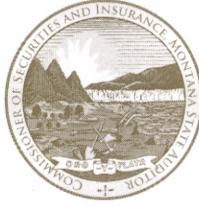


COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER



OFFICE OF THE MONTANA
STATE AUDITOR

ADVISORY MEMORANDUM

TO: HEALTH INSURERS INTENDING TO ISSUE OR RENEW MAJOR MEDICAL
HEALTH INSURANCE IN 2016

FROM: Monica J. Lindeen, Commissioner of Securities and Insurance

DATE: March 18, 2015

2016 HEALTH PLAN FORM FILINGS, INCLUDING RECOMMENDATIONS REGARDING QUALIFIED HEALTH PLAN CERTIFICATION

The Montana State Auditor, Office of the Commissioner of Securities and Insurance [CSI] is the marketplace plan manager for the State of Montana and will be performing the plan management functions required for insurers' participation in the federally facilitated marketplace (FFM), along with its regular function to approve forms, templates, network adequacy and review rates for all health plans sold in Montana. My goal is to make health plan regulation as efficient and streamlined as possible for health insurers and thereby reduce costs and complications and to create a level playing field in Montana. This memorandum provides instructions for on and off-exchange health plans. The timeline for filing plans and rates for 2016 is the same for qualified health plan issuers (QHP issuers) and issuers that have no QHPs (non-QHP issuers) because of requirements placed on all health insurers by new federal regulations that require QHP and non-QHP rate filings to follow the same deadlines. These instructions, including the timeline, apply to individual and small employer group health insurance. The CSI is the primary regulator for all health insurance products sold in Montana.

By operation of federal law, in 2016 the definition of small employer group size changes to 1 to 100. In addition, employee choice must be offered in the SHOP.

TIMELINE FOR FILING

All major medical health insurers that wish to issue or renew small employer group or individual health insurance coverage must file with the CSI their forms—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, 2016, no later than **May 15, 2015, by 5:00 PM MST**. The opportunity for filing binders containing the required templates will open on April 15, 2015. However, the CSI encourages all issuers to file policy forms, amendments to policy forms, membership booklets and other non-template plan documents as soon as possible and well before the May 15th filing deadline for binders. Rate filings and network information must also be filed by May 15th. **Late filings will not be accepted.** Pursuant to federal law, new QHP plan filings in the individual market cannot be accepted after May 15, 2015; no exceptions. New templates must be filed even if the policy form has not changed. The uniform rate review template (URRT) must be used and placed in a separate rate filing.

If a policy form that will be used in 2016 has no changes from the approved form for 2015, the issuer may file an attestation certifying that there are no changes in the form. However any changes to cost-sharing will trigger a new filing for the Summary of Benefits and Coverage (SBC), outline of coverage (OOC) and schedule of benefits documents.

All SBC and OOC documents must be filed at the same time as the policy forms. See the CSI bulletin on SBC's and OOC's, entitled "Federal and State Consumer Disclosures" dated July 6, 2012, on the CSI website: www.csi.mt.gov For the 2016 plan year, the CSI is requiring OOC's and SBC's to be filed separately for each specific health plan (each specific cost-sharing plan design.) No "bracketed" SBC's or OOC's will be accepted. Small employer group and individual health plans must be submitted in separate filings and binders. Correspondence related to the binder must be attached to the binder filing.

The CSI's initial review of forms and templates will be completed by July 9, 2015, and all rate, network, form, and binder filings must be fully and finally approved by **5:00 PM MST on August 24, 2015**. No exceptions will be permitted.

CSI will conduct the preliminary review for qualified health plan (QHP) certification and make a recommendation to the FFM. All issuers must file their binders and other required documents in the State Electronic Rate and Form Filing system (SERFF). For 2016, QHP issuers must also file their binders in HIOS no later than May 15, 2015. However, because Montana is a plan management state, CCIIO will not do substantive reviews on binders submitted until after July 10th. After that date, CCIIO will send all substantive corrections to CSI BEFORE sending those requested corrections to the issuer. Please do not make corrections without first seeking permission and approval from CSI to make those corrections through SERFF.

New or amended health plans may not be marketed or offered for sale until all parts of the CSI review and approval process are complete.

Guidance in the FFM's Letter to Issuers

All filers should carefully review the Letter to Issuers for 2016 that is posted on the CMS website. That document contains detailed guidance regarding QHP certification, as well as other important federal guidance for health plans in general. The CSI seeks to promote a level playing field inside and outside the exchange to the greatest extent possible at all times.

Except as noted here, the CSI will review health plans that will be sold on the FFM and outside the FFM according to the guidance issued in that letter and the requirements of Montana law and federal law. Throughout this process, the CSI continues to seek voluntary compliance with the minimum requirements of federal law that are legally applicable to issuers in Montana. If voluntary compliance is not achieved, the CSI will notify CMS for follow up and enforcement.

The process for meeting FFM expectations regarding QHP accreditation, benefit design, review for non-discrimination and meaningful difference, annual maximum out-of-pocket and other topics is outlined in the issuer letter. All health plans will be reviewed for possible discriminatory benefit design. Non-discrimination attestations from all health insurers must be submitted to the CSI through State Electronic Rate and Form Filing system (SERFF). Montana does not have any state specific benefit mandates that go beyond the essential health benefit categories.

Use of SERFF Required

All filings must be submitted through SERFF. Please check the SERFF website for information and instructions about how to use SERFF.

All major medical health insurance forms must be filed through SERFF, even if those health plans are offered only in the market outside the FFM. The data templates for benefits and rates must be completed for all individual and small employer group health plans, even if the plan is not seeking QHP certification (except the Administrative Data Template is not required for non-QHP issuers). New templates for 2016 must be filed even if no changes were made to the underlying policy forms. These templates are only available through the SERFF system. General instructions to filers in Montana will be provided on Montana's state page in SERFF—including any updates to these instructions. Please check SERFF on a regular basis for important general information, as well as specific information about your company's filings.

Rate Review—separate rate filing required

All insurers operating in the individual and small employer group major medical market must submit the federal rate data templates (contained in the plan binder) and the URRT, even if they do not intend to sell in the FFM. 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 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.

With regard to the pending matter in the U.S. Supreme court, until King vs Burwell is decided, the assumptions regarding enrollment distributions and underlying morbidity used in pricing should reflect the current status quo--advanceable premium tax credits will be available on the Montana FFM in 2016.

When filing small employer group rates and forms, please note the change in group size that is scheduled to go into effect in 2016 pursuant to specific provisions of the ACA. In addition, note that there are significant changes to the actuarial value (AV) calculator that may trigger cost-sharing changes that will need careful consideration.

Other instructions related to the rate filing are as follows:

- Geographic rating factor support must include documentation regarding how utilization was removed from the development of those geographic rating factors.
- Pursuant to federal regulations, Parts I-III of the Rate Filing Justification for ALL individual and small employer group health plans must be completed and submitted to both CMS and the state insurance regulator in HIOS and SERFF, even if the state is an effective rate review state.
- The rate plan information and R2D2 must be completed for all rate filings. Any correspondence related to information contained in the rating filing must be filed as part of the rate filing.
- Rates entered into the rate filing or plan binder by the issuer should have no more than 2 decimal points in order to avoid validation errors later in the review.
- Smoking rate ups are 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, 2016. No interim rate revisions will be permitted.
- Rates for small employer group health plans, both on and off the exchange, must be filed for the entire calendar year of 2016. The initial rates for 2016 may be submitted with quarterly trend factors for the entire year. Subsequent quarterly rate revisions will be accepted, but they must be submitted 60 days in advance of use,

as outlined in Mont. Code Ann. 33-22-156. As in past years, it is required that the components of the AV Pricing Values, as described in 45 CFR Part 156, §156.80(d) (2), be documented and supported in the filing. It is recommended that these components be summarized in a table in the Part III section.

- It should be noted that, based on the CMS instructions for Parts I & III, there are three distinct subcomponents to the AV and cost-sharing design component described in § 45 CFR 156.80(d)(2)(i) – cost-sharing design, utilization differences as a result of the design, and any adjustment for tobacco surcharge. Particular attention will be paid to the justification for the assumed utilization differences.
- As noted in the CMS Part III instructions, it is allowable for the actuary to qualify their 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 “confidential”. 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 a separate affidavit from an authorized company representative who identifies specific reasons under Montana law that serve as a legal justification for the company to seek a trade secret designation for that particular information. The Part II justification for a rate increase must be published pursuant to federal law and cannot be designated a trade secret. The Commissioner or her designee will make the final agency 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 as been granted by the Commissioner. 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 URRT, 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. Those rate justifications will be posted on the CSI website immediately after they are received for all health plans sold in Montana, both on and off the exchange.

The geographic rating areas set for 2015 will remain the same in 2016.

Technical Assistance for Issuers & Consumer Complaint Handling

The CSI will provide technical assistance to health insurers throughout the form approval/QHP certification recommendation process, as it always has. All consumer complaints about insurers, including QHP issuers, will be handled by the CSI. Consumer complaints about insurers that are 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 them to the FFM when requested.

NETWORK ADEQUACY

Network information must still be supplied for all “PPO type” products, even if there are no other changes in the policy forms in 2016. Plans that are defined under Chapter 31 as “HMO” plans must seek a network adequacy determination through the Montana Department of Public Health and Human Services (DPHHS). However, because of requirements related to federal ACA requirements and QHP certification requirements, issuers who are filing HMO health plans must also submit these provider lists to the CSI, as well as the network template form, even though network work adequacy is governed for HMO products under Mont. Code Ann., Title 33, Chapter 36. That information will be kept on file for HMO products for certification and enforcement purposes. HMO issuers must also submit to CSI the network adequacy determinations received from DPHHS.

The healthcare providers list must be submitted in an Excel workbook with an .xlsx file extension. The following categories of healthcare providers must be submitted in separate Excel worksheets within the Excel workbook: advanced practice registered nurses, chiropractors, dentist, licensed clinical professional counselors, licensed clinical social workers, naturopaths, optometrist, physical therapists, physician assistants, physicians, and psychologists. Cardiologists, primary care physicians, ob/gyns and oncologists must be specifically identified in the provider specialty column of the physician list.

A sample Excel workbook with the required information and format for submitting the in-network healthcare provider list can be found on the CSI website at www.csi.mt.gov. The Excel worksheets must be named as shown in the sample. The file won't be processed if the worksheet names are changed. All Excel worksheets are located on and must be submitted through SERFF. All Excel worksheets have been updated for 2016. Issuers must use the new worksheets.

The following information must be provided for each contracted healthcare provider in the applicable Excel worksheet: the location (city, state, and zip code), the Montana license number as issued by the Montana Department of Labor, the provider type, any identified specialty (if available), NPI number must also be included. If you do not know the NPI for your provider, contact the provider to acquire it. If a provider does not have an NPI, enter **000000000 (10 digits)** in the NPI field. If the company's network includes access to providers that are in the network via contracts the company has with other networks the name of the network that the provider has a signed contract with must be reported in the column named “Contract Network”. If a healthcare provider has more than one location, that healthcare provider should be listed for each location in separate rows in the Excel worksheet.

Only providers that are actively practicing medicine may be included. Companies must eliminate providers with an inactive or “on probation” license status as these will not be included when calculating the network adequacy percentage. The column names in the Excel worksheets must not be changed. Also ensure that ALL worksheets in the Excel workbook are not shared and not protected. Include the Company Name, Network Name (if more than one), and the date in the file name. Example: ABC Insurance-Choice NetworkProviders-4-11-15. If the file submitted does not meet the above criteria, it will be rejected. The master list of healthcare providers used by the CSI to review healthcare provider networks for 2016 is available upon request.

The CSI is using 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, surgi-centers and chemical dependency treatment centers. The master facilities list must be submitted in an Excel workbook. The network adequacy master facilities list workbook can be found on the CSI website at www.csi.mt.gov . The Excel workbook contains the complete list of facilities being used in the evaluation of the network. When completing the master facilities list worksheet place a "Y" in the column, with the heading "In Network", to indicate yes; the facility has been contracted and is in network. Place an "N" in the column, with the heading "In Network" of the Master Facilities List worksheet to indicate, “No, the issuer has not contracted with the facility to be in network.” Do not add other facilities (such as labs and MRI centers) that are not on the list at this time. Do not change the worksheet format. Also ensure that the worksheet in the Excel workbook is not shared and not protected. Include the Company Name, Network Name (if more than one), and the date in the file name. Example: ABC Insurance-Choice Network Facilities-4-11-15. Stand-alone dental and vision plans do not need to complete and submit a facility list at this time; only the in-network healthcare provider list must be submitted.

All QHP issuers must include essential community providers (ECPs) in their networks. ECPs are defined in federal law as those providers that serve low-income and medically underserved individuals. The list of ECPs published by CMS for Montana is incomplete. The complete list is posted on the CSI website. The list will be updated in April 2015 to reflect some changes in the federal list and to indicate where different names have been used for the same facility. The federal network adequacy standard requires only 30 percent of all ECPs to be “in network” and 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 published list. If a health plan is unable to meet that standard, CSI will review the adequacy of the ECP network and make a determination on a case-by-case basis. The ECP list includes county health departments that offer immunizations. In some counties, the county health department is the only medical provider that offers immunizations. If an issuer encounters difficulties when contracting with county health departments, please contact the CSI for further instructions.

If a QHP issuer does not include all Indian health care providers in its networks, it must submit proof that a provider contract was offered to and refused by the Indian provider. If a QHP does not have all Indian Health Services (IHS) providers in its network by the time it files its provider lists it must include an attestation that outlines its attempts to contract with IHS providers.

The CSI ECP list must be submitted in an Excel workbook. The ECP list workbook can be found on the CSI website at www.csi.mt.gov. The Excel workbook contains the list of ECPs used in the evaluation of the network. When completing the ECP list worksheet place a "Y" in the column, with the heading "In Network", to indicated yes; the ECP has been contracted and is in network. Place an "N" in the column, with the heading "In Network" of the ECP List worksheet to indicated no; the issuer has not contracted with the ECP to be in network. Do not add other ECPs that are not on the list at this time. Do not change the worksheet format. Also ensure that the worksheet in the Excel workbook is not shared and not protected. Include the Company Name, Network Name (if more than one), and the date in the file name. Example: ABC Insurance-Choice Network ECP-4-11-15.

If an issuer requires insureds to use "preferred pharmacies" to obtain prescription drugs, please submit that list to the CSI as well, in an Excel format as an attachment to the SERFF filing. Mail order pharmacies should be included in that list. If the plan requires "specialist" pharmacies to be used in certain circumstances, those types must be listed also and identified specifically.

Health plans that are determined to have an "inadequate" network are subject to a maximum 25 percent reimbursement differential as applied to the consumer's cost-sharing. An explanation of the formula used by CSI to determine the 25 percent differential allowed under Mont. Code Ann. § 33-22-1706 is available upon request. The CSI will determine if the differential is 25 percent or less after the appropriate information has been submitted. If a network of healthcare providers or dental providers is determined by the Commissioner to be a "non-viable network," that insurer must issue a plan that does not use a network—in network and out of network cost sharing must be the same.

Pursuant to federal guidance and Montana law, provider directories must be complete and transparent. Provider directories must be prominently displayed on the insurer's website, and there may not be "log in" requirements that act as a barrier to transparency—such as a membership number requirement. In addition, ALL in network providers and provider types must be included, even those that some insurers consider "invisible," such as radiologists and anesthesiologists. The CSI will be performing accuracy checks on all provider directories after the approval and certification process is complete for 2016.

Please submit all healthcare provider, facility, pharmacy (if applicable) and ECP files through SERFF. Technical questions about completion of the Excel workbooks can be

sent to David Dachs at ddachs@mt.gov. All other questions regarding Montana's network adequacy requirements can be sent to Christina Goe at cgoe@mt.gov. Your rate, form and template review cannot be completed until the adequacy of your network is determined and approved by the Commissioner. Additionally, companies must also complete and submit any of the required CMS network and ECP templates.

PRESCRIPTION DRUG PLANS

Formulary drug lists must be transparent in the same way as provider directories. The drug formulary information must be prominently displayed on the insurer's website, and there may not be "log in" requirements that act as a barrier to transparency—such as a membership number requirement.

All QHP issuers must have one plan design that includes flat dollar, pre-deductible copayments for prescription drugs. All cost sharing for prescription drugs must be reasonably graduated and proportionately related in all tier levels. In addition, all prescription drug tiers will be carefully reviewed to ensure that the assignment of "tiers" to particular drugs was not done in a way that resulted in a discriminatory practice.

Pursuant to federal guidance, issuers may not require that all prescriptions be obtained through a mail order pharmacy in order to be covered.

HEALTHCARE CO-OPS, STUDENT HEALTH PLANS, and MULTI-STATE PLANS

Even though healthcare co-ops are "deemed" certified, as described in the Letter to Issuers, the CSI will review co-op health plan forms in the same way as all other health insurers—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 (OPM) according the same instructions and timelines outlined in this memorandum. MSP insurers will be notified by CSI if there is an alteration in these instructions that applies to them.

Pursuant to federal law, student health plan forms and rates must be filed and reviewed as individual health insurance products. The only differences from the individual market that will be allowed are those that are identified in federal regulations that apply specifically to student health plans. Student health plan forms rates must be filed with and reviewed by the CSI at least 60 days before they are offered for sale. For more detailed instructions, please contact the CSI.

STAND-ALONE DENTAL PLANS

Qualified Stand-alone dental plans (QDPs) must file their rates, forms, plan binders and network lists according to the same timelines and instructions that apply to all QHP

issuers. Montana's PPO network adequacy law applies to dental and vision plans. The benefits template will be modified for dental plans as described in 2016 FFM letter to issuers. Each QDP issuer must specify whether or not the rates contained in the templates are guaranteed to consumers or will be subject to change (underwriting).

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

CONCLUSION

There will be an all-filer conference call/meeting on March 24, 2015, at 10:30 AM MST. You may attend the meeting in person at the CSI offices in Helena or call the following phone number, 712-432-1212; access code: 236-818-232 to join the conference call. This will be your opportunity to ask questions about this process.

Before and after that call, if you have questions that cannot be answered through the SERFF process, please contact Rosann Grandy, Forms Bureau Chief, or Christina Goe, General Counsel at 406-444-2040 or rgrandy@mt.gov or cgoe@mt.gov .