

COMMISSIONER OF SECURITIES & INSURANCE

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COMMISSIONER



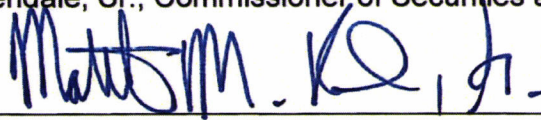
OFFICE OF THE
MONTANA STATE AUDITOR

ADVISORY MEMORANDUM

TO: HEALTH INSURERS INTENDING TO ISSUE OR
RENEW HEALTH INSURANCE IN 2021

FROM: Matthew M. Rosendale, Sr., Commissioner of Securities and Insurance

DATE: April 9, 2020



2021 FORM, RATE, & NETWORK ADEQUACY FILING REQUIREMENTS INCLUDING QUALIFIED HEALTH PLAN CERTIFICATION

**This Advisory Memorandum has changed from previous years.
Please read it in its entirety.**

The Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), will continue to perform the plan management functions required for insurers choosing to participate in the Federally Facilitated Marketplace (FFM) in 2021.

This Memorandum provides instructions for filing both on-exchange and off-exchange health plans. Due to federal requirements, the timeline for filing plans and rates for 2021 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, and Network Information Due	May 15, 2020
Rate Filings Due - 1 Day Only	June 11, 2020
Initial Rate Transfer to CMS	June 17, 2020
Binder, Form, Rates, and Network Filings Finalized	August 12, 2020
CMS Binder Final Deadline	August 19, 2020

NOTE: This Memorandum is subject to change based on CMS' issuance of the Final Notice of Benefit and Payment Parameters for 2021. CSI will provide notice of any changes to this Memorandum as soon as possible.

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ITEMS OF NOTE FOR 2021

- 1) **SERFF Required.** All filings must be submitted through SERFF. Please check the SERFF website for information and instructions on how to use SERFF.
- 2) **Health Insurance Provider fee (“HIP fee,” “Health Insurer Tax,” or “HIT”).** Pursuant to US SB19-172, permanent repeal of the HIT is effective in January 2021.
- 3) **Transparency in Coverage.** Under Section 1311(e)(3) of the Patient Protection and Affordable Care Act, as implemented by regulations at 45 CFR 155.1040(a) and 156.220, Health insurers seeking certification of a health plan as a qualified health plan (QHP) must complete the Transparency in Coverage template and submit with the Binder filing. This template requires information concerning number of claims and denials, appeals, requires HIOS issuer and plan IDs, and information on 2019 QHP exchange status.
- 4) **Summary of Benefits and Coverage Revision.** Updated versions of the 2021 Summary of Benefits and Coverage (SBC) Template have been released by DOL/HHS and must be used in 2021. Templates and instructions are available here: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits>.
- 5) **Risk Adjustment Transfer Elements Extract (RATEE) file.** As with previous years, CSI will again be requesting that issuers provide their final RATEE file. This deadline has been pushed back and will likely be available around May 15th. CSI will notify issuers via email with further details.
- 6) **URRT.** The updated URRT v5.1 has been loaded into the URR Module of HIOS. The updated 2021 URR Instructions for Parts I, II, and III were released in early 2020, however the version currently available in HIOS is a DRAFT from May 2019.

Note: CSI will upload the most recent versions of all documents to SERFF, however, due to the lack of clarity on this issue from CMS, the posted versions may change without notice.

- 7) **Silver Loading Guidance Clarified.** 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, 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 insurers will develop rates for ACA plans that distribute the cost of CSRs only to CSR-eligible plans. Since CSR eligibility requires that a policy be exchange-sold, insurers 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 as well at the same premium rate.
- 8) **New Actuarial Value Calculator.** CCIIO/CMS has released a new **Actuarial Value Calculator** and methodology that can be found here:
<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2021-AV-Calculator-Methodology.pdf>
- 9) **Reinsurance Program Rate Requirement.** Insurers must include in their filing a report detailing premium amounts with and without taking the reinsurance program into consideration.
- 10) **Small Employer Groups.** The definition of small employer group 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 2021.

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 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, 2021, no later than **5:00 PM MDT on May 15, 2020**. 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 2021 has no changes from the approved form for 2020, the insurer 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 insurer on a continuous basis. CSI will not use "correction windows." CCIIO will send all substantive corrections to CSI BEFORE sending those requested corrections to the health issuer. Please do not make corrections without first receiving approval from CSI.

Corrections to all rate, network information, form, and binder filings must be finalized by 5:00 PM MDT on August 12, 2020. No exceptions will be permitted.

Prescription Drug Coverage

QHP insurers must comply with the final PY 2021 EHB Crosswalk in setting formulary design. The effective Crosswalk was updated in February 2019, to contain 7554 RXCUIs, representing 1329 chemically distinct drugs, 48 categories, and 168 classes. Additional information is available here: <https://www.ghpcertification.cms.gov/s/Review%20Tools>

An insurer's formulary drug list must be displayed on the insurer's website and updated regularly. Formulary lists will be reviewed to ensure assignment of drugs to tiers does not discriminate, as defined in Section 1557 of the Affordable Care Act.

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

Insurers 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.

Product Withdrawals

If an insurer is discontinuing any products in the individual, small group or large group markets, the insurer must provide 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 2021 plan when "auto-renewal" occurs. 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 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 2021 Letter to Issuers, 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, CSI will review multi-state plans (MSPs) under contract with the Office of Personnel Management according 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 CSI at least 60 days before they are offered for sale. All forms, rates, and binders must follow the same requirements as an ACA submission. For more detailed instructions, please contact CSI.

Stand-Alone Dental Plans

Qualified Stand-alone Dental Plans (QDPs) must file their forms, plan binders and network lists according to the same timelines and instructions that apply to all QHP issuers. There is no due date for the rate filing submission. Rates can 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 2021 Letter to Issuers. Each QDP issuer must specify whether the rates contained in the templates are guaranteed to consumers or will be subject to underwriting.

QDP 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 QDPs 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 on June 11, 2020 and are due by 5:00 PM MDT. This will allow CSI to notify insurers of any significant problems with the form filing that may affect the rates. It will also allow time for additional 2020 claims information to be collected. Proposed rate increases will be published on or before CMS' August 19th deadline.

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 insurers do not intend to sell on the FFM.

With the binder filing due earlier than the rate filing, CSI understands rates may not be finalized at the time of filing the RDT. However, to ensure the binder is validated, the RDT must still have all fields completed. Therefore, the RDT initially submitted under the binder may be populated with "dummy" rates. CSI will not review this initial RDT. The RDT must be updated at the time the rate filing is submitted and will be reviewed in conjunction with the rate filing.

The submission of the RDT in the binder does not constitute a rate filing under § 33-22-157(4) as it does not contain the required support. Rates will not be considered filed until a separate rate filing is submitted via SERFF.

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 CSI's website regardless of average or plan-level rate impact (as noted elsewhere in this document), and it will be posted in Rich Text Format (RTF) in HIOS if any renewing plan within a product has a rate increase of 15% or more. With the addition of RTF support, consistency between the two documents is now possible.

Although there are not specific CSI instructions for Part II, there are two differences required by CSI. First, the PDF version for CSI website 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). Second, the PDF version 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:

- 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 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, 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, 2021. 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 2021 calendar year. The initial rates for 2021 may be submitted with quarterly trend factors for the entire year. Subsequent quarterly rate revisions will be accepted but must be submitted 60 days in advance of use, as outlined in § 33-22-156.
- 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. 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, it is required that the components of the AV Pricing Values, as described in 45 CFR 156.80(d)(2), 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 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 insurer 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 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 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. 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 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 2021 LETTER TO ISSUERS

All health issuers should carefully review the CCIIO/CMS 2021 Letter to Issuers that is posted on the CMS website.

NETWORK ADEQUACY

To assess compliance with state and federal network adequacy laws for PPO and "PPO type" health plans offered in 2021, health, vision, and dental issuers (including non-QHP issuers), must provide 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 insurers, even if there are no other changes to the policy form.

Plans defined under Title 33, Chapter 31 of the Mont. Code Ann. 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 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 CSI. As the plan manager, CSI must review the adequacy of the network pursuant to federal standards.

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.

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. 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 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 community providers (ECP) template at this time; only CSI healthcare provider template must be submitted.

If an insurer requires use of "preferred pharmacies" or offers better pricing for prescription drugs obtained at a preferred pharmacy, 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 2021 will be available upon request.

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. Note: the list of ECPs published by CMS for Montana is incomplete. The federal

network adequacy standard requires only 20 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, 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 INSURERS & CONSUMER COMPLAINT HANDLING

CSI will continue to provide technical assistance to insurers throughout the form approval/QHP certification recommendation process. All consumer complaints regarding issuers, including QHP issuers, will be handled by CSI. Consumer complaints regarding insurers received by the FFM through its toll-free phone number, the FFM website, or in any other manner, will be forwarded to CSI for resolution. 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: Tiffany Caverhill (tcaverhill@mt.gov) or Karen Beyl (kbeyl@mt.gov)

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

Rates: Ashley Perez (aperez@mt.gov)