

COMMISSIONER OF SECURITIES & INSURANCE

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COMMISSIONER



OFFICE OF THE MONTANA
STATE AUDITOR

ADVISORY MEMORANDUM

TO: HEALTH INSURERS INTENDING TO ISSUE OR RENEW MAJOR
MEDICAL HEALTH INSURANCE IN 2018

FROM: Matt M. Rosendale, Commissioner of Securities and Insurance

DATE: April 5, 2017

2018 REQUIREMENTS HEALTH PLAN FORM AND RATE FILING INCLUDING 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 of approving forms, templates, network adequacy and reviewing rates for all health plans sold in Montana. The goal is to make health plan regulation as efficient and streamlined as possible for health insurers, thereby reducing costs and complications and creating 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 2018 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.

The definition of small employer group for 2018 is 1-50 fulltime or fulltime equivalent employees. Federal counting methods apply. The SHOP in Montana will offer both "horizontal choice" and "vertical choice" in 2018.

Some instructions for large employer group insurance are outlined at the end of this memorandum.

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, 2018, no later than **May 1, 2017 by 5:00 PM MDT**. The opportunity for filing binders containing the required templates will open on April 14, 2017. 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 1st filing deadline for binders. Network information must also be filed by May 1st. **Late filings will not be accepted.** New individual plan filings cannot be accepted after May 1, 2017; no exceptions.

If a policy form that will be used in 2018 has no changes from the approved form for 2017, 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. **New templates must be filed every year, even if there are no changes in the policy language.**

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.csimt.gov. For the 2018 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.

Rate filings will not be accepted until after the form and binder filings have been submitted and are due by June 8, 2017. This will allow the CSI to notify issuers of any significant problems with the form filing that may affect the rates. It will also allow time for additional 2017 claims information to be collected. Proposed rate increases will be published sometime on or before the August 1 deadline set by CMS.

The CSI's initial review of forms and templates will be completed by June 19, 2017 because the second SERFF data transfer deadline for states performing plan management is June 21, 2017. All corrections to forms and templates will be done on a continuous basis. CSI will not use "correction windows." Because Montana is a plan management state, CCIO will not do substantive reviews on binders submitted until after June 21. After that date, CCIO 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. Corrections will then be transferred to HIOS through SERFF by the CSI.

All rate, network, form, and binder filings must be fully and finally approved by 5:00 PM MDT on August 11, 2017. No exceptions will be permitted.

CSI will make recommendations to CMS about QHP certification by August 16, 2017. 2018 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 2018 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 inside the FFM and SHOP and outside the FFM and SHOP 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 CMS 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. The federal tools will be used by CSI to aid that process. All health plans will be reviewed for possible discriminatory benefit design and full compliance. Non-discrimination attestations from all health insurers must be submitted to the CSI through State Electronic Rate and Form Filing system (SERFF).

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 (including large group) 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 2018 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.

Network Adequacy

In order to assess compliance with state and federal network adequacy laws for PPO and "PPO type" health plans offered in 2018, health insurers, vision insurers and dental insurers (including non-QHP issuers) must provide the CSI with a complete healthcare provider directory for each health plan/ vision/ dental plan offered for sale in Montana.

If an issuer is using a different network for different health plans, all networks must be properly identified and submitted separately.

All networks must be resubmitted every year by all major-medical health insurers, dental insurers and vision insurers, even if there are no other changes to the policy form.

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) pursuant to Title 33, Chapter 36. However, because of federal ACA requirements and QHP certification requirements, issuers who are filing HMO health plans must also submit provider lists to the CSI, as well as the network template form, so that CSI, as the plan manager, can review the adequacy of the network pursuant to federal standards. 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, licensed clinical professional counselors, licensed clinical social workers, naturopaths, optometrist, physical therapists, physician assistants, physicians, licensed addiction counselors, licensed marriage and family therapists, and psychologists.
- Cardiologists, endocrinologist, infectious disease specialists, primary care physicians, ob./gyns, rheumatologist and oncologists must be specifically identified in the provider specialty column of the provider list.
- If dental coverage, including pediatric dental coverage, is embedded in the health plan, dentists must be included in the network lists.

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.csimt.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 workbooks are located on and must be submitted through SERFF. Issuers must use the 2018 workbooks located on the CSI website and SERFF.

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), and NPI number must also be included. If you do not know the NPI for a provider, contact the provider to acquire it. If a provider does not have an NPI, enter 0000000000 (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 which 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-5-09-17. If the file submitted does not meet the above criteria, an automatic objection letter will be sent, prompting the company to make the needed revisions.

The master list of healthcare providers used by the CSI to review healthcare provider networks for 2018 is available upon request.

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 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.csimt.gov. The Excel workbook contains the complete list of facilities 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-5-09-17.

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 federal network adequacy standard requires only 20 percent of all ECPs to be “in network” and 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 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 based on the Montana Administrative Rules 6.6.5901, et seq. 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. The proof required is an attestation that outlines its attempts to contract with the Indian 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.csimt.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 indicate 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 indicate no, the issuer has not contracted with the ECP to be in network. Do not add other ECPs that are not on the list. 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-5-09-17.

If an issuer requires insureds to use "preferred pharmacies" or offers better pricing for prescription drugs obtained at a preferred pharmacy, a network pharmacy list must be submitted to the CSI, 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.

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 2018. Provider directories must be updated on a regular basis. Failure to keep the provider directory up to date may constitute a misrepresentation. For a more complete understanding of network adequacy requirements in Montana, refer to the Administrative Rules of Montana at 6.6.5901 et seq.

Please submit all healthcare provider, facility, pharmacy (if applicable) and ECP files through SERFF. All questions regarding Montana's network adequacy requirements can be sent to David Dachs at ddachs@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, QHP issuers must also complete and submit the required CMS network and ECP templates.

Rate Filing Requirements

All insurers 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 they do not intend to sell in the federally facilitated marketplace (FFM).

Because the binder filing is due earlier than the rate filing, the rates may not be finalized at the time of filing the RDT. In order to get the binder to validate the RDT must have all fields completed. Therefore, the RDT initially submitted under the binder may need to be populated with "dummy" rates. The CSI will not review this initial RDT, but it should be updated at the time the rate filing is submitted, as the RDT will be reviewed in conjunction with the rate filing.

A rate filing that contains the URR 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.

Unlike for 2017 rate filings, there is no required format for the 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.

The Part II serves two purposes – it will be posted in PDF format to the CSI website regardless of average or plan-level rate impact (as noted elsewhere in this document), and it will be required to be posted in Rich Text Format (RTF) in HIOS if any renewing plan within a product has a rate increase of 10% or more. The support of RTF in HIOS is new for plan year 2018. With the addition of RTF support, consistency between the two documents is now possible. The only difference required by the CSI is that the PDF version for the CSI website should include a header containing the following identifying information:

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

Additional instructions related to rate filings are as follows:

- 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 to both CMS and the CSI in HIOS and SERFF, respectively.
- 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.
- 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, 2018. 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 calendar year of 2018. The initial rates for 2018 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.

- 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, 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. However, in contrast to the 2017 rate filing requirements, no template will be provided for this information, but rather, 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 §156.80(d)(2)(i) – cost-sharing design, utilization differences as a result of the design, and an adjustment for non-tobacco user status. 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 the 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 the Part I and thoroughly documented and supported in the 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 serve a legal justification for the company to seek a 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 their designee will 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 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 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. Those rate justifications will be posted on a CSI website immediately after they are received for all health plans sold in Montana, both on and off the exchange.

Exclusions for Specific Provider Types

Policies may not exclude the services of specific types of providers that are acting within the scope of their license and providing a service that is a covered benefit, including, but not limited to, licensed marriage and family therapists and licensed addiction counselors. This practice may violate section 2706 of the ACA, as well as Mont. Code Ann. 33-22-111

and 33-30-1019. Broad exclusions for “family therapy,” “play therapy” and “group therapy” may be disapproved. Those services must be reviewed under medical necessity requirements that respect the parameters of the Mental Health Parity and Addiction Equity Act.

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. Formulary drug lists must be updated on a regular basis.

All QHP issuers must have one plan design that includes flat dollar, pre-deductible copayments for all prescription drug tiers. All cost sharing for prescription drugs must be reasonably graduated and proportional 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 results in discrimination.

Pursuant to federal guidance, issuers may not require that all prescriptions be obtained through a mail order pharmacy in order to be covered. All members must have access to a “brick and mortar” pharmacy.

Drug Formulary Exception Process

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

Product Withdrawals

If an insurer is discontinuing any products in the individual, small group or large group markets, the insurer must supply the CSI with a list of withdrawn products and the number of members affected by that withdrawal. In addition, the insurer must specify how each of those plans will be “mapped” to a 2018 when “auto-renewal” occurs. The CSI will not allow mapping to a lower metal tier without the express 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 insurer.

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

Even though healthcare co-op plans 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 as 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 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 and rates must be filed with and reviewed by the CSI at least 60 days before they are offered for sale. The individual templates must also be submitted with filing and a rate filing is required, but will not be accepted until the form filing is complete. For more detailed instructions, please contact the CSI.

Standalone 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 2018 FFM letter to issuers. Each QDP issuer must specify whether 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.

Transitional Policy

On February 23, 2017, CMS published a [bulletin](#) extending the transitional policy for non-grandfathered coverage in the small group and individual market through calendar year 2018 in order to facilitate smooth transitions to ACA-compliant coverage. CMS is allowing States to extend the transitional policy to policy years beginning on or before October 1, 2018, provided that all policies end by December 31, 2018. The CSI will allow insurers to exercise this policy; however, plan years may not be longer than 12 months.

Large Employer Group Insurance

Large employer group insurers should follow the instructions regarding network lists that must be filed annually, the prohibition on any exclusions for services for individuals, the prohibitions on services for specific provider types, and product withdrawal. Policy forms must be updated as needed to comply with new state and federal regulations, including but not limited to 33-22-139 and Title 33, Chapter 32, and the guidance on prohibited exclusions contained in this memorandum. All policy filings must be completed through SERFF.

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.

Conclusion

If you have questions, please contact Richard Hersey, Forms Bureau Chief (forms and templates), David Dachs, Market Conduct Examiner (network adequacy), or Nic Ramey, contract actuary (rate filing questions) at rhersey@mt.gov, ddachs@mt.gov, or nramey@leif.net.