COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(617) 521-7794 Toll-free (877) 563-4467
http://www.mass.gov/doi

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

JAY ASH
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

JOHN C. CHAPMAN
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

GARY D. ANDERSON
ACTING COMMISSIONER OF INSURANCE

MERGED MARKET HEALTH COVERAGE
Filing Guidance Notice: 2017-A

TO: Insurance Issuers Offering and/or Renewing Insured Health and Dental Plans in the Massachusetts Merged Small Group/Individual Market to be effective January 1, 2018

FROM: Kevin Beagan, Deputy Commissioner, Massachusetts Division of Insurance
Tracey McMillan, Director, Bureau of Managed Care

DATE: April 24, 2017

RE: Submission of Policy Form/Rate Materials Necessary for the Review of Merged Market Health and Dental Benefit Plans Proposed to be Available as of January 2018

The purpose of this Notice is to provide guidance on filing policy forms and rates with the Massachusetts Division of Insurance ("Division") necessary for reviewing coverage intended to be issued and/or renewed in the Massachusetts merged small group/individual market as of January 1, 2018. The guidance provided in this Notice applies to all health benefit plans and dental plans offered and/or renewed in the merged market, including the Qualified Health Plans ("QHPs") and Qualified Dental Plans ("QDPs") that must be certified by the Commonwealth Health Insurance Connector Authority ("the Health Connector") for offer through the Massachusetts State-Based Market Exchange.

General Information:

Pursuant to Section 1302 of the Patient Protection and Affordable Care Act and federal rule 45 CFR 156.100, the Commonwealth selected the HMO Blue New England $2000 Deductible Plan ("HMO Blue New England") offered by Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. as its 2017 base-benchmark plan, supplemented with the FEDVIP High Option plan for pediatric vision services and the Massachusetts CHIP plan for pediatric dental services. All merged small group/individual market health benefit plans offered and/or renewed in 2018 should include all Essential Health Benefits ("EHBs") as further outlined on the Division's website http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/essential-health-benefit-benchmark-plan-2017.html and must meet actuarial value levels associated with "metallic tiers" established under rules developed by the federal Secretary of Health and Human Services, as calculated using the most recently available federal actuarial value calculator.

Massachusetts Issuers must cover all mandated benefits and medications, in addition to the EHBs and Preferred Pharmacy Drug List ("PDL") as outlined on the Division's website http://www.mass.gov/ocabr/docs/doi/consumer/healthlists/mndatben.pdf.

INSTRUCTIONS FOR QHP AND QDP FILINGS

The Division requires all Issuers to submit form, binder and rate filings via the System for Electronic Rate and Form Filing ("SERFF"). Instructions on using SERFF are available through the help module.
https://login.serff.com/onlineHelpState.html

FILINGS MODULE – FORMS:

1. Issuers must submit any material changes to a product being offered and/or renewed (the BINDER documentation may be submitted at the same time as the material changes form filings).
2. For the 2018 filings and beyond, within each Plan Management/Binder, Issuers are required to identify in the "Associate Schedule Items" tab the corresponding "Form Schedule Items" associated with EACH filed HIOS number.
3. Issuers must submit any new products being offered and/or renewed (the BINDER documentation may be submitted at the same time as the new product form filing).
4. Issuers must submit completed Managed Care Checklists (as appropriate) for each SERFF filing. The Managed Care checklists are located on the Division's website. http://www.mass.gov/ocabr/licensee/license-types/insurance/insurance-companies/policy-form-and-rate-filing/checklists.html
5. Issuers must adhere to all Massachusetts General Laws, state regulations, mandates and bulletins as applicable to health insurance even if guidance is not provided in the Managed Care Checklists. Online resources are available on the Division's website. http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/
6. In addition to the requirements outlined in the Managed Care Checklist(s), Issuers must also submit the following for each product offered and/or renewed:
    a. Evidences of Coverage and Schedules of Benefits (i.e. member cost-sharing responsibilities);
        i. As a reminder, Issuers that intend to provide rewards for actions on the part of members or discounts for services or providers should refer to Filing Guidance Notice 2012-D "Filings for Products that Include Rewards and/or Discounts" issued on July 11, 2012. http://www.mass.gov/ocabr/docs/doi/companies/checklists/2012-d.pdf
    b. Essential Community Provider Supplemental Response Form.
    c. Unique Plan Design Supporting Documentation and Justification.
    d. Pharmacy Drug List.
    e. Drug Formulary/Inadequate Category/Class Count Supporting Documentation and Justification;
    f. All Issuers that embed dental benefits within their medical products must submit all dental contract boilerplates via SERFF:
        i. Boilerplate contract(s) must be submitted regardless of whether the Issuer has recently filed the contract(s) and even if there have been no material changes; and
        ii. All boilerplate contracts must comply with 211 CMR 52.12. http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-52.pdf
    g. An attestation that each of the Issuer's health benefit plans has been tested and is in full compliance with the requirements of federal regulation 45 CFR 146.136 - *Parity in mental health and substance use disorder benefits*; and

h. Plan provider network documents including:
    i. Electronic copies of medical, dental and vision provider directories; and
    ii. Geo-access maps of each network identified by network name, along with separate geo-access maps which include access standards for each of the following provider types based for the following: acute care facilities; inpatient behavioral health facilities; Primary Care Practitioners; and the following five specialists: Gynecology, Orthopedics, Cardiology, Oncology and Mental Health/Substance Use Disorder. The Geo-access maps shall be informed by the electronic copies of all directories.

*** If the Issuer does not believe that any part of the above-noted requested documentation is applicable to its filing, please provide a note in SERFF that explains the justification by line item.**

PLAN MANAGEMENT MODULE – BINDER:

1. Issuers are to complete the SERFF Plan Management Binder that identifies each separate insured health benefit plan or dental plan - identified by the Marketing Name for each plan design in the "Plan" tab – which the Issuers intend to offer and/or renew for the 2018 Open Enrollment period.
2. The Plan Management Binder is to include those plans that the Issuer intends to offer and/or renew in 2018.
3. Issuers are to provide a statement to confirm whether they have filed a variable cost-sharing template [including the appropriate SERRF filing number(s)] that include proposed 2018 plan designs.
4. In addition to the help documentation provided in SERFF, the following are new instructions and/or explanations under the Plan Tab in the Plan Management module. The below is applicable to both QHPs and QDPs.

Field:	Description:
Availability (Plan Tab)	The Issuers shall select the following attribute from the dropdown based on each standard component ID/plan. **Both** = The plan is being offered and/or renewed both on and off the Exchange. *Due to Massachusetts guaranteed availability requirement, any plan offered and/or renewed on the Exchange must be offered and/or renewed off the Exchange. **Off-Exchange** = The plan is only being offered and/or renewed off the Exchange.
Disposition Status (Plan Tab)	Upon final review of the filing, the Division will select one of the following attributes from the drop down based on each standard component ID/plan. **State Certified for Inside Exchange** = The availability of the component ID/plan "both" OR "off-Exchange" AND the component ID/plan has been accepted and meets all the requirements of an acceptable plan. *Historically, the Division used the "placed on file" selection from the drop menu. **State Review Completed Outside the Exchange** = If the availability of the product reflects off Exchange and the component ID/plan meets all requirements of an acceptable plan. *Historically, the Division used the "placed on file" selection from the drop menu. **Disapprove** = If the component ID/plan does not meet all requirement of an acceptable plan. **Not Determined** = The component ID/plan is not certified because it has been withdrawn as requested by the Issuers. **Certification Denied** = The component ID/plan does not meet all the requirements of an acceptable plan. **Withdrawn** = The Issuer has requested that the component ID/plan be withdrawn.

5. Templates
    a. Issuers must complete all templates and submit them to the Division (unless otherwise noted) as part of the Plan Management/Binder via SERFF. Templates are on the Centers for Medicare & Medicaid Services ("CMS") website https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html

Template:	Description:
Plans and Benefits Template	Collects plan and benefit data. (The template has a dependency on the Plan and Benefits Add-In Template)
Plan and Benefits Add-In Template	Collects data from Issuers to complete the Plan and Benefits Template. The template is not a separate attachment and should only be used as a resource for Issuers. Issuers do not need to submit the add-in template in SERFF.
Prescription Drug Template	Collects Formulary data for plans.
Network Template	Information identifying an Issuer's product/provider network.
Service Area Template	Information identifying an Issuer's geographic service area.
Essential Community Providers/Network Adequacy Template	Collects data on the Essential Community Provider Network.

***** Pre-loaded templates will be provided in SERFF by the National Association of Insurance Commissioners ("NAIC") for Issuers to download.

    b. For more info on the above Massachusetts Division of Insurance required templates listed above, Issuers may visit the following website. https://www.qhpcertification.cms.gov/s/Application%20Instructions
    c. Issuers may be required to submit additional templates to those listed above, as required and defined by CMS/CCIIO. If new templates are required, the Division will notify Issuers as soon as the information is available.
    d. The templates listed below are optional, and Issuers may or may not include them in the submission.
        i. National Committee for Quality Assurance (NCQA) Template.
        ii. Utilization Review Accreditation Commission (URAC) Template

6. Rate Filings:
    a. Issuers must submit the following as part of the Plan Management/Binder in SERFF:
        i. Actuarial Value Calculation Explanation - Additional documentation of Actuarial Value calculation should be attached as supporting documentation for each plan noting the appropriate HIOS number per Binder. Please refer to the Division's Filing Guidance Notice 2013-G for specific requirements.
        ii. Issuers must submit proposed rate filings for single risk pool coverage intended to be effective January 1, 2018 (for both QHPs and non-QHPs), as well as the Binder's Business Rules Template and the Rate Data Template, no later than 180 days prior to their effective date, i.e., by July 5, 2017 for a January 1, 2018 effective date. Rate filings and supporting information shall be submitted through SERFF, with federal Rate Filing Justification materials simultaneously posted in the Health Insurance Oversight System ("HIOS"). (Please note that 2nd, 3rd, and 4th quarter Rate Filing Justification materials continue to be required to be posted in HIOS 105 days prior to the proposed effective date).

Template:	Description:
Rate Data Template	Collects rate data for each plan and rating area to be offered on the Exchange.
Rating Business Rules Template	A federal data collection template for the Issuer-specific business rules to calculate rates based on various factors.

    b. Issuers must submit the following using the HIOS:
        i. Federal rules require the filing of rate filing materials via HIOS. Issuers will be required to submit appropriate Rate Filing Justification materials, according to the form and manner prescribed by the federal Secretary of Health and Human Services, for all plans and products that are subject to a rate increase, regardless of the size of the increase.
        ii. Rate Filing Justification materials include the following:
            1. Part I - Unified rate review template;
            2. Part II - Written description justifying the rate increase; and
            3. Part III - Actuarial Memorandum and Certification.7.
        iii. For more information on the final 2018 Notice of Benefit and Payment Parameters, Issuers should refer to https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-12-16.html
        iv. For additional guidance on the submission of the noted materials to HIOS, Issuer should refer to https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html#Review%20of%20Insurance%20Rates

7. Supporting documentation
    a. Issuers must complete the previously provided organization contact list for each entity and license type and submit the document in the SERFF Plan Management binder under the supporting documentation tab.
        i. Content provided must include the contact information of each of the below within the organization:
            1. President of Company
            2. CEO of Company
            3. Compliance Officer
            4. Regulatory Affairs Representative
            5. Medical Director
            6. Finance Representative
            7. SERFF Filer
        ii. Issuers may include additional contacts (if necessary).
        iii. Contact list will be used to update the Division's Bureau of Managed Care Distribution List.
        iv. Depending on the Issuer's preference, not all contacts will receive notifications of Division bulletins, updated regulations, new projects, new mandates, etc.
        v. Issuers should email any contact list material changes after the initial filing to bmc.mailbox@state.ma.us.

QHP and QDP Certification Timeline

Issuers shall refer to the Health Connector RFR for Seal of Approval instructions and additional timeline for QHP and QDP activities.
https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-14-1175-1175C-1175L-14119

Below is the timeline related to the Division's review of QHP and QDP filings and all associated activities.

Dates:	Activity:
4/24/2017	Division Issues QHP and QDP Filing Guidance Notice to all Issuers.
Ongoing	Issuers to submit questions via email to the Division related to the QHP Filing Guidance. Send questions to bmc.mailbox@state.ma.us.
Ongoing	The Division responds to questions via email to Issuers and posts final FAQs on the Division website. Issuers will be notified of the location and link where the FAQs will be posted. *Note: FAQs will be updated periodically with questions that are submitted from Issuers and answered by the Division after the deadline. Please check the location and link of the FAQs periodically for the most up-to-date information http://www.mass.gov/ocabr/licensee/license-types/insurance/insurance-companies/policy-form-and-rate-filing/checklists.html
5/17/2017	**On-Exchange Health and Dental Products:** Issuer deadline to submit Plan Management Binders with all completed templates and supporting documentation except the Binder's Business Rules Template and the Rate Data Template to the Division via SERFF. *Note: all On-Exchange products will be offered and/or renewed off the Exchange per the Massachusetts guaranteed availability requirements.
5/2017 – 10/2017	Division begins review of SERFF filings; completion date may differ based on each Issuer submission.
6/30/2017	**Off-Exchange Health and Dental Products Only:** Issuer deadline to submit Plan Management Binders with all completed templates and supporting documentation except the binder's Business Rules Template and the Rate Data Template to the Division via SERFF.
7/5/2017	Rate Filings due to the Division for all products via SERFF - includes the Binder's Business Rules Template and the Rate Data Template.
No later than 10/2017	Division places submissions on file and certifies plans in SERFF (for approved plans).