COMMISSIONER OF SECURITIES AND INSURANCE

Troy Downing
Commissioner

Office of the
Montana State Auditor

ADVISORY MEMORANDUM

To: ALL INTERESTED PERSONS

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

Date: April 10, 2024

Ref: **2025 Form, Rate, & Network Adequacy Filing Requirements Including Qualified Health Plan Certification**

The Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), will continue to perform the plan management functions required for issuers choosing to participate in the Federally Facilitated Exchange (FFE) in 2025, with the exception of reviewing certain network adequacy standards, as described in more detail below.

This Memorandum provides instructions for filing both on-exchange and off-exchange health plans. The Centers for Medicare & Medicaid Services (CMS) issued the 2025 Notice of Benefit Payment Parameters (2025 Final Rule) on April 2, 2024, which finalized changes to the payment parameters, some of which are summarized below in the "Items of Note for 2025." *See* 2025 Final Rule at:

- https://www.cms.gov/files/document/cms-9895-f-patient-protection-final.pdf

While this Memorandum explains certain issuer requirements, it is not a complete list of all regulatory requirements. CSI expects issuers to consult all applicable laws and regulations, in conjunction with this Memorandum, to ensure compliance with the requirements of the Affordable Care Act (ACA) and other applicable state and federal requirements.

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Due to federal requirements, the timeline for filing plans and rates for 2025 is the same for both qualified health plan (QHP) issuers and health issuers with no QHPs.

Filing Requirements for Montana	Due Date
Binder, Form, & Network Info Due	May 15, 2024
Rate Filings Due	May 15-June 5, 2024
Initial Rate Transfer to CMS	June 12, 2024
Final day for Issuers to make changes to Binder, Form, and Rates	July 31, 2024
CMS Binder Final Deadline	August 14, 2024

ITEMS OF NOTE FOR 2025

1) **Unified Rate Review Template (URRT).** The updated URRT and corresponding URR instructions have been released by CMS and are required for 2025 rate filings. Please see:

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

2) **New Actuarial Value (AV) Calculator.** CMS has released a new **AV Calculator** and methodology for 2025 that can be found here:

   - https://www.cms.gov/files/document/final-2025-av-calculator.xlsm [cms.gov]
   - https://www.cms.gov/files/document/final-2025-av-calculator-methodology.pdf [cms.gov]

3) **Defrayal of State Mandated benefits**. The 2025 Final Rule provides that state-mandated benefits are not considered "in addition to Essential Health Benefits (EHB)" under CMS's defrayal policy if the mandated benefit is an EHB in the State's EHB-benchmark plan. Additional guidance on the submission of claims to CSI for defrayal is provided below.

4) **Standardized Plan Options**. The 2025 Final Rule provides that CMS will follow the approach finalized in the 2024 Final Notice of Benefit and Payment Parameters (2024 Final Rule) concerning standardized plan option metal levels and to otherwise maintain continuity with the approach to standardized plan options finalized in the 2023 and 2024 Final Rules. With the 2025 Final Rule, CMS finalized only minor updates to the plan designs for plan year (PY) 2025 to ensure these plans have actuarial values within the permissible *de minimis* range for each metal level.

5) **Non-Standardized Plan Options.** 45 CFR § 156.202, as finalized in the 2024 Final Rule, reduces the limitation on the number of non-standardized plan options for PY2025 to two per service area in each combination of the product network type; metal level (excluding catastrophic plans); and inclusion of dental and/or vision coverage. (This is a reduction from PY2024, which was four non-standardized plans.) The 2025 Final Rule provides an exceptions process to this limitation on the number of non-standardized plans. Under this exceptions process, for PY2025 and subsequent years, issuers may offer additional non-standardized plan options beyond the two-plan limit for each product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area if it demonstrates that that these additional non-standardized plans' cost sharing for benefits pertaining to the treatment of chronic and high-cost conditions is at least 25% lower than the cost sharing for the same corresponding benefits in an issuer's other non-standardized plan option offerings in the same product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area.

6) **Prescription Drugs.** The 2025 Final Rule codifies CMS's current policy that prescription drugs that a plan covers in excess of those covered by a state's EHB-benchmark plan are considered EHBs and subject to EHB protections, including the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits, unless the coverage of the drug is mandated by state action such that it would not be considered EHB. (The Departments of Labor, Health and Human Services (HHS), and the Treasury issued an FAQ to address the applicability of this provision in the 2025 Final Rule to self-insured group health plans and large group market plans for purposes of the prohibition on lifetime and annual limits that can be found at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66.)

7) **Stand-Alone Dental Plans (SADPs)**. Beginning in PY2024, 45 CFR § 156.230 requires all QHP issuers, including SADPs, to use a provider network that meets network adequacy standards. 45 CFR § 156.230(a)(4) contains a limited exception for SADPs that sell plans in areas where it is prohibitively difficult to establish a network of dental providers. CMS has approved Montana as one of these "prohibitively difficult" areas for PY2025.

8) **Network Adequacy and Essential Community Provider (ECP) Standards.** As mentioned, 45 CFR § 156.230 requires all marketplace plans, Small Business Health Options Programs (SHOPs), and SADPs (but not SADPs issued in Montana, which has qualified for the "prohibitively difficult" exception for PY2025, as explained above) to use a network of providers that complies with CMS's network adequacy and ECP requirements and eliminates the exemption for plans that do not maintain a provider network.

   Beginning in 2023, CMS required QHP issuers to meet both time and distance and minimum appointment wait time standards. In the 2024 Final Rule, CMS delayed implementation of requirements related to appointment wait time standards to PY2025. The 2025 Final Rule does not address implementation of the appointment wait time standards for FFE issuers, thus, CMS will begin reviewing issuer attestations of compliance with appointment wait time standards. Appointment wait time standards are set forth in Chapter 2, section 3.ii.b of the 2023 Final Letter to Issuers, and Chapter 2, section 3.iii.b of the 2025 Draft Letter to Issuers (link below).

9) **Employee Counting Method.** As with prior years, the definition of a small employer group is 1-50 full-time or full-time equivalent employees. Federal counting methods set forth in 26 USC § 4980H(c)(2) apply. *See* 42 USC § 18024(b)(1), (2), as amended by the PACE Act, and 45 CFR § 155.20. Accordingly, the determination of whether an employer is considered a large or small employer for the purposes of QHP certification is conducted on an annual basis. Guaranteed renewability rights under the ACA do not allow a large group to continue its existing coverage if it has become a small group because such continued coverage is prohibited by other laws. The SHOP in Montana will offer both "horizontal choice" and "vertical choice" in 2025.

10) **Redline Form Revisions.** If the Issuer files previously approved forms with new revisions, all revisions must be illustrated in a redlined version submitted under supporting documentation in the System for Electronic Rate and Form Filing (SERFF) filing.

GUIDANCE IN THE CCIIO/CMS 2025 LETTER TO ISSUERS

All health issuers should carefully review the Center for Consumer Information and Insurance Oversight (CCIIO)/CMS 2025 Draft Letter to Issuers in the FFE that is posted on the CMS website. To the extent that the finalized 2025 Letter to Issuers materially changes the form, rate, or network adequacy standards or filing requirements described herein, CSI will issue an addendum to this Advisory Memorandum, as needed. For the 2025 Draft Letter to Issuers, please see:

- https://www.cms.gov/files/document/2025-draft-letter-issuers-11-15-2023.pdf

DEFRAYAL OF STATE MANDATES

Per 45 CFR § 155.170 of the ACA, the state of Montana is required to pay the costs of certain state benefit mandates enacted after December 31, 2011. The defrayal requirement applies to issuers selling QHPs in the individual and/or small group markets, on-exchange and off-exchange.

Currently in Montana, mandatory benefits that are subject to defrayal include those covered under § 33-22-128, MCA, which requires coverage for children with hearing loss. For defrayal under § 33-22-128, MCA, issuers are required to submit relevant claims of costs incurred and paid in 2023 to CSI for review. Last year, based on CMS's prior interpretation of defrayal under § 33-22-128, MCA, CSI instructed issuers to include costs related to cochlear implants in their defrayal claims, even though cochlear implants are included in Montana's EHB-benchmark plan. Because the 2025 Final Rule provides that state-mandated benefits are not considered "in addition to EHB" if the mandated benefit is an EHB in the State's EHB-benchmark plan (*see* "Items of Note" #3, above), costs related to cochlear implants will no longer need to be defrayed. On March 13, CSI provided additional guidance to the issuers on the process to submit defrayal claims.

Other mandatory benefits that are subject to defrayal include those covered under § 33-22-2103, MCA, which requires coverage of standard fertility preservation services when an insured member is diagnosed with cancer and the standard of care involves medical treatment that may directly or indirectly cause iatrogenic infertility (defined in statute). Section 33-22-2103, MCA, became effective on January 1, 2024, which means in 2025, issuers will be required to submit relevant claims of costs incurred and paid in 2024 to CSI for review.

For PY2025, the rate filing will need to reflect estimated defrayal costs as was done for PY2024. The Actuarial Memorandum should state the amount the issuer anticipates the state will defray,

and issuers should follow the URR instructions on how to document benefits in addition to EHB. This applies to issuers in both the individual and small group markets.

FORM FILINGS

All major-medical health issuers that wish to issue or renew small employer group, individual health insurance coverage, or SADPs 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, 2025, no later than **5:00 PM MDT on May 15, 2024**. 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 2025 has no changes from the approved form for 2024, the issuer may file an attestation certifying that there are no changes in the form. However, any changes to cost-sharing will require a new filing for the Summary of Benefits (SBC), Outline of Coverage (OOC), and Schedule of Benefits (SOB) documents. **Note: new templates must be filed every year, even if there are no changes in the policy language.**

All SBCs and OOCs must be filed at the same time as the policy forms. See CSI's bulletin on SBC's and OOC's, entitled "Federal and State Consumer Disclosures," dated July 6, 2012:

- https://csimt.gov/wp-content/uploads/2022/12/2012-07-06-Federal-and-State-Consumer-Disclosures.pdf

All required corrections to forms and templates must be made by the issuer on a continuous basis. CSI will not use "correction windows." CCIIO will send all corrections to the issuer and CSI. 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 July 31, 2024. No exceptions will be permitted.

Presumptively Discriminatory Benefit Designs

The 2023 Final Notice of Benefit and Payment Parameters (2023 Final Rule) provided that, under 45 CFR § 156.125(a), an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and that a nondiscriminatory benefit design that provides EHB is one that is clinically based. This is referred to in the 2023 Final Rule as the "refined EHB nondiscrimination policy." According to the 2023 Final Rule, the policy became applicable starting on the earlier of January 1, 2023, or upon renewal of any plan subject to the EHB requirements.

Regarding State-mandated benefits, the 2023 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 45 CFR § 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.

According to the 2023 Final Rule, a plan that covers diagnoses and treatment of Autism Spectrum Disorder (ASD) as an EHB but limits such coverage in its plan benefit design based on age is

presumptively discriminatory under 45 CFR § 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 of age 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 is only covered for members under age 19), this EHB-benchmark benefit design qualifies as presumptively discriminatory under the finalized examples set forth in the 2023 Final Rule, unless the limitation is clinically based.

In accordance with CMS guidance 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, CSI instructs issuers that any 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 CMS's refined EHB nondiscrimination policy, notwithstanding the current EHB benchmark plan provision related to ASD.

Prescription Drug Coverage

QHP issuers must comply with the EHB Crosswalk in setting formulary design. The effective Crosswalk was updated in 2023, to contain 8359 Clinical Drug Components (RXCUIs), representing 1,531 chemically distinct drugs, 47 categories and 156 classes for a combination of 169 unique category/class combinations. Additional information is available here:

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

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

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

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

In order not to discriminate under 45 CFR § 156.125, the issuer's EHB prescription drug benefit design must be clinically based. According to CMS, placing all drugs for a high-cost chronic condition on the highest formulary tier is a presumed discriminatory design, even when those drugs are costly. Issuers should expect to demonstrate that neutral principles were used when assigning tiers to such drugs and that those principles were consistently applied across types of drugs.

Product Withdrawals

If an issuer is discontinuing any products in the individual, small group or large group markets, the issuer must provide CSI with a list of withdrawn products and the number of members affected by that withdrawal. In addition, the issuer must specify how each of those plans will be "mapped" to a 2025 plan when "auto-renewal" occurs. CSI will not allow mapping to a lower metal tier without the express written permission of CSI. 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 by CMS, 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 to the same instructions and timelines outlined in this Advisory Memorandum. MSP issuers are treated as separate issuers.

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. The student health plan forms and rate filings do not need to follow the URR filing requirements; therefore, a binder filing is no longer required. The submission of forms and rates with supporting documentation are the only documents required to be submitted in SERFF. For more detailed instructions, please contact CSI.

Stand-Alone Dental Plans

Issuers offering SADPs must file their forms, plan binders, and network lists according to the same timelines and instructions that apply to all QHP issuers. Rates should be filed in conjunction with the form and binder filings. Although CMS has approved Montana as an area where it is prohibitively difficult to establish a network of dental providers for PY2025, and Montana SADPs are therefore excepted from the network requirement for QHP certification for SADPs, Montana's Preferred Provider Organization (PPO) network adequacy laws continue to apply to dental plans. The benefits template will be modified for dental plans. Each SADPs issuer must specify whether the rates contained in the templates are guaranteed to consumers or will be subject to underwriting.

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

A health service corporation is required to pay a filing fee pursuant to § 33-30-204, MCA. Please submit the filing fee for each binder.

MEDICAL RATE FILINGS

Rate filings will only be accepted from May 15 - June 5, 2024, and are due by 5:00 PM MDT June 5, 2024. Proposed rate increases will be published on or before CMS' August 14th deadline.

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

All filings must be submitted through SERFF. SERFF has made updates to the URR transfer process. All URRT submissions should be completed within SERFF and not directly in the Health Insurance Oversight System (HIOS) URR module. All new filings need to be submitted using the new SERFF to URR Transfer Process. This is done by using the new URRT Tab in SERFF. If an issuer enters their rate submission incorrectly through HIOS instead of SERFF, CMS will deactivate that submission and notify the issuer and the state that it must be entered through the SERFF Transfer Process.

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 also be posted in PDF in HIOS if any renewing plan within a product has a rate increase of 15% or more.

Although there are no specific CSI instructions for Part II, since the PDF is posted to the CSI website, Part II should discuss not only the HIOS-required change derived by the URRT, but also the actuary's best estimate of the impact of the rate change on the current insured members as reported in SERFF (note – Part III's discussion of rate impact should also address both perspectives). Part II should include a header containing the following identifying information:

- Title – Part II Justification for Proposed Rate Increase;
- Issuers name;

- Market segment (individual or small group); and
- Rate effective date.

Reinsurance Program Rate Requirement: Montana received a Section 1332 State Innovation Waiver allowing the state to implement a reinsurance program (Program) in the individual market. For all years that the Program is in place (January 1, 2020, through December 31, 2025), in support of rates filed in the Montana individual Affordable Care Act (ACA) market and for federal pass-through funding calculation purposes:

- Issuers must include in their filing a report detailing premium amounts with and without taking the reinsurance program into consideration.
- Issuers must submit the "without reinsurance" RDT under a user-created Rate/Rule Schedule Item in the rate filing (the "with reinsurance" RDT will continue to be submitted under the binder filing as required by CMS).
- A separate "without reinsurance" URRT must be submitted under a user-created component on the Supporting Documents tab in the SERFF rate filing. The "with reinsurance" URRT must be submitted under the URRT tab in the SERFF rate filing.
- Issuers must include in their filing detailed numeric support for the claim and rate impacts of the 1332 waiver program assumed in the development of their filed rates.

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

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.
- As with previous years, CSI will again be requesting that issuers provide their final RATEE file. CSI will notify issuers via email with further details.
- Parts I, II, and III of the Rate Filing Justification for ALL individual and small employer group health plans must be completed and submitted in SERFF.
- All filings need to be submitted using the new SERFF to URR Transfer Process. This is done by using the new URRT Tab in SERFF.
- The Company Rate Information and the Rate Review Detail on the Rate/Rule Schedule tab in SERFF must be completed for all filings. The values for rate impact generally should

agree with those reported in the URR Parts II and III. Although no determination method of the rate impact is mandated, CSI requires that support be provided in the rate filing. Please submit this support in SERFF separately from the URR components.

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

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

- Individual Market health plan rates, both on the exchange and off the exchange, must be guaranteed for the calendar year beginning January 1, 2025. No interim rate revisions will be permitted.

- Rates for the Small Group Market, both on the exchange and off the exchange, must be filed for the entire 2025 calendar year. The initial rates for 2025 may be submitted with quarterly trend factors for the entire year. Subsequent quarterly rate revisions will be accepted but as outlined in the URRT instructions, must be submitted at least 105 days prior to the effective date of the rate change and finalized at least 45 days prior to the effective date.

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

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

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

- Based on the CMS instructions for Parts I and III, there are two distinct subcomponents to the AV and cost-sharing design component described in 45 CFR § 156.80(d)(2)(i) – cost-sharing design and utilization differences as a result of the design. Attention will be paid to thejustification for the assumed utilization differences.

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

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

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

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

- If an issuer wishes to identify any part of the rate filing as confidential, it must first be identified as a "trade secret." Do not mark the entire filing as a "trade secret." Reasons for a trade secret determination must be specific for each item of information in the rate filing. Each item that properly deserves trade secret status must be clearly identified and accompanied by an affidavit from an authorized company representative identifying specific reasons under Montana law that legally justifies the company's claim for trade secret designation for that particular information. The Part II justification for a filed rate increase must be published pursuant to federal law and cannot be designated a trade secret. The Commissioner will review and make the ultimate determination as to trade secret status. After the rate review process is complete, all parts of the rate filing will be treated as public unless trade secret status has been granted by the Commissioner. Please contact CSI for more detailed instructions if you have questions. More information regarding the confidentiality process can be found in the Commissioner's April 14, 2022 memorandum, https://csimt.gov/wp-content/uploads/2022/12/2022-04-14-Requests-for-Trade-Secret-Protection-on-Rate-and-Form-Filings2-1-1.pdf.

- 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 the exchange and off the exchange.

NETWORK ADEQUACY

To assess compliance with state and federal network adequacy laws for PPO and "PPO-type" health plans offered in 2025, 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. Reviews of network adequacy for PY2025 remain on a dual track: one track through CMS for QHP certification for compliance with the federal QHP network adequacy requirements and one track through CSI for insurance policies or subscriber contracts for compliance with Montana network adequacy standards. Issuers seeking QHP certification for PY2025 must submit network information to CMS in accordance with the 2025 Final Rule and 2025 Final Letter to Issuers, when issued by CMS.

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

Federal QHP Network Adequacy Standards

CMS will review federal QHP network adequacy standards for Montana issuers seeking QHP certification for PY2025.

Starting in PY2024, CMS evaluated QHPs for compliance with network adequacy standards based on time and distance standards. CMS will also evaluate QHPs for compliance with appointment wait time standards in PY2025, as explained in more detail below.

CMS 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 PY2025. Accordingly, for PY2025, CMS will evaluate the federal network adequacy standards for Montana issuers seeking QHP certification. 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. CMS's Instructions and FAQs provide more detail on the network adequacy review process and what issuers need to submit to CMS to demonstrate compliance with network adequacy standards at the following links:

- www.qhpcertification.cms.gov/s/Essential%20Community%20Providers%20and%20Network%20Adequacy%20FAQs

- www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy

For PY2025, with regard to appointment wait time standards, issuers will demonstrate compliance via attestation, as provided in the 2023 Final Rule. CMS established appointment wait time standards in Chapter 2, section 3.ii.b of the 2023 Final Letter to Issuers, and are currently reiterated in Chapter 2, section 3.iii.b of the 2025 Draft Letter to Issuers.

Reviews of time and distance standards will be conducted by CMS as part of QHP certification. The time and distance standards are established in Chapter 2, section 3.ii.a, of the 2023 Letter to Issuers. Regarding these 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.

As with PY2023 and PY2024, if an issuer's application does not satisfy the network adequacy standard, an issuer is required to include a satisfactory justification as part of its application for QHP certification. The justification process remains unchanged for PY2025. If it is determined that an issuer does not meet one of the 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 to CMS. The justification process will require issuers that do not yet meet the network adequacy standards to detail: the reasons that one or more standards were not met; the mitigating measures the issuer is taking to ensure enrollee access to respective provider specialty types; information on enrollee complaints regarding network adequacy; the issuer's efforts to recruit additional providers; and an attestation regarding the provider's contribution to meeting the standards.

All issuers seeking certification of plans to be offered as QHPs through the FFEs must submit information about whether network providers offer telehealth services. 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.

Montana Network Adequacy Standards

CSI will review networks for insurance policies or subscriber contracts for compliance with Montana network adequacy standards for PY2025.

Although CSI has not elected to review the federal QHP network adequacy standards for PY2025, 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. The deadline to submit networks to CSI for review under the Montana adequacy standards is May 15, 2024.

CSI's healthcare provider template requires reporting the following provider types:

- Advanced practice registered nurses,
- Chiropractors,
- Dentists,
- Licensed addiction counselors,
- Licensed clinical professional counselors,
- Licensed clinical social workers,
- Licensed marriage and family therapists,
- Naturopathic Physicians,
- Optometrists,
- Physical therapists,
- Physician assistants,
- Physicians,
- 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 and pharmacies, can be found on CSI's website at https://csimt.gov/advisory-memos/ and in the State filing instructions on SERFF.

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

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

Once finalized, the master list of healthcare providers used by CSI to review healthcare provider networks for 2025 will be available upon request.

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 the issuer's 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 CSI. Additionally, QHP issuers must also complete and submit the required CMS network and ECP templates.

TECHNICAL ASSISTANCE FOR ISSUERS & CONSUMER COMPLAINT HANDLING

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

CONTACT INFORMATION

If you have questions, please contact the following:

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This advisory memorandum is informational only and does not enlarge, limit, or 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.