justifies the company's claim for trade secret designation for that particular information. The Part II justification for a filed rate increase must be published pursuant to federal law and cannot be designated a trade secret. The Commissioner or his designee will review and make the ultimate determination as to trade secret status. After the rate review process is complete, all parts of the rate filing will be treated as public unless trade secret status has been granted by the Commissioner. Please contact the CSI for more detailed instructions if you have questions.

Rate justifications, as required by applicable federal regulations and contained in Part II of the URR, must be submitted with the initial rate filing and for all subsequent rate increases, no matter how large or small the increase. The Part II rate justification is the consumer- friendly explanation/justification for the rate. Rate justifications will be posted on the CSI's website immediately after they are received for all health plans sold in Montana, both on and off the exchange.

GUIDANCE IN THE CCIIO/CMS 2023 LETTER TO ISSUERS

All health issuers should carefully review the CCIIO/CMS 2023 Letter to Issuers in the Federally-facilitated Exchanges that is posted on the CMS website; please see

https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf.

NETWORK ADEQUACY

To assess compliance with state and federal network adequacy laws for Preferred Provider Organization (PPO) and "PPO-type" health plans offered in 2023, health, vision, and dental issuers (including non-QHP issuers), must provide the CSI with a completed healthcare provider template for each health, vision, and dental plan offered for sale in Montana. If an issuer uses a different network for different health plans, all networks must be properly identified and submitted separately.

All networks must be resubmitted each year by all health, dental, and vision issuers, even if there are no other changes to the policy form.

Plans defined under Mont. Code Ann. Title 33, Chapter 31 as Health Maintenance Organizations (HMOs) must seek a network adequacy determination through the Montana Department of Public Health and Human Services (DPHHS) pursuant to Title 33, Chapter 36.

HMO issuers must submit to the CSI the network adequacy determinations received from DPHHS. However, due to federal ACA requirements and QHP certification requirements, issuers who are filing HMO health plans must also submit the relevant CSI network adequacy templates to the CSI. As the plan manager, the CSI must review the adequacy of the network pursuant to federal standards.

The CSI's healthcare provider template submitted must report the following provider types:

- advanced practice registered nurses,
- chiropractors,
- licensed addiction counselors,
- licensed clinical professional counselors,
- licensed clinical social workers,
- licensed marriage and family therapists, naturopaths, optometrist, physical therapists, physician assistants, physicians, and psychologists.

The CSI uses a list of facilities to determine network adequacy for hospitals and other types of facilities. This list includes hospitals, critical access hospitals, residential treatment centers, surgical centers and chemical dependency treatment centers. The CSI's facilities template must be submitted for each network.

Excel workbook templates, which include instructions detailing the required information and format for submitting the in-network healthcare providers, facilities, pharmacies, and essential community providers, can be found on the CSI's website at www.csimt.gov and in the State filing instructions on SERFF.

Stand-alone dental and vision plans do not need to complete and submit a facility template or essential ECP template at this time; only the CSI healthcare provider template must be submitted.

If an issuer requires use of "preferred pharmacies" or offers better pricing for prescription drugs obtained at a preferred pharmacy, the CSI's pharmacy template must be completed and submitted.

Once finalized, the master list of healthcare providers used by the CSI to review healthcare provider networks for 2023 will be available upon request.

All QHP issuers must include ECPs in their networks. ECPs are defined in federal law as those providers that serve low-income and medically underserved individuals. ECPs must be contracted within the network tier that results in the lowest cost-sharing obligation for the respective plan's enrollees to count toward the issuer's satisfaction of each element of the ECP standard. Note: the list of ECPs published by CMS for Montana maybe incomplete. The federal network adequacy standard requires only 35 percent of all ECPs to be "in network"; however, that percentage is not adequate to meet the requirements of Montana law. QHP issuers should strive to meet a standard that includes at least 80 percent of all ECPs on the CSI's ECP template. If a health plan is unable to meet that standard, the CSI will review the ECP network and make a determination as to adequacy based on the Administrative Rules of Montana 6.6.5901, et seq.

If a QHP issuer does not include all Indian health care providers in its networks, it must submit proof, in the form of an attestation, that a provider contract was offered to and refused by the Indian provider. The attestation must outline its attempts to contract with the Indian providers.

Rate, form and template reviews cannot be completed until the adequacy of the network is determined and approved by the Commissioner. Additionally, QHP issuers must also complete and submit the required CMS network and ECP templates.

TECHNICAL ASSISTANCE FOR ISSUERS & CONSUMER COMPLAINT HANDLING

The CSI will continue to provide technical assistance to issuers throughout the form approval/QHP certification recommendation process. All consumer complaints regarding issuers, including QHP issuers, will be handled by the CSI. Consumer complaints regarding issuers received by the FFM through its toll-free phone number, the FFM website, or in any other manner, will be forwarded to the CSI for resolution. The CSI will track complaints concerning QHP issuers and forward to the FFM when requested.

CONTACT INFORMATION

If you have questions, please contact the following people:

Forms and Binders: Karen Beyl (kbeyl@mt.gov)

Network Adequacy: David Dachs (ddachs@mt.gov)

Rates: Ashley Perez (aperez@mt.gov)

This advisory memorandum is informational only and does not enlarge, delimit, or otherwise modify any requirements of applicable law or in any way limit the authority of CSI under applicable law. CSI encourages interested persons to consult with independent legal counsel for guidance on the application of law to any particular circumstances.