STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

BULLETIN 2017-05-INS

In the Matter of

2018 Form and Rate Filing
Requirements for Medical Plans
_____/

(See separate Bulletin 2017-06-INS
for Stand-Alone Dental Plans)

Issued and entered
this 31st day of March, 2017
by Patrick M. McPharlin
Director

Information in this Bulletin is subject to change as federal guidance is finalized.[1] 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-MARKETPLACE

General Information

DIFS will continue to perform Plan Management functions for the 2018 plan year. Plan Management functions are part of DIFS' regulatory role for products offered on- and off-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-Marketplace and these items are referenced in this Bulletin.

New Plans and Recertification of QHPs

For the 2018 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**

[1] See Final Market Stabilization Rule.

requirements is not necessary. For additional guidance, issuers are urged to refer to the 2018 Letter to Issuers in the Federally-Facilitated Marketplace ("Letter").

Healthy Michigan Marketplace Option

As required by Section 105d(20) of PA 107 and the Section 1115 Demonstration Amendment (approved by CMS), certain beneficiaries of Michigan's Medicaid expansion program, the Healthy Michigan Plan (HMP), must obtain health care coverage through a Qualified Health Plan (QHP) offered on the Marketplace beginning April 1, 2018. Michigan has designated this program as the "HMP Marketplace Option", or "HMP-MO". Guidance was issued jointly by MDHHS and DIFS, which can be found on the DIFS website.

Individual issuers participating on-Marketplace are required to submit the HMP Marketplace Option Form, FIS 2323, to indicate whether you are participating in the option. Submit this form in the Binder under Supporting Documentation. As noted on the form, this only requires that certain plans be designated for HMP-MO enrollment and does not require that unique plans be developed for the option.

New 2018 Submission Timelines

DIFS has established the following submission dates for Michigan issuers to file their proposed Forms, Rates and Binders for the 2018 plan year, for small group and individual markets.

Small Group

Small Group issuers submit **Forms, Rates and Binders** for all on- and off-Marketplace plans in SERFF by May 12, 2017. Rate filing justifications must also be submitted into the URR Module of HIOS by this date. See Exhibit 1 for the list of required templates and documents.

Individual

Individual issuers submit **Forms, Rates and Binders** for all on- and off-Marketplace plans in SERFF by June 12, 2017. Rate filing justifications must also be submitted into the URR Module of HIOS by this date. See Exhibit 1 for the list of required templates and documents.

Rates

These are to be the issuers **final** Rates, the Rate Filing Justification Parts I, II and III, and related supporting documents. Note that DIFS will not accept changes to the Rates Table Template after the submission deadline, unless required by DIFS as part of the rate review process.

All SMALL GROUP AND INDIVIDUAL Products: On- and Off-Marketplace

Activity		Small Group Dates	Individual Dates
DIFS Submission **(Exhibit 1)**	Filing Deadline – Forms & Rates and Binder	**5/12/17**	**6/12/17**
	DIFS 1st transfer of plan data to CMS	**6/21/17**	
	CMS reviews plan data; sends correction notices	**6/22/17 to 8/2/17**	
Final Review	Final deadline for submission of QHP Data	**8/16/17**	
	Final CMS review of revised QHP Application Submissions received as of August 16	**8/17/17 to 9/11/17**	
QHP Agreement/ Final Certification	Issuers send signed Agreements, confirmed Plan Lists and final Plan Crosswalks to CMS	**9/16/17 to 9/27/17**	
	CMS sends Certification Notices with countersigned Agreements and final plan lists to issuers	**10/11/17 to 10/12/17**	
	Limited data correction window: Outreach to issuers with CMS or state identified data errors; issuers submit corrections; CMS reviews and finalizes data for Open Enrollment	**9/15/17 to 10/7/17**	
Open Enrollment		**11/1/17 to 12/15/17**	

2018 Filing Requirements

A complete submission includes SERFF Rate/Form filing and Binder, with all required validated templates and associated items, as outlined in Exhibit 1. Issuers are required to run the 2018 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.

2018 Quality Improvement Strategy Filing Requirement

An issuer participating in the Marketplace for two or more consecutive years must implement and report on a Quality Improvement Strategy (QIS), in accordance with section 1311(g) of the Affordable Care Act.

Issuers should consult the User Guide for the 2018 Coverage Year for instructions on how to meet the QIS requirements for the 2018 Qualified Health Plan (QHP) Application Period. Issuers must complete and submit a QIS Implementation Plan to the Department of Insurance and Financial Services (DIFS).

The QIS Implementation Plan and Progress Report Form must be submitted to DIFS via SERFF and included in the issuer's Binder. The deadline for submitting this form in the small group market is May 12, 2017, and the deadline for the individual market is June 12, 2017.

2018 Checklist Requirements

Checklists that must be completed and filed as shown in Exhibit 1 are:

- Checklist for Individual and Small Group Medical Plans–Forms (FIS 2307);
- Checklist for Individual and Small Group Medical Plans–Rates (FIS 2306);
- Checklist for Individual and Small Group Medical Plans–Network Adequacy (FIS 2313).

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 document number. Forms not being revised must still be submitted.

NOTE: There have been numerous revisions to the Michigan Insurance Code, the Patient's Right to Independent Review Act, and the Coordination of Benefits Act due to changes in legislation pursuant to PA 274, PA 275, and PA 276 of 2016.

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 HHS Notice of Benefit and Payment Paraments for 2018 ("Notice") 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;
- Healthy Michigan Marketplace Option Participation form.

SERFF Filings

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

All federal and Michigan-specific templates must be filed in the Rate/Form filing and in the Binder in Excel (xlsm) formats. Do not submit templates in PDF. Additionally, **do not** submit templates in the Supporting Documentation tab of the Binder, except for the Plan ID Crosswalk template.

Product Withdrawal

Plans may be withdrawn in accordance with the timeline published in the "Letter." The final opportunity to withdraw plans will be during the plan confirmation process. Issuers opting to withdraw must submit in both the SERFF Rate/Form filing and Binder:

1. A completed CMS Plan Withdrawal form for plans offered either on-Marketplace or on- and off-Marketplace ***or*** a list of plans to be withdrawn for those offered off-Marketplace only.
2. A letter to the DIFS Director outlining the Issuer's intent and how it will comply with both state and federal guaranteed renewability and availability requirements.
3. A copy of the letter that will be sent to enrollees/consumers outlining the issuer's intent and detailing ***all*** options available to the enrollee/consumer.
4. Do not make changes to templates.

Note: Pursuant to Michigan statute, MCL 500.2213b(6), once an issuer withdraws from a nongroup or group market completely, there is a 5-year waiting period during which that Issuer may not issue health coverage in the market from which it withdrew.

Uniform Modification and Plan ID Crosswalk

DIFS requires that the Michigan Uniform Modification Justification form (FIS 2316) and Plan ID Crosswalk be submitted as shown on Exhibit 1.

CMS requires that the Plan ID Crosswalk Template be submitted to QHP_Applications@cms.hhs.gov by June 21, 2017 for QHPs in the individual market after it is approved by DIFS.

Licensure and Good Standing

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

Annual Limit on Cost-Sharing

The 2018 out-of-pocket maximums for Marketplace-certified QHPs are $7,350 for individuals and $14,700 for families.

Changes to Cost-Sharing

After the initial transfer to CMS, changes made to copay amounts and coinsurance percentages cannot be made without DIFS' approval.

Service Area

New for plan year 2018: No changes may be made after the submission deadline by an issuer to its plans' service areas without submitting a petition to CMS. Issuers must submit petitions for all changes to service area, including responding to a CMS-identified correction, during CMS application reviews. The petition process requires a signed data change request form, justification for the change, and evidence of State approval. Petitions must be submitted by August 4, 2017, to allow CMS sufficient time for review. Upon CMS approval of petition, and prior to the final data submission deadline, issuers must submit service area-related changes in SERFF. For further information about what constitutes a change to an issuer's plan's service area, please see "Letter."

As in plan year 2017, 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, or other factors that exclude specific high utilizing, high cost or medically underserved populations. 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 case-by-case basis.

Network Adequacy

The Michigan Network Adequacy Guidance reflects current network sufficiency standards and requirements and is available on DIFS website and under the Plan Management General Instructions tab in SERFF.

Essential Community Providers

As of the date of this bulletin, the federal government has not finalized the Market Stabilization Rule. Under current requirements for plan year 2018:

- Issuers of plans on the Marketplace are required to contract with at least 30 percent of available Essential Community Providers (ECPs) in each plan's service area to participate in the plan's provider network;
- The write-in process for ECPs has been discontinued.

If the Market Stabilization Rule is finalized in its proposed form, the following requirements would apply[2] for plan year 2018:

- Issuers of plans on the Marketplace would be required to contract with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network;
- The write-in process for ECPs would continue.

For additional ECP requirements, see the "Letter" and the Payment "Notice." Issuers are also strongly encouraged to monitor the finalization of the Market Stabilization Rule.

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

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

[2] See Final Market Stabilization Rule.

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, contracts, 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. Each form must be printed with font size not less than 10 point.

Guaranteed Renewability

All individual and small group plans offered on- and off-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-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.

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 federal and state anti-discrimination law, including but not limited to Section 1557 of the Affordable Care Act, 42 USC 18116. Issuers are encouraged to review in its entirety the Final Rule on Nondiscrimination in Health Programs and Activities, which is set forth at 45 CFR Part 92 (Final Rule). The Final Rule prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. *As of the date of this Bulletin, the Final Rule remains in force, except for its prohibitions on discrimination based on gender identity and termination of pregnancy. See Order, Franciscan Alliance v Burwell, No. 7:16-cv-00108-O (N.D. Tex.) (Dec. 31, 2016).*

Regarding age limits specifically: note that, under the Final 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 2018, 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.

Summary of Benefits and Coverage

DIFS will require the new 2018 form of Summary of Benefits and Coverage (SBC). This form applies to all individual and small group on-Marketplace plans beginning on or after April 1, 2017. Each plan must have its own, unique, SBC, with the associated URL link noted in the Plans and Benefits Template.

SECTION 4: RATING REQUIREMENTS (APPLICABLE TO ALL PLANS)

NOTE: DIFS will **not** accept more than one filing per market (individual or small group). Issuers that offer both PPO/EPO or HMO/POS must submit both filings in the same Rate/Form filing.

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:

Age Rating

Michigan plans must adhere to the 3:1 ratio and federal default age curve for both individual and small group markets. A new federal default age curve is applicable for plan years beginning on or after January 1, 2018, as detailed in CMS Insurance Standards Bulletin: Guidance Regarding Age Curves and State Reporting. Dec. 16, 2016.

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 plan year 2018. 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 147.110; 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

/s/

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Patrick M. McPharlin
Director

Exhibit 1
2018 Medical Plans Filing Requirements

SERFF Form Filing and Binder

	Requires Submission via SERFF		
Federal Required Templates	On- and On-/Off-Marketplace	Off-Marketplace	SERFF Location:
Essential Community Providers/Network Adequacy	Yes	No	Binder only
Plans and Benefits	Yes	Yes	Binder only
Service Area	Yes	Yes	Binder only
Network ID	Yes	Yes	Binder only
Prescription Drug	Yes	Yes	Binder only
Rates Table	Yes	Yes	Rate/Form Filing & Binder
Business Rules – One per Issuer, include both Individual and Small Group on the same template	Yes	Yes	Rate/Form Filing & Binder
Accreditation	Yes	No	Binder only
*Plan ID Crosswalk (Individual only)	Yes	Yes	Binder only
Michigan Required Documents			
Michigan Network Data Template	Yes	Yes	Binder only
Checklist for Individual and Small Group Medical Plans – Forms	Yes	Yes	Rate/Form Filing & Binder
Checklist for Individual and Small Group Medical Plans – Network Adequacy	Yes	Yes	Binder only
MI Uniform Modification Justification Form	Yes	Yes	Rate/Form Filing & Binder
Healthy Michigan Marketplace Option Participation Form (Individual Only)	Yes	No	Binder only
Filing Deadlines:	**Small Group 5/12/2017**		
	Individual 6/12/2017		

Exhibit 1
2018 Medical Plans Filing Requirements

Rates

	Requires Submission via SERFF			
Federal Required Templates	On- and On-/Off-Marketplace	Off-Marketplace	Requires Submission via HIOS	SERFF Location:
Part I: Unified Rate Review (URRT)	Yes	Yes	Yes	Rate/Form Filing & Binder
Part II: Written Description Justifying the Rate Increase	Yes, for plans with ≥10% increase	Yes, for plans with ≥10% increase	Yes, for plans with ≥10% increase	Rate/Form Filing & Binder
Part III: Actuarial Memorandum	Yes	Yes	Yes	Rate/Form Filing & Binder
Rates Table	Yes	Yes	No	Rate/Form Filing & Binder
Michigan Required Documents				
Michigan Supplemental Health Care Exhibit	Yes	Yes	No	Rate/Form Filing & Binder
Checklist for Individual and Small Group Medical Plans –Rates	Yes	Yes	No	Rate/Form Filing & Binder
Filing Deadlines:	**Small Group 5/12/2017**			
	Individual 6/12/2017			

NOTE: All required templates must be completed and, if applicable, validated before filing. Use of the 2018 QHP Application Tools and Data Integrity Tool is required for the initial template and any subsequent template submissions. All Template revisions must be uploaded to the same locations as originally filed (i.e., SERFF Rate/Form Filing, Binder or BOTH). *With the exception of the Plan ID Crosswalk template, **do not** submit templates in the Supporting Documentation tab of the Binder.