STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Bulletin 2021-14-INS

In the matter of:

2022 Form and Rate Filing
Requirements for Medical Plans
_____/

Issued and entered
this 23rd day of March 2021
by Anita G. Fox
Director

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 PY22. 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.

Issuers will again be required by CMS to be registered for the CCIIO Plan Management Community (PM Community). This platform will be utilized to issue all notices, including corrections and notifications.

New Information

Michigan's EHB-benchmark plan for PY22 has been supplemented to include two additional benefits:

- Coverage of at least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.
- Removal of barriers to prescribing Buprenorphine or generic equivalent products for medication-assisted treatment of opioid use disorder.

In accordance with the Interoperability and Patient Access Final Rule, finalized on May 1, 2020, Issuers must comply with the requirements of 45 CFR 156.221 including the implementation and maintenance of a patient access application programming interface (API) and related documentation requirements.

As the COVID-19 pandemic continues, DIFS will also focus on all COVID-related changes in PY22 submissions. Issuers are reminded of the availability of the CMS Vaccine Toolkit.

New Plans and Recertification of QHPs

For PY22, 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 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 2022 Draft Letter to Issuers (Draft Letter).

PY22 SUBMISSION TIMELINES

DIFS has established the following submission dates for Michigan issuers to file their proposed Forms, Rates, and Binders for PY22 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, 2021. Rate filing justifications must also be submitted into the URR Module of HIOS by this date. See Exhibits 1 and 2 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 9, 2021. Rate filing justifications must also be submitted into the URR Module of HIOS by this date. See Exhibits 1 and 2 for the list of required templates and documents.

Note: with regard to small group and individual rates, these are to be the issuers' **final** rates, with the Rate Filing Justification Parts I, II, and III, and related supporting documents. **Also note:** DIFS will not accept changes to the Rates Table Template after the submission deadline, unless the changes are required by DIFS as part of the rate review process.

Timeline for Medical Submissions

Activity		Small Group Dates	Individual Dates
Medical Application Submission and Review Process	Filing Deadline – Forms & Rates and Binder	**5/12/21**	**6/9/21**
	DIFS' 1st transfer of plan data to CMS; Transparency in Coverage and Plan ID Crosswalk Templates submission deadline	**6/16/21**	
	CMS reviews and posts initial QHP application results in PM Community	**6/17/21 to 7/16/21**	
	DIFS' 2nd transfer of plan data to CMS	**7/21/21**	
	Deadline for Service Area Data Change Request to CMS	**8/10/21**	
Final Review	DIFS' final transfer of plan data to CMS	**8/18/21**	
	CMS reviews and posts final QHP application results in PM Community	**8/19/21 to 9/13/21**	
QHP Agreement/ Final Certification	CMS sends Certification Notices	**9/14/21**	
	Limited data correction window and last date to withdraw plans	**9/16/21 to 9/17/21**	
	CMS posts QHP agreements; Issuers send signed agreements; States confirm final plan recommendations	**9/14/21 to 9/22/21**	
Open Enrollment		**11/1/21 to 12/15/21**	

PY22 Filing Requirements and Templates

A complete submission includes the SERFF Form/Rate filing and Binder, with all required validated templates and associated items, as outlined in Exhibit 1. Issuers are required to run the PY22 QHP Application Review Tools including the Data Integrity Tool for the initial and any subsequent template submissions.

All template revisions made during DIFS' review must be uploaded to the same locations as originally filed i.e., filing, binder, or both. See Exhibit 1.

Note: only one Business Rules Template and Transparency in Coverage Template needs to be completed. Each template should include both individual and small group plans and be submitted in the SERFF Binder. The exception is the Transparency Coverage Template is not required for off-Marketplace only submissions.

PY22 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 QHP Certification Application Materials for instructions on how to meet the QIS requirements for the PY22 QHP Application Period. Issuers must complete and submit a QIS Implementation Plan to 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, 2021, and the deadline for the individual market is June 9, 2021.

Please refer to the 2018 Letter to Issuers for more information on the QIS filing. CMS intends to provide information on the applicable QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2022 Plan Year.

PY22 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); and
- 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 Form/Rate filing under the same document number. **Note:** forms not being revised must still be submitted.

File Naming

Certain items under the Supporting Documentation tab in the Form/Rate filing and/or 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. 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;
- Michigan Network Data Template;
- Rates Table Template;
- Actuarial Memorandum;
- URRT;
- Michigan Uniform Modification Justification form;
- Justifications and Attestations;
- Summary of Benefits and Coverage; and
- Any document that is amended from its original version that is not automatically versioned through SERFF.

Transitional Plans

The option to offer Transitional Plans has been extended. See Order 2021-13-M.

SERFF Filings

All federal and Michigan-specific templates must be filed in Excel formats. Do not submit templates in PDF. Additionally, **do not** submit templates under the Supporting Documentation tab of the Binder, except for the Plan ID Crosswalk and MI Network Data templates.

Under Section 234 of the Michigan Insurance Code, MCL 500.234, the Director has the discretion to designate certain records to be nonpublic. Accordingly, issuers have the option to mark their filings as confidential upon submission. The filings will remain confidential until one day after the submission deadline at which time DIFS will make the filings public.

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.

Plan Withdrawal

Plans may be withdrawn in accordance with the timeline published in the Draft Letter. The final opportunity to withdraw plans will be during the plan confirmation process. Issuers opting to withdraw must submit the following in both the SERFF Form/Rate 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 proposed letter that will be sent to enrollees/consumers outlining the issuer's intent and detailing all options available to the enrollee/consumer, including seeking coverage from a different issuer. This letter must not be sent to enrollees/consumers until approved by DIFS.

Note: Do not make changes to templates. Also, 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, together with authorization from DIFS, be submitted to CCIIO Plan Management Community for QHPs in the individual market. The deadline for this submission is June 16, 2021.

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 proposed PY22 out-of-pocket maximums for Marketplace-certified QHPs are $9,100 for individuals and $18,200 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 PY22, issuers must create separate Service Area IDs for individual and small group service areas. Issuers must either use the same Service Area Template across all binders or ensure no Service Area IDs repeat across the binders, even when the service area is intended to serve both markets.

DIFS' review of service areas remains unchanged from PY21.

To change service area data after DIFS' data transfer to CMS on June 16, 2021, issuers must submit a data change request (DCR) to CMS through the PM Community. This applies even when the requested change is directed by DIFS or CMS. The DCR must include an explanation and justification for the change(s) and the DCR Supplement by August 10, 2021. As CMS no longer requires the signed State Authorization of QHP Data Change Request Form for Michigan issuers, DIFS' approval may be obtained through email and attached to the DCR in the PM Community.

Examples of service area data changes:

1. Revising Service Area Template to:
    a. change any service area name or ID
    b. add or remove a service area
    c. add or remove a county/ies to a service area
2. Changing the service area ID associated with a plan on the Plans and Benefits Template
3. Any change to the list of counties associated with a particular plan

For more information, see CMS' data change windows page and the Data Change Request Instructions and Supporting Documents.

Network Adequacy

The network adequacy requirements, standards, and approach for review are unchanged from PY21. The Michigan Network Adequacy Guidance reflects network sufficiency requirements and standards. See also Network Data Template Instructions, Michigan Service Area Maps, and Network Adequacy Checklist - Individual and Small Group Medical Plans (FIS 2313).

Essential Community Providers

The Essential Community Providers (ECP) requirements, standards, and the approach for review are unchanged from PY21.

DIFS requires issuers to submit the results of the ECP Tool in SERFF under Supporting Documentation of the Plan Management Binder, as applicable.

See CMS' web page QHP Certification Application Materials for Application Instructions, ECP and Network Adequacy, and Review Tools.

Patient Safety Standards

DIFS no longer requires issuers submit a separate attestation for PY22 and beyond as the State Partnership Exchange (SPE) Issuer Attestation Response Form includes verification of compliance with Patient Safety Standards in accordance with 45 CFR.156.

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. 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.
2. 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.)

3. Each form must be printed in font size not less than 10 point.

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

Internal Formal Grievance and External Review Procedures

QHPs offered by commercial issuers must offer a formal grievance procedure pursuant to MCL 500.2213 and adhere to the external review process under the Patient's Right to Independent Review Act (PRIRA), PA 251 of 2000 (MCL 550.1901 to 550.1929). These procedures must be part of the policy and submitted for approval with the Medical filing. If the issuer has DIFS-approved grievance and external review procedures, these must be filed under the Supporting Documentation tab of the SERFF Form/Rate filing.

Complaint and Grievance Policy and Procedures must include information on DIFS' Health Care Appeals – Request for External Review (FIS 0018) and contact information for DIFS including fax number, email address, and mailing address.

Actuarial Value (AV) Requirements

All individual and small group plans offered on- and off-Marketplace must be assigned to one of the approved "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:

1. The employer will not contract, arrange, or pay for contraceptive benefits for employees.
2. The issuer will instead provide contraceptive benefits for employees (including notification to employee).
3. The costs for these benefits are not included in the program paid for the healthcare coverage.

ESSENTIAL HEALTH BENEFITS (EHB)

EHB Benchmark Plan

Issuers must use Michigan's 2022 EHB benchmark plan and review the benchmark to ensure their plans on- and off-Marketplace conform to it.

Mental Health Parity and Addiction Equity Act (MHPAEA)

All individual and small group plans must comply with the federal MHPAEA 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 compliant 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.

Regarding age limits *specifically*, 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 PY22, 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)

Data Corrections After the Final Application Submission Deadline

Issuers must request data correction changes and receive explicit direction and approval from CMS and DIFS.

- Data change requests to CMS must be initiated in the PM Community, include an explanation and justification for each requested change, and evidence of DIFS' approval. Issuers should work with DIFS to make any change.
- URL changes must be approved by DIFS (CMS authorization is not required) before making changes in the Supplemental Submission Module.
- Post-Certification Assessment(s) received from CMS require issuers to communicate to DIFS how errors or corrections were addressed.

Once SERFF binders are closed, DIFS will only reopen the binder for issuers to make data changes approved by CMS. Issuers must provide DIFS with evidence of CMS' approval for each data change.

Accreditation

45 CFR 155.1045 establishes the timeline by which issuers offering plans on- Marketplace must be accredited by NCQA, URAC, or AAAHC. An issuer's accreditation status will be available to consumers at the Marketplace website. Please include Accrediting Information in the SERFF Binder under the Company and Contact tab.

Summary of Benefits and Coverage

DIFS requires the 2021 form of Summary of Benefits and Coverage (SBC) as posted by CCIIO on February 3, 2020. This form applies to individual and small group on-Marketplace plans. The updated materials are available here. Each plan must have its own unique SBC, with the associated URL link, submitted via the Supplemental Submission Module in HIOS.

SECTION 4: RATING REQUIREMENTS (APPLICABLE TO ALL PLANS)

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 Form/Rate filing.

Per 45 CFR 154.200, the Part II Justification remains at 15%. Issuers must use only the revised URRT.

Any proposed rate changes related directly to COVID-19 must be presented in accordance with instructions included on the FIS 2306 Medical Rate Checklist.

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-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.

In August 2020, the Court of Appeals of the Federal Circuit Court concluded that issuers are entitled to unpaid CSRs, with the expectation that the unpaid CSRs will be offset in some manner for issuers' CSR premium loading. The decision could lead to CSR payments being restored by either Congress or HHS, but neither has taken action to date. As a result, DIFS will continue to require issuers to submit rates assuming no CSR payments will be made (CSR load) for PY22. If CSR payments are restored by either Congress or HHS prior to the finalization of rates, DIFS may require companies to update their rates to remove the CSR provision. These rates apply only to on-Marketplace silver plan premiums. The actuarial memorandum should disclose the amount of CSR load included in the silver plan rates and the methodology for determining the load. Support should include current and projected distribution of silver plan members by variant level (70/73/87/94) and the associated rate impacts that produce the overall CSR load.

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. The federal default age curve, applicable for plan years beginning on or after January 1, 2018, is detailed in the 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, if 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 an equivalent 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

For PY22, Michigan will continue using the previously defined 16 geographic rating areas for both the individual and small group market. The 16 defined geographic areas, within each of the 83 counties in Michigan, 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 W. Allegan Street—7th Floor
Lansing, Michigan 48933
Toll Free: (877) 999-6442

/s/

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Anita G. Fox
Director

DIFS
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Exhibit 1 – FORMS
PY22 Medical Plans Filing Requirements

	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	Form/Rate Filing & Binder
Business Rules – One per Issuer, include both Individual and Small Group on the same template	Yes	Yes	Binder only
Accreditation	Yes	No	Binder only
Plan ID Crosswalk (Individual only) *	Yes	Yes	Binder only
Transparency in Coverage – One per Issuer, include both Individual and Small Group on the same template**	Yes	No	Binder only
Michigan Required Supporting Documentation			
Michigan Network Data Template *	Yes	Yes	Binder only
Checklist for Individual and Small Group Medical Plans – Forms	Yes	Yes	Form/Rate Filing & Binder
Checklist for Individual and Small Group Medical Plans – Network Adequacy	Yes	Yes	Binder only
MI Uniform Modification Justification Form	Yes	Yes	Form/Rate Filing & Binder
Filing Deadlines	**Small Group 5/12/2021**		
	Individual 6/9/2021		

NOTE: All required templates must be completed and, if applicable, validated before uploading to SERFF. Use of PY22 QHP Application Review Tools including the Data Integrity Tool is required for the initial template submission and any subsequent submission. All template revisions must be uploaded to the same locations as originally filed (i.e., SERFF Form/Rate Filing, Binder or BOTH).

*Except for the Plan ID Crosswalk and MI Network Data Templates, **do not** submit templates in the Supporting Documentation in SERFF.

**The Transparency Coverage Template is not required for off-Marketplace only submissions.

DIFS
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Exhibit 2 – RATES
PY22 Medical Plans Filing Requirements

	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	Form/Rate Filing & Binder
Part II: Written Description Justifying the Rate Increase *	Yes, for plans that exceed the federal rate review threshold	Yes, for plans that exceed the federal rate review threshold	Yes, for plans that exceed the federal rate review threshold	Form/Rate Filing & Binder
Part III: Actuarial Memorandum	Yes	Yes	Yes, for plans with any increase	Form/Rate Filing & Binder
Rates Table	Yes	Yes	No	Form/Rate Filing & Binder
Michigan Required Templates				
Michigan Supplemental Health Care Exhibit	Yes	Yes	No	Form/Rate Filing & Binder
Checklist for Individual and Small Group Medical Plans – Rates	Yes	Yes	No	Form/Rate Filing & Binder
Filing Deadlines	**Small Group 5/12/2021**			
	Individual 6/9/2021			

* Subject to final CMS notification.