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MI Bulletin 2016-10-INS (March 14, 2016)
This document supplements 2011-17- INS
MICHIGAN INSURANCE BULLETINS AND RELATED MATERIALS
BULLETINS

Bulletin 2016-10-INS
March 14, 2016

FROM: Patrick M. McPharlin
Director Of Insurance
DATE: March 14, 2016
RE: IN THE MATTER OF: 2017 FORM AND RATE FILING REQUIREMENTS FOR MEDICAL PLANS

Information in this Bulletin is subject to change as federal guidance is finalized. Issuers are strongly urged to routinely check the Department of Insurance and Financial Services (DIFS) website and the System for Electronic Rate and Form Filing (SERFF) State Messages for updates.

SECTION 1: CERTIFICATION AND RECERTIFICATION FILING REQUIREMENTS FOR MEDICAL PLANS ON AND OFF THE MARKETPLACE

GENERAL INFORMATION

DIFS will continue to perform Plan Management functions for the 2017 plan year. [FN1] Plan Management functions are part of DIFS' regulatory role for products offered on and off the Marketplace. Issuers will work directly with DIFS to submit all Qualified Health Plan (QHP) application data in accordance with federal and state guidelines. SERFF will be used by issuers to transmit information to DIFS, and DIFS will use SERFF to transmit information to the Centers for Medicare & Medicaid Services (CMS).

Many of the same guidelines apply to issuers filing plans offered off the Marketplace and these items are referenced in this Bulletin.

NEW PLANS AND RECERTIFICATION OF QHPS

For the 2017 plan year, DIFS' process for certification and recertification of a QHP is consistent with the process used in prior plan years. Issuers submitting previously-approved plans for recertification will be required to submit much of the same information as for prior plan years. Issuers submitting plans for certification for the first time should review the pertinent federal and state guidance. THE OMISSION OF ANY PARTICULAR FEDERAL OR STATE REQUIREMENT FROM THIS BULLETIN SHOULD NOT BE CONSTRUED TO MEAN THAT COMPLIANCE WITH THOSE REQUIREMENTS IS NOT NECESSARY. For additional guidance, issuers are urged to refer to the 2017 LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED MARKETPLACE ("Letter").

NEW 2017 SUBMISSION TIMELINES

DIFS has established two submission windows for Michigan issuers to file their proposed Forms, Binders and Rates for the 2017 plan year. [FN2]

SUBMISSION 1: FORMS AND BINDERS

Submission 1 requires issuers to submit FORMS AND BINDERS for all on- and off-Marketplace plans in SERFF by the following dates: April 11, 2016 for the small group market, and May 9, 2016 for the individual market. This includes all policy forms, certain federal templates, and related supporting documents. See Exhibit 1 for the list of required templates and documents for Submission 1. Note that while a preliminary, validated Rates Table Template is required during Submission 1, DIFS will not review these preliminary rates.

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SUBMISSION 2: RATES

Submission 2 requires issuers to submit RATES and rate-related documentation for all on- and off-Marketplace plans in SERFF by the following dates: June 1, 2016 for the small group market, and June 20, 2016 for the individual market. This includes final Rates, the Rate Filing Justification Parts I, II and III, and related supporting documents. See Exhibit 2 for the list of required templates and documents for Submission 2. Rates included with Submission 2 will be deemed an issuer's final rates subject to approval. Note that DIFS will not accept changes to the Rates Table Template after the Submission 2 deadline, unless required by DIFS as part of the rate review process.

DIFS will consider a filing complete only when the requirements for both Submission 1 and 2 are met.

ALL SMALL GROUP PRODUCTS -- ON AND OFF MARKETPLACE

ACTIVITY		DATES
DIFS Submission 1 (EXHIBIT 1)	DIFS FILING DEADLINE -- SMALL GROUP FORM AND BINDER	4/11/2016
	DIFS 1st Transfer of Plan Data to CMS	5/11/2016
	CMS Reviews Plan Data; Sends Correction Notices	5/12/2016 to 6/16/2016
DIFS Submission 2 (EXHIBIT 2)	DIFS FILING DEADLINE -- SMALL GROUP RATES	6/01/2016
	DIFS 2nd Transfer of Plan Data to CMS	6/30/2016
	CMS Reviews Plan Data; Sends 2nd Set of Correction Notices	7/01/2016 to 8/09/2016
Final Review	Final Deadline for Submission of QHP Data	8/23/2016
	Final CMS Review of Revised QHP Application Submissions Received as of August 23	8/24/2016 to 9/09/2016

CMS QHP Agreement and Final Certification	Certification Notices Sent to Issuers; Agreements Signed, by Issuers; Validation Confirming Final Plan List	9/15/2016 to 10/04/2016
Open Enrollment		11/01/2016 to 1/31/2017
ALL DATES BASED ON CMS FUNCTIONS ARE SUBJECT TO CHANGE		

***3**
NOTE: No advance marketing or enrollment activity allowed until open enrollment begins on November 1, 2016.

ALL INDIVIDUAL PRODUCTS -- ON AND OFF MARKETPLACE

Activity		Dates
DIFS Submission 1 (EXHIBIT 1)	DIFS FILING DEADLINE -- INDIVIDUAL FORM AND BINDER	5/09/2016
	DIFS 1st Transfer of Plan Data to CMS	5/11/2016
	CMS Reviews Plan Data; Sends Correction Notices	5/12/2016
DIFS Submission 2 (EXHIBIT 2)	DIFS FILING DEADLINE -- INDIVIDUAL RATES	6/20/2016
	DIFS 2nd Transfer of Plan Data to CMS	6/30/2016
	CMS Reviews Plan Data; Sends 2nd Set of Correction Notices	7/01/2016 to 8/09/2016
Final Review	Final Deadline for Submission of QHP Data	8/23/2016
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ALL DATES BASED ON CMS FUNCTIONS ARE SUBJECT TO CHANGE		

***4**
NOTE: No advance marketing or enrollment activity allowed until open enrollment begins on November 1, 2016.

2017 FILING REQUIREMENTS

A complete submission includes SERFF Rate/Form filing and Binder, with all required validated templates and associated items, as outlined in Exhibits 1 and 2. Issuers are required to run the 2017 QHP Application Tools and the Data Integrity Tool for the initial and any subsequent template submissions. PLEASE NOTE: only one Business Rules Template needs to be completed, and should include both individual and small group plans. However, the Business Rules Template must be submitted in both the individual and small group SERFF Rate/Form filing and Binder.

2017 CHECKLIST REQUIREMENTS

The CHECKLIST FOR INDIVIDUAL AND SMALL GROUP MEDICAL PLANS -- FORMS (FIS 2307), the CHECKLIST FOR INDIVIDUAL AND SMALL GROUP MEDICAL PLANS -- RATES (FIS 2306), and THE CHECKLIST FOR INDIVIDUAL AND SMALL GROUP MEDICAL PLANS -- NETWORK ADEQUACY (FIS 2313) must be completed and filed as shown in Exhibits 1 and 2.

REVISIONS TO PREVIOUSLY-APPROVED QHPS: RED-LINED VERSIONS

Issuers revising previously-approved QHP forms must provide red-lined versions, as well as clean versions. The red-lined and clean versions should both be filed under the Forms Schedule tab of the SERFF Rate/Form filing under the same item number. Forms not being revised must still be submitted.

STANDARDIZED PLANS

Although not a DIFS requirement, issuers choosing to offer individual QHP standardized options in the individual market must do so in compliance with the 2017 Payment Notice Final Rule as noted in the “LETTER.“

FILE NAMING

Certain items under the Supporting Documentation tab in the Rate/Form filing and/or the Binder filing must adhere to a standard naming convention as follows: IssuerName_MIFormDescription_Version#.

The purpose of adherence to a standard naming convention is to have the ability to track new versions as they are updated on the system. It is important to start with Version 1 and use the same issuer name and form description in the file name each time. In addition, all review tools must be run each time a template is revised.

Items that are required to have a standard naming convention are:

• DIFS Medical Forms Checklist;

• DIFS Medical Rates Checklist;

• DIFS Medical Network Adequacy Checklist;

• MI Network Data Template;

• Rates Table Template;

• Actuarial Memorandum;

• URRT;

• Justifications and Attestations;

• Summary of Benefits and Coverage;

• Any document that is amended from its original version that is not automatically versioned through SERFF.

SERFF FILINGS

All filings submitted via SERFF (on and/or off the Marketplace) are considered to be public immediately upon being filed in SERFF.

***5**
All federal and Michigan-specific templates must be filed in the Rate/Form filing and in the Binder in Excel (xml and xlsm) formats. Do not submit templates in PDF.

PRODUCT WITHDRAWAL AND UNIFORM MODIFICATION

All plans submitted for the 2017 year are subject to product withdrawal/uniform modification rules, whether offered on or off the Marketplace. DIFS requires that the Michigan Uniform Modification Justification form (FIS 2316) be submitted as shown on Exhibit 1.

In addition, CMS requires that the Plan ID Crosswalk Template be submitted to QHP_Applications@cms.hhs.gov by May 11, 2016 for plans in the individual Marketplace. DIFS will request a final copy by June 23, 2016.

LICENSURE AND GOOD STANDING

DIFS will review the licensure status of all issuers filing plans on and/or off the Marketplace.

ANNUAL LIMIT ON COST-SHARING

The 2017 out-of-pocket maximums for Marketplace-certified QHPs are $7,150 for individuals and $14,300 for families.

SERVICE AREA

With regard to plans on the Marketplace, CMS requires that any partial service areas (geographic areas smaller than a county) must be established without regard to racial, ethnic, language, or health status factors. Issuers with partial service areas must submit a partial service area justification in the Supporting Documentation tab of the Binder. Issuers should refer to the CMS Service Area Partial County Justification Instructions regarding acceptable reasons for partial service areas. Partial service area requests will be reviewed on a caseby- case basis. Issuers of plans on the Marketplace are urged to refer to the "LETTER."

NETWORK ADEQUACY

The MICHIGAN NETWORK ADEQUACY GUIDANCE reflects current network sufficiency standards and requirements. This Guidance has recently been updated to address:

• Continuity of care

• Network configurations

• Network provider definition

• CMS oversight of specific network specialties

The Michigan Network Adequacy Guidance is also available under the Supporting Documentation tab in SERFF.

ESSENTIAL COMMUNITY PROVIDERS

Issuers of plans on the Marketplace should refer to the "LETTER" for current Essential Community Provider requirements.

PATIENT SAFETY STANDARDS

As outlined in the "LETTER," issuers contracting with hospitals with more than 50 beds must verify that the hospital (as

defined in section 1861(e) of the Social Security Act) is Medicare-certified or has been issued a Medicaid-only CMS Certification Number. To comply with this requirement, issuers must include in their binder submission, within the Supporting Documentation tab, an attestation that the issuer has collected and is maintaining the required documentation from its network hospitals.

SECTION 2: CONTRACT REQUIREMENTS (APPLICABLE TO ALL PLANS)

READABILITY

***6** Submitted forms must comply with the following readability standards found under MCL 500.2236(3):

1. Each form entered in the SERFF Forms Schedule tab shall include the form's readability score.

2. The readability score must be based on the Microsoft Word Flesch Reading Ease test and have a score of 45 or higher. Forms with a Microsoft Word Flesch Reading Ease score lower than 45 will not be approved by DIFS or transferred to CMS for certification.

3. Health care policies and certificates, dental policies and certificates, and certificates of coverage, with more than 3,000 words printed on not more than three pages, or more than three pages of text regardless of the number of words, shall contain a table of contents. (This requirement does not apply to riders or endorsements).

4. Be printed with font size not less than 10 point (an exception under MCL 500.2236(3) for policies of disability insurance as defined in section MCL 500.3400); font requirement found in MCL 500.3402.

GUARANTEED RENEWABILITY

All individual and small group plans offered on and off the Marketplace must comply with federal and state law regarding guaranteed renewability, including all applicable federal regulations and guidance, and DIFS Bulletin 2011-17-INS.

ACTUARIAL VALUE (AV) REQUIREMENTS

All individual and small group plans offered on and off the Marketplace must be assigned to one of the four "metal level" AV tiers or be classified as a catastrophic plan. Determinations of AV must conform to 45 CFR 156.140.

RELIGIOUS EMPLOYER EXEMPTION

DIFS will allow issuers providing benefits for RELIGIOUS EMPLOYERS, NON-PROFIT RELIGIOUS EMPLOYERS OR CLOSELY HELD FOR PROFIT COMPANIES WITH STRONG RELIGIOUS BELIEFS who qualify for contraceptive coverage exemptions under federal rules, to include additional language describing the administration of these benefits. The purpose of the additional language will be to clarify for employees that the:

1. Employer will not contract, arrange, or pay for contraceptive benefits for employees.

2. Issuer will instead provide contraceptive benefits for employees (including notification to employee).

3. Costs for these benefits are not included in the premium paid for the healthcare coverage.

ESSENTIAL HEALTH BENEFITS (EHB)

EHB BENCHMARK PLAN

Issuers must use MICHIGAN'S 2017 BENCHMARK PLAN. Issuers should review the benchmark to ensure their plans on and off the Marketplace conform to it.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

All individual and small group plans must comply with the federal Mental Health Parity and Addiction Equity Act and applicable regulations. In particular, issuers should carefully review the final rule implementing the MHPAEA, issued on November 13, 2013, and generally applicable to plan and policy years on or after July 1, 2014. Issuers should review the final rule to determine whether a particular plan is subject to the MHPAEA and is in compliance with that statute and regulations.

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ACTUARIALLY EQUIVALENT SUBSTITUTIONS OF EHB

Actuarially equivalent substitutions of EHB are not permitted in Michigan.

ANTI-DISCRIMINATION IN EHB

DIFS will review policy and certificate forms for compliance with all provisions of the proposed federal anti-discrimination rules issued on September 8, 2015. See 80 Fed. Reg. 54172-54221. Issuers are strongly encouraged to review the proposed rules in their entirety, particularly proposed rule 45 CFR 92.207, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. This rule, among other things, prohibits issuers from categorically excluding all health services related to gender transition, and from denying or limiting coverage for gender transition if doing so results in discrimination against a transgender individual.

Under the rule, age limits that are included by statute are generally permissible (for example, in Michigan's autism mandate), but age limits not found in statute may be prohibited. DIFS will review policy and certificate forms for impermissible age limits.

REHABILITATIVE AND HABILITATIVE SERVICES; AUTISM SPECTRUM DISORDER

All plans must cover at least 30 visits for speech therapy, plus a combined 30 visits for physical and occupational therapy for rehabilitative services. For 2017, plans must ALSO cover at least the same number of visits for habilitative services. However, for treatment of autism spectrum disorder specifically, plans may not limit the number of visits for any mandated type of treatment, including speech therapy, physical therapy and occupational therapy.

SECTION 3: CONTRACT REQUIREMENTS (APPLICABLE TO ON-MARKETPLACE PLANS ONLY)

ACCREDITATION

45 CFR 155.1045 establishes the timeline by which issuers offering plans on the Marketplace must be accredited by NCQA, URAC or AAAHC. An issuer's accreditation status will be available to consumers at the Marketplace website.

REQUIRED COST-SHARING VARIATIONS FOR INDIVIDUAL MARKET PLANS ONLY

45 CFR 156.420 requires several cost-sharing plan variations for issuers offering coverage in the individual market on the Marketplace. Issuers must submit for approval the three plan variations for each silver plan offered, and the zero and limited cost-sharing variations for each plan at the platinum, gold, silver, and bronze metal levels.

SECTION 4: RATING REQUIREMENTS (APPLICABLE TO ALL PLANS)

RATING FACTORS

Rates may vary based only on the following factors:

• Rating area;

• Age (within a ratio of 3:1 for adults);

• Tobacco use (within a ratio of 1.5:1).

ADDITIONAL MICHIGAN RATING FACTOR DETERMINATIONS

Michigan has made the following determinations related to the allowable rating factors, applicable to all individual and small group plans:

***8**
AGE RATING

Michigan plans must adhere to the 3:1 ratio and federal default age curve for both individual and small group markets.

TOBACCO RATIO

Issuers will not be required to use a tobacco ratio less than 1.5:1. Issuers will be allowed to vary their tobacco ratio based on age, as long as the ratio does not exceed 1.5:1 for any specific age.

STANDARD FAMILY TIER

Michigan will not allow the use of a standard family tier.

PER-MEMBER RATING

Michigan requires per-member rating in the small group market. Issuers wishing to offer small employers the option to be billed on a composite premium basis must comply with the requirements set forth at 45 CFR 147.102(c)(3), including the development of separate composite premiums for individuals age 21 and older and individuals under age 21.

GEOGRAPHIC RATING

Michigan will maintain the same geographic areas for use in both the individual and small group market for the 2017 year. The 16 defined geographic areas, with each of the 83 counties in Michigan assigned to one of 16 geographic areas and labeled A through P, can be found on the DIFS website here.

MERGING OF MARKETS

Pursuant to 45 CFR 156.80, Michigan requires issuers to maintain separate risk pools for the individual and small group markets.

SECTION 5: WELLNESS PLANS

GENERAL GUIDELINES

Wellness plans, either participatory or health-contingent, may be offered with both individual and small group plans. Any wellness plan must:

• Meet the requirements of 45 CFR 146.121 and 147.11 O; and

• Be a part of the policy (i.e., not offered separately).

SMALL GROUP PLANS THAT RATE FOR TOBACCO USE

Issuers must include a health-contingent wellness plan in the small group market if they are rating for tobacco use. The plan must provide for a reduction or elimination of the tobacco rating if the insured participates in a tobacco cessation program. The plan must also meet the requirements stated in the General Guidelines above. The plan materials must describe the conditions and benefits of the wellness plan; simply stating that a wellness plan is offered is not sufficient.

Any questions regarding this bulletin should be directed to:

Department of Insurance and Financial Services

Office of Insurance Rates and Forms

530 West Allegan Street, 7th Floor

P.O. Box 30220

Lansing, Michigan 48909-7720

Toll Free: (877) 999-6442

 Image 1 within document in PDF format.

Exhibit 1 & 2

[FN1] Federal law permits states to choose whether to allow large group plans to participate on the Marketplace in 2017. DIFS has chosen NOT to allow large group coverage to be offered in the Marketplace in 2017, but will continue to monitor this issue.

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[FN2] In the February 29, 2016 RATE FILING JUSTIFICATION BULLETIN, CMS granted Federally-Facilitated Marketplace states with Effective Rate Review programs flexibility to establish uniform deadlines as long as they occur between May 11, 2016 and July 15, 2016. DIFS has established two separate windows to allow rate filings to be made in accordance with this guidance.

End of Document