COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

ADVISORY MEMORANDUM

TO: HEALTH INSURERS INTENDING TO ISSUE OR RENEW MAJOR MEDICAL HEALTH INSURANCE IN 2017

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

DATE: March 31, 2016

2017 REQUIREMENTS FOR HEALTH PLAN FORM FILINGS AND 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 health 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 2017 is the same for qualified health plan insurers (QHP insurers) and insurers that have no QHPs (non-QHP insurers) 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.

Because of the federal PACE Act and related federal law, the definition of small employer group for 2017 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 2017.

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

ISSUES AFFECTING 2017 POLICIES

Exclusions Relating to Transgender Individuals Must be Removed

The CSI has reviewed existing policy language from several insurers and discovered that all of them contain various exclusions for transgender services. Health care services related to the treatment of gender dysphoria are medically necessary for transgender people and are not "cosmetic." All of the medical professional associations agree that transition-related medical services, including mental health services, hormone therapy, and surgery (including gender confirmation surgery) are medically necessary for many transgender people who suffer from gender dysphoria. Gender dysphoria is also explicitly recognized and described in the DSM-5.

Policy language that explicitly excludes services for transgender people may constitute a discriminatory practice that violates Mont. Code Ann. 33-18-206, which prohibits discrimination between "individuals of the same class and of essentially the same hazard." Transgender individuals have the same insurable risk as non-transgender individuals who may have a mental health condition or gender-related health condition, and therefore they should not be discriminated against.

In addition, the Patient Protection and Affordable Care Act (ACA) prohibits health insurers from discriminating against transgender people. 45 C.F.R. 156.125(b) (requiring insurers to comply with 45 C.F.R. 156.200(e), which prohibits insurers that offer qualified health plans from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation); 45 C.F.R. 147.104(e) (prohibiting "marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions"); 45 C.F.R. 156.225 (prohibiting insurers from "employ[ing] marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs"). [See also the proposed regulations implementing Section 1557 of the ACA.]

Some of these federal regulations apply only to QHPs and others apply more broadly to all major medical health insurance, including individual, small employer group and large employer group. The CSI is charged by state and federal law to maintain a level playing field. In order to properly apply the provisions of Mont. Code Ann. 33-18-201, which do not allow unfair competition, the prohibition on discrimination based on gender identity must be enforced as to all types of health insurance, including large employer group.

There is ample evidence to show that the cost of transgender services have a negligible effect on premium. Transgender services remain subject to medical necessity requirements, and are eligible for all levels of internal and external appeal identified in Mont. Code Ann. Title 33, Chapter 32.

Transitional policies

The CSI allowed insurers to continue certain coverage that was issued in 2013 (transitional policy renewals) pursuant to guidance issued by CMS in November 2013. Only two insurers opted to offer "transitional" renewals to policyholders, and the majority of those policyholders are small employers, who can purchase new coverage any time during the year and are not restricted to calendar year policy period. Those transitional policies may not be renewed after October 1, 2016; in other words, all transitional policies must end by October 1, 2017. On February 29, 2016, CMS announced that it would allow states to extend that end date to December 31, 2017. Montana will not allow that extension. All transitional policies must be terminated and ACA compliant policies must be issued by October 1, 2017. Plan years may not be longer than 12 months.

Standardize Benefit Plans

In the HHS Notice of Benefit and Payment Parameter for 2017, finalized on March 8, 2016, CMS established voluntary standardized cost-sharing designs for bronze, silver and gold plans sold in the FFM. The CSI urges all Montana health insurers in the individual market to offer at least one product that follows the standardized cost-sharing design, except the CSI will not allow coinsurance for specialty drugs in the standardized cost-sharing plans (because of discrimination issues discussed later in the memorandum.) These standardized designs include flat dollar, pre-deductible copayments for out-patient visits and prescription drugs.

The CSI is concerned about the affordability of health plans that offer no coverage for out-patient visits until the deductible has been met. The average annual household income for a family of four in Montana is approximately $46,000. Every year, the deductibles and maximum out-of-pocket increase substantially, creating a barrier to accessing healthcare for many Montana families. Discouraging access to primary care and medically necessary medications will increase future healthcare costs. Therefore, the CSI hopes that Montana health insurers will consider offering the standardized option as a choice for Montana families.

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. Refusing to allow entire categories of provider types into the insurer's network 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.

Drug Formulary Exception Process

Insurers 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, insurers 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 no later than June 1, 2016. In addition, the insurer must specify how each of those plans will be "mapped" to a 2017 plan 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 insured.

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, 2017, no later than **May 9, 2016 by 5:00 PM MST**. The opportunity for filing binders containing the required templates will open on April 15, 2016. However, the CSI encourages all insurers 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 9th filing deadline for binders. Network information must also be filed by May 9th. **Late filings will not be accepted**. New individual plan filings cannot be accepted after May 9, 2016; no exceptions.

If a policy form that will be used in 2017 has no changes from the approved form for 2016, the insurer 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 2017 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 due or accepted until June 15, 2016. This time lag will allow the CSI to notify insurers of any significant problems with the form filing that may affect the rates. It will also allow time for additional 2016 claims information to be collected. Instructions for the rate filing will be sent in mid-April. The URRT will be required, but the CSI will be requesting additional information outside of the URRT in the initial rate filing. Proposed rate increases will be published sometime on or before the August 1, 2016 deadline set by CMS. The CSI will be using different consulting actuaries for the 2017 major medical rate filings. If you have questions, please contact Christina L. Goe, General Counsel.

The CSI's initial review of forms and templates will be completed by June 28, 2016 because the second State Electronic Rate and Form Filing (SERFF) data transfer deadline for states performing plan management is June 30, 2016. 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, CCIIO will not do substantive reviews on binders submitted until after June 30. After that date, CCIIO will send all substantive corrections to CSI BEFORE sending those requested corrections to the insurer. 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 the SERFF by the CSI.

All rate, network, form, and binder filings must be fully and finally approved by 5:00 PM MST on August 19, 2016. No exceptions will be permitted.

CSI will make recommendation to CMS about QHP certification by August 23, 2016. 2017 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 Insurers

All filers should carefully review the Letter to Insurers for 2017 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 insurers 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 insurer 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 with mental health parity. Non-discrimination attestations from all health insurers must be submitted to the CSI through State Electronic Rate and Form Filing system (SERFF). Montana does not have any state specific benefit mandates that go beyond the essential health benefit categories

Use of SERFF Required

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

All major medical health insurance forms (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 insurers). **New templates for 2017 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.

Technical Assistance for Insurers & 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 insurers, 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 insurers and forward them to the FFM when requested.

NETWORK ADEQUACY

In order to assess compliance with state and federal network adequacy laws for PPO and "PPO type" health plans offered in 2017, health insurers, vison insurers and dental insurers (including non-QHP insurers) must provide the CSI with a complete healthcare provider directory for each health plan/ vison/ dental plan offered for sale in Montana. **If an insurer 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 Mont. Code Ann. Title 33, Chapter 36. However, because of federal ACA requirements and QHP certification requirements, insurers 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 insurers 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 ***(some are new for 2017)*** must be submitted in separate Excel worksheets within the Excel workbook:

- Advanced practice registered nurses, chiropractors, licensed clinical professional counselors, licensed clinical social workers, **licensed addiction counselors, licensed marriage and family therapists**, naturopaths, optometrist, physical therapists, physician assistants, physicians, 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. All Excel workbooks have been updated for 2017. Insurers must use the new workbooks.

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-5-9-16. If the file submitted does not meet the above criteria, it will be rejected.

The master list of healthcare providers used by the CSI to review healthcare provider networks for 2017 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, surgi-centers and chemical dependency treatment centers. The master facilities list must be submitted in an Excel workbook. The network adequacy master facilities list workbook can be found on the CSI website at www.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 insurer 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-5-9-16.

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 insurers must include essential community providers (ECPs) in their networks. ECPs are defined in federal law as those providers that serve low-income and medically underserved individuals. The list of ECPs published by CMS for Montana is incomplete. The complete list is posted on the CSI website. The list will be updated in April 2016 to reflect some changes in the federal list and to indicate where different names have been used for the same facility. The federal network adequacy standard requires only 30 percent of all ECPs to be "in network" and that percentage is not adequate to meet the requirements of Montana law. QHP insurers 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 Admin. Rules of Mont. 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 insurer encounters difficulties when contracting with county health departments, please contact the CSI for further instructions.

If a QHP insurer 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 insurer 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-4-11-15.

If an insurer 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. 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.

The pharmacy list workbook can be found on the CSI website at www.csimt.gov . The Excel workbook contains worksheets for community, institutional, limited service, outpatient surgical, and mail order pharmacies used in the evaluation of the network. When completing the pharmacy list worksheets for community, institutional, limited service, and outpatient surgical pharmacies place a "Y" in the column, with the heading "In Network", to indicated yes; the pharmacy has been contracted and is in network. Place an "N" in the column, with the heading "In Network" of the pharmacy List worksheet to indicated no; the insurer has not contracted with the pharmacy to be in network. The following information must be enter on the mail order pharmacy worksheet for each mail order pharmacy in network, business name, the location (city, state, and zip code), the Montana license number as issued by the Montana Department of Labor. Insurers may look up the Montana license number at https://ebiz.mt.gov/pol/. If the insurer's pharmacy benefit includes tiers that pay benefits at a different level (i.e.: preferred and non-preferred "in network" pharmacies), then enter that information, such as preferred or standard, etc. that corresponds to the tiers in the insurer's plan in the tier level column of the worksheet. Enter N/A in the tier level column if there are no differences between in network pharmacies. 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 Pharmacy-5-11-16.

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 2017. Provider directory must be updated on a regular basis. Failure to keep the provider director up to date may constitute a misrepresentation. For a more complete understanding of network adequacy requirements in Montana, refer to the Admin. Rules of Mont. at 6.6.5901 et seq.

Please submit all healthcare provider, facility, pharmacy (if applicable) and ECP files through SERFF. Technical questions about completion of the Excel workbooks can be sent to David Dachs at ddachs@mt.gov. All other questions regarding Montana's network adequacy requirements can be sent to Christina Goe at cgoe@mt.gov. Your rate, form and template review cannot be completed until the adequacy of your network is determined and approved by the Commissioner. Additionally QHP insurers must also complete and submit the required CMS network and ECP templates.

PRESCRIPTION DRUG PLANS

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

All QHP insurers 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, insurers 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.

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 Insurers, 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 are treated as a separate insurer.

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.

STAND-ALONE DENTAL PLANS

Qualified Stand-alone dental plans (QDPs) must file their rates, forms, plan binders and network lists according to the same timelines and instructions that apply to all QHP insurers. Montana's PPO network adequacy law applies to dental **and vision** plans. The benefits template will be modified for dental plans as described in 2017 FFM letter to insurers. Each QDP insurer must specify whether or not the rates contained in the templates are guaranteed to consumers or will be subject to change (underwriting).

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

LARGE EMPLOYER GROUP INSURANCE

Large employer group insurers should follow the instructions regarding network lists that must be filed annually, the prohibition on exclusions for services for transgender 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.

CONCLUSION

If you have questions, please contact Richard Hersey , Forms Bureau Chief (forms and templates), David Dachs, Market Conduct Examiner (network list filing), or Christina Goe, General Counsel (legal questions) at 406-444-2040 or rhersey@mt.gov , cgoe@mt.gov , or ddachs@mt.gov .