COMMISSIONER OF SECURITIES AND INSURANCE
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Office of the
Montana State Auditor

ADDENDUM TO
APRIL 14, 2022 ADVISORY MEMORANDUM

To: ALL INTERESTED PERSONS

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

Date: May 13, 2022

Updated Requirements for Qualified Health Plan (QHP) Certification related to the 2023 Final Notice of Benefit Payment Parameters

The Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), issues this Addendum to the Advisory Memorandum, dated April 14, 2022, titled, "2023 Form, Rate, & Network Adequacy Filing Requirements including Qualified Health Plan Certification," which summarized proposed provisions set forth in the Draft Notice of Benefit Payment Parameters (Proposed Rule) issued by the U.S. Department of Health and Human Services (HHS) through the Centers for Medicare & Medicaid Services (CMS). HHS/CMS issued the 2023 Final Notice of Benefit Payment Parameters (Final Rule), on April 28, 2022. This Addendum summarizes any provisions proposed but not finalized and highlights certain other clarifications in the Final Rule.

Neither the April 14 Advisory Memorandum nor this Addendum exhaustively discuss QHP certification requirements, or all new requirements set forth in the Final Rule. Issuers should independently review the Final Rule and related publications. Please see the following links for specific information:

Letter to Issuers: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf

Final Rule Display: https://www.cms.gov/files/document/cms-9911-f-patient-protection-final-rule.pdf

Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet

NONDISCRIMINATION POLICY

Nondiscrimination Policy Under § 156.125

The Final Rule provides that, under 45 CFR § 156.125(a), an issuer does not provide Essential Health Benefits (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, qualify of life, or other health conditions; and that a nondiscriminatory benefit design that provides EHB is one that is clinically based. This is referred to in the Final Rule as the "refined EHB nondiscrimination policy." Although the Proposed Rule provided that the refined EHB nondiscrimination policy would be applicable 60 days after the Proposed Rule was finalized, the Final Rule states that the policy will be applicable starting on the earlier of January 1, 2023 or upon renewal of any plan subject to the EHB requirements.

Presumptively Discriminatory Benefit Designs

The Final Rule clarified that the refined EHB nondiscrimination policy applies only to services covered as EHB under a plan. Regarding State-mandated benefits, the Final Rule clarified that a benefit required by a State enacted on or after January 1, 2012 is generally not considered an EHB pursuant to 45 CFR § 155.170. Consequently, a State-required benefit enacted on or before December 31, 2011 is considered an EHB pursuant to § 155.170, and issuers covering that benefit would therefore be required to comply with the nondiscrimination standards when including that benefit in their plan designs.

Sexual Orientation and Gender Identity. As noted in paragraph 8 of CSI's April 14 Advisory Memorandum, the Proposed Rule explicitly identified and recognized discrimination on the basis of sexual orientation and gender identity. In the Final Rule, HHS did not address this proposed language, explaining it would be more prudent to address the nondiscrimination proposals on this basis at a later time to ensure that HHS is consistent with the policies and requirements that will be included in HHS's current rulemaking under Section 1557 of the Affordable Care Act (ACA). As a result, HHS did not address or provide a final example of a presumptively discriminatory benefit design related to gender-affirming care.

Limitations on hearing aids for children. In finalizing the presumptively discriminatory benefit design example related to limitations on coverage for hearing aids for children, the Final Rule specifically provides that if this benefit is covered pursuant to a State mandate adopted on or after January 1, 2012, it is not considered an EHB and would therefore not be subject to the policy reflected in the example.

Montana's requirement for hearing aid coverage for children 18 or younger was enacted in 2021. (*See* § 33-22-128, MCA.) Therefore, this State-mandated benefit is not considered an EHB, and the refined EHB nondiscrimination policy does not apply to this benefit design.

Limitations on coverage for Autism Spectrum Disorder (ASD). The Final Rule concludes that a plan that covers diagnoses and treatment of ASD as an EHB but limits such coverage in its plan benefit design based on age is presumptively discriminatory under § 156.125 unless the limitation is clinically based. Montana's requirement that issuers cover diagnosis and treatment of ASD for a covered child 18 years or younger was enacted in 2009. (*See* §§ 33-22-515 and 33-22-703, MCA.) In turn, Montana's EHB-benchmark plan includes an ASD benefit, but limits coverage of Applied Behavior Analysis (ABA) to members under age 19.

Coverage of diagnosis and treatment of ASD is an EHB because it is a benefit required by the State enacted before December 31, 2011. Because coverage of this EHB is limited on the basis of age (i.e., ABA therapy only covered for members under age 19), this EHB-benchmark benefit design qualifies as presumptively discriminatory under the finalized examples set forth in the Final Rule, unless the limitation is clinically based.

Guidance for EHB-benchmark benefit designs considered presumptively discriminatory. The Final Rule does not require States to go through the formal process of updating EHB-benchmark plans solely for the purpose of removing discriminatory benefit designs. HHS clarifies that it will not consider State EHB-benchmark plan designs to be out of compliance with 45 CFR § 156.110(d) or § 156.111(b)(2)(v) if the State provides guidance or otherwise directs issuers to comply with the refined nondiscrimination standards, notwithstanding any aspects of the EHB-benchmark plan that are not consistent with the refined nondiscrimination standards.

Pursuant to the Final Rule, CSI directs issuers that plans providing benefits that are substantially equal to the EHB-benchmark provision on ASD must not replicate that benefit design by limiting ABA therapy to children under 19, unless they show such a limitation is clinically based. CSI directs issuers to comply with HHS's refined nondiscrimination standards, notwithstanding aspects of the EHB-benchmark plan provision related to ASD.

Adverse Drug Tiering. The Final Rule provides clarification that the example of a presumptively discriminatory benefit design related to adverse tiering of prescription drugs does not apply to benefits that are not EHB. The Final Rule also clarifies that HHS is not prohibiting issuers from considering drug cost in setting drug formularies; but rather HHS believes it is prudent for a plan to consider a drug's cost in determining on which tier to place a particular drug. Under the finalized example, formularies are presumptively discriminatory when all or a majority of drugs for a particular condition are placed on a high-cost prescription drug tier to discourage enrollment by those with that condition.

NETWORK ADEQUACY

Reviews of network adequacy for PY 2023 will be on a dual track: one track through CMS for QHP certification for compliance with the new federal QHP network adequacy requirements and one track through CSI for insurance policies or subscriber contracts for compliance with Montana network adequacy standards. As explained in detail below and in the Final Rule, the Final Rule sets forth new QHP network adequacy standards for provider networks of QHPs offered through FFEs. Issuers seeking QHP certification for PY 2023 must submit network information to CMS in accordance with the Final Rule and Letter to Issuers (links provided above).

Federal QHP Network Adequacy Standards

CMS will review federal QHP network adequacy standards for Montana issuers seeking QHP certification for PY 2023.

The Final Rule provides that, starting in PY 2023, CMS will evaluate QHPs for compliance with network adequacy standards based on time and distance standards. Starting in PY 2024, CMS will also evaluate QHPs for compliance with appointment wait time standards.

CMS clarified it will not evaluate QHP network adequacy in FFE states performing plan management functions that elect to perform their own reviews of plans seeking QHP certification in their state, so long as the state applies and enforces quantitative network adequacy standards that are at least as stringent as the federal network adequacy standards established for QHPs. CSI has **not** elected to review the federal QHP network adequacy standards for PY 2023. Accordingly, for PY 2023, CMS will evaluate the federal network adequacy standards for Montana issuers seeking QHP certification. The finalized Letter to Issuers (link provided above) provides CMS's standards for time and distance (and appointment wait times applicable for PY 2024). In all FFE states, like Montana, issuers will be required to submit their network adequacy data to CMS via the Essential Community Provider/Network Adequacy (ECP/NA) template.

With regard to time and distance standards, taxonomy codes that crosswalk into each individual provider and facility specialty type are listed in the Taxonomy Codes tab of the ECP/NA template so that issuers know which providers to include in the respective individual and facility specialty categories. CMS's Instructions and FAQs will provide more detail on the network adequacy review process and what issuers need to submit to HHS to demonstrate satisfaction of network adequacy standards.

If it is determined that an issuer does not meet one of the time and distance standards, the issuer can: (1) contract with more providers to come into alignment with the standards and re-submit an updated ECP/NA template; or (2) submit a completed Network Adequacy Justification Form. The justification process will require issuers that do not yet meet the time and distance standards to detail: the reasons that one or more time and distance standards were not met; the mitigating measures the issuer is taking to ensure enrollee access to respective provider specialty types; information regarding enrollee complaints regarding network adequacy; and the issuer's efforts to recruit additional providers.

Montana Network Adequacy Standards

CSI will review networks for insurance policies or subscriber contracts for compliance with Montana network adequacy standards for PY 2023.

Although CSI has not elected to review the federal QHP network adequacy standards for PY 2023, CSI maintains its plan management status with respect to all other areas of QHP certification. In addition, the federal QHP network adequacy standards do not preempt or replace Montana network adequacy standards or filing requirements set forth in Title 33, Montana Code Annotated. Issuers in Montana seeking QHP certification must comply with the federal network adequacy standards, in addition to the Montana network adequacy standards.

CSI will review networks for insurance policies or subscriber contracts issued or delivered in Montana. CSI will use the templates and processes described in the April 14 Advisory Memorandum as used in past years, **except for** the Montana-specific ECP template. Issuers shall use and submit those network templates, excluding the Montana-specific ECP template, to CSI for review. The deadline to submit networks to CSI for review under the Montana adequacy standards is May 20, 2022, as stated in the April 14 Advisory Memorandum.

Tiered Networks

As noted in paragraph 11 of the April 14 Advisory Memorandum, the Proposed Rule included language that, for plans using tiered networks, to count toward the issuer's satisfaction of the network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. After considering commenter concerns that the policy could unduly restrict plan network designs and innovation, HHS did not finalize this policy.

Telehealth Reporting

The Final Rule requires all issuers seeking certification of plans to be offered as QHPs through the FFEs to submit information about whether network providers offer telehealth services. This requirement is applicable beginning with the QHP certification cycle for PY 2023 and will be used for informational purposes. The Final Rule confirms that issuers should not construe this proposal to mean that telehealth services could be counted in place of in-person service access for the purpose of network adequacy standards.

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.