



COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE

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MERGED MARKET HEALTH COVERAGE
Filing Guidance Notice: 2021-B

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, 2022

FROM: Niels Puetthoff, Director, Bureau of Managed Care 

DATE: April 9, 2021

RE: Submission of Policy Form/Rate Materials for the Review of Merged Market Health and Dental Benefit Plans Proposed to be Available as of January 2022

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, 2022.

The guidance provided in this notice applies to all insured 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 Division of Insurance 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 and subsequent years thereafter base-benchmark plan, supplemented with the FEDVIP High Option plan for pediatric vision services and the Massachusetts CHIP plan for pediatric dental services. This continues to be the benchmark plan for year 2022 and going forward.

All merged small group/individual market health benefit plans offered and/or renewed in 2022 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>

QHP and QDP Certification Timeline

Issuers shall refer to the Health Connector RFR for Seal of Approval instructions and additional timelines for QHP and QDP activities at <https://www.commbuys.com/bsa/external/bidDetail.sdo?bidId=BD-19-1175-1175C-1175L-60138&parentUrl=activeBids>.

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

Dates:	Activity:
4/9/2021	Division Issues QHP and QDP Filing Guidance Notice to all Issuers.
5/14/21	On-Exchange Health and Dental Products: Issuer deadline to submit to the Division (1) Plan Management Binders with all completed templates and supporting documentation except the Binder’s Business Rules Template and the Rate Data Template are to be submitted to the Division via SERFF; and (2) On-Exchange product filings are to be submitted to the Division via SERFF. *Note: all On-Exchange products will also be available off the Exchange per the Massachusetts guaranteed availability requirements. The deadline for submissions to the Health Connector is 5/14/2021.
5/14/2021 – 10/2021	Division reviews SERFF filings; completion date may differ based on each Issuer submission.
7/01/2021	Off-Exchange Health and Dental Products Only: Issuer deadline to submit (1) Plan Management Binders with all completed templates and supporting documentation except the binder’s Business Rules Template and the Rate Data Template are to be submitted to the Division via SERFF; and (2) Off-Exchange-Only product filings are to be submitted to the Division via SERFF.
7/01/2021	Rate Filings due to the Division for all products via SERFF, which must include the Binder’s Business Rules Template and the Rate Data Template.
No later than 10/2021	Division places submissions on file and certifies plans in SERFF (for approved plans).

INSTRUCTIONS FOR OHP AND ODP 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/serff/signin.do>

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 2022 filings, within each Plan Management/Binder, in the “Associate Schedule Items” tab, Issuers are required to identify 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. <https://www.mass.gov/lists/policy-form-and-rate-filing-checklists>
5. Issuers must adhere to all Massachusetts General Laws, state regulations, mandates and bulletins, and relevant federal rules, 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. <https://www.mass.gov/orgs/division-of-insurance>
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. Evidence of Coverage and Schedule 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, including a Drug Formulary/Inadequate Category/Class Count and Non-Discrimination Clinical Appropriateness Supporting Documentation and Justification. Issuers must attach completed copies of the Drug Count Review Tool and the Formulary Review Suite to report results of the Category & Class Drug Count Review and the Non-Discrimination Clinical Appropriateness review for each of the issuer’s formularies. Issuers must report deficiencies identified by these review tools by submitting a combined Prescription Drug Supporting Documentation and Justification Form for each deficiency identified. Please add the Drug Count Review Tool and the Formulary Review Suite as an additional item within the Supporting Documentation Tab.
 - e. 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 52.11. <http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-52.pdf>
 - f. 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
 - g. 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 that include access standards for each of the following provider types: 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 contain the same data as 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.

Below is a list of links that will help Issuers locate important documentation re: additional requirements.

- a. Division of Insurance homepage:
<https://www.mass.gov/orgs/division-of-insurance>
- b. Division of Insurance Bulletins:
<https://www.mass.gov/lists/doi-bulletins>
- c. Division of Insurance Regulations:
<https://www.mass.gov/service-details/division-of-insurance-regulations>
- d. Massachusetts General Laws:
<https://malegislature.gov/Laws/GeneralLaws>
- e. Health Care Consumer Guides including Mandates:
<https://www.mass.gov/lists/health-care-consumer-resources>
<http://www.mass.gov/ocabr/docs/doi/consumer/healthlists/mndatben.pdf>
- f. Managed Care Checklists:
<https://www.mass.gov/lists/policy-form-and-rate-filing-checklists>
- g. Health Filing Guidance:
<https://www.mass.gov/lists/policy-form-and-rate-filing-checklists>

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 2022 Open Enrollment period.
2. The Plan Management Binder is to include those plans that the Issuer intends to offer and/or renew in 2022.
3. Each Plan shall be associated with a unique HIOS ID number and should not be duplicated in other binders for the upcoming plan year.

Example #1: If the Issuer is offering an Individual plan, the plan must also be made available to small groups; and if the Issuer is offering a Small Group plan, the plan must also be made available to individuals due to the Massachusetts Guaranteed Availability requirements. This plan will need to be designated with 2 unique HIOS ID numbers, (1) for the Individual market type and (2) for the Small Group market type.

Example #2: If the Issuer is submitting a small group plan in SERFF to be offered on-Exchange (i.e., the availability column = to “both” in SERFF), the Issuer will need to add the corresponding Individual plan with separate HIOS ID number in the Individual on-Exchange binder. Note: while the Health Connector may ask some carriers to offer certain plans on the Connector only to small groups, the carrier will still need to identify the corresponding Individual HIOS ID numbers in the carrier’s submission to the Division. This can be done by adding the plan to the Individual on-exchange binder and entering “off-exchange” in the availability column in order to ensure compliance with the requirement that any small group plan is also made available to individuals. Plans that will be sold on the Connector only to small groups should not be included in the carrier’s separate non-group Seal of Approval submission to the Health Connector.

4. 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 includes proposed 2022 plan designs.
5. In addition to the help documentation provided in SERFF, the following are instructions and/or explanations under the Plan Tab in the Plan Management module that will be used to identify filings either by the Issuer or the Division. The below is applicable to both QHPs and QDPs.

Field:	Description:
Availability (Plan Tab)	<p>The <u>Issuer</u> shall select the following attribute from the dropdown based on each standard component ID/plan.</p> <p>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 made available and/or renewed off the Exchange. Do not select “On Exchange” from the dropdown.</p> <p>Off-Exchange = The plan is only being offered and/or renewed off the Exchange.</p>
Disposition Status (Plan Tab)	<p>Upon final review of the filing, the Division will select one of the following attributes from the drop-down menu based on each standard component ID/plan.</p> <p>State-Certified for Inside the 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.</p> <p>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.</p> <p>Not Determined = The component ID/plan has been withdrawn as requested by the Issuers.</p> <p>Certification Denied = The component ID/plan does not meet all the requirements of an acceptable plan.</p> <p>Withdrawn = The Issuer has requested that the component ID/plan be withdrawn.</p>

6. 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. Each template may include one or more templates, instructions, and supporting documentation. There is also a section for review tools available to validate a completed template. Issuers may access the templates, relevant materials, and review tools on the Centers for Medicare & Medicaid Services (“CMS”) website at <https://www.qhpcertification.cms.gov/s/Application%20Materials>

Template:*	Description:
Plan and Benefits Template	Collects plan and benefit data.
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.
Plan Crosswalk	Collects the mapping (crosswalks) of the 2021 QHP plan ID and service area combinations (e.g., plan ID and county combinations) to a 2022 QHP plan ID.
Service Area Template	Information identifying an Issuer’s geographic service area.
Essential Community Providers/Network Adequacy Template and Network ID 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 required templates listed above, Issuers may visit the following website. <https://www.qhpcertification.cms.gov/s/QHP>
- c. Issuers may be required to submit templates in addition to those listed above, as required and defined by CMS. If new templates are required, the Division will notify Issuers as soon as the information is available.

7. Rate Filings and related Items:

a. Issuers must submit the following in SERFF:

- i. Actuarial Value Calculation Explanation - Additional documentation of Actuarial Value calculation should be attached in the Plan Management/Binder as supporting documentation for each plan, while appropriately noting the appropriate HIOS number for each 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, 2022 (for both QHPs and non-QHPs), as well as the Binder’s Business Rules Template and the Rate Data Template, by July 1, 2022 through SERFF, with federal Rate Filing Justification materials simultaneously posted in the Health Insurance Oversight System (“HIOS”).

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

b. Federal rules require the filing of rate filing materials via HIOS within the Unified Rate Review system. Details are as follows:

- i. 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. (In addition, Issuers are reminded to post rate filing justifications on their websites, in accordance with 45 CFR § 155.1020(a).)
- ii. Rate Filing Justification materials include the following:
 - 1. Part I - Unified Rate Review Template (URRT)
 - 2. Part II - Written Description Justifying the Rate Increase (Consumer Justification Narrative)
 - 3. Part III - Rating Filing Documentation (Actuarial Memorandum)
- iii. For more information on the 2022 Unified Rate Review and Instructions, Issuers should refer to the final instructions for 2022 when they become available on the appropriate CMS website.

If carriers have any questions about the filing instructions, they should contact Niels Puetthoff at niels.puetthoff@mass.gov.