PY2025

ACA-Compliant
Health Insurance Form Filing Guidance

Pennsylvania Insurance Department

As of March 28, 2024

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Guidance –PY 2025 Filing Instructions for ACA-Compliant Individual and Small Group Products

This guidance provides instructions for on and off-exchange Affordable Care Act (ACA)-compliant individual and small group major medical health plans and stand-alone dental plans (SADPs).[1] The timeline for filing plans and rates for Plan Year 2025 is the same for qualified health plan issuers (QHP issuers) and issuers that have no QHPs (non-QHP issuers).

The Pennsylvania Insurance Department (PID) is the primary regulator for all health insurance products sold in Pennsylvania. In addition to reviewing and approving rates and forms, PID will continue to perform plan management functions required for insurers' participation on the State-based exchange (Pennie®) for Plan Year 2025. These functions complement our traditional review and approval of forms and rates. By conducting these plan management functions, our goal is to make health plan regulation as efficient and streamlined as possible for health insurers, thereby reducing costs and complications and supporting a robust insurance market in Pennsylvania.

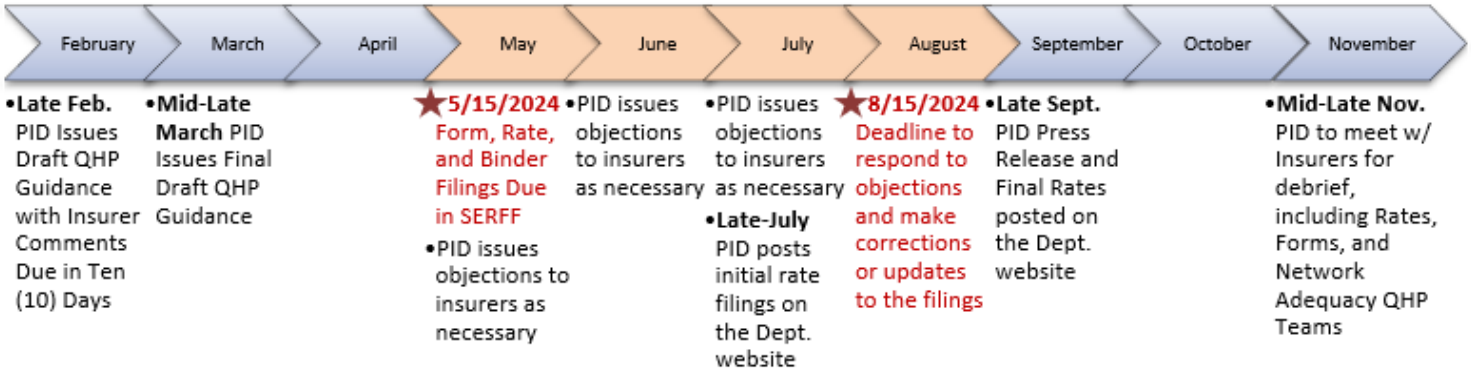
****For instructions for ACA-compliant individual and small group rate filings, see separate rate filing guidance at http://www.insurance.pa.gov/Companies/ProductAndRateRequire/.****

Are you new to Pennsylvania or considering moving into the individual or small group market for the first time?
Please let us know ASAP by reaching out to the following resource account: ra-rateform@pa.gov

Timeline for Form and Binder Filings

All health issuers that wish to issue or renew ACA-compliant individual or small group health insurance coverage on or after January 1, 2025, must file their forms (including all required documents for policies, certificates, or membership contracts) and plan binders containing all required templates beginning May 8, 2024, but no later than **May 15, 2024**. Late filings will not be accepted. A complete filing is required even if a policy form that will be used in 2025 has no changes from the approved form for 2024. A binder is required for each market type (individual or small group). "On/off exchange" plans and "off-exchange only" plans should appear within the same binder; do not file separate binders based on exchange intentions.

Forms, rates, and binder filings updates and/or corrections should be submitted to the PID by August 15, 2024. No exceptions will be permitted. A timeline* of key dates and activities is provided below. **Dates and Tasks are subject to change*



SERFF Submission and Required Documents

Please submit all filings through the System for Electronic Rate and Form Filings (SERFF) under the appropriate Type of Insurance (TOI).

Plan Validation Workspace in HIOS

Please do not submit QHP application data through HIOS, other than the pre-submission review Plan Validation Workspace in the HIOS Marketplace Plan Management System (MPMS) Module. Otherwise, submitting QHP application data through HIOS will result in system malfunctions that could cause plan data to fail to display on Pennie®.

[1] By "ACA-compliant individual and small group plans," the PID means major medical (also known as comprehensive medical) plans that are fully compliant with the 2014 ACA market reforms. This excludes grandfathered plans and transitional (sometimes called grandmothered) plans if the transitional policies are offered exclusively in the small group market. The federal government announced the indefinite continuation of its limited non-enforcement policy for transitional plans by letter on March 22, 2022. PID is following the federal government's guidance as of this writing. Starting in PY2025, the PID will discontinue the non-enforcement policy for individual transitional plans only; the non-enforcement policy for small group transitional plans will continue until further notice, or until the federal government discontinues its non-enforcement policy. Affected insurers may continue to offer renewal of the individual transitional plans for a policy year starting before October 1, 2024, but the coverage would have to come into compliance with all ACA requirements by January 1, 2025.

Major medical plans should be submitted under the appropriate TOI and corresponding sub-TOI.	**Stand-Alone dental plans** should be submitted using the proper TOI.
• H16G: Group Health – Major Medical • H16I: Individual Health – Major Medical • HOrg02G: Group Health Organizations - Health Maintenance (HMO) • HOrg02I: Individual Health Organizations –Health Maintenance (HMO)	• H10I: Individual Health – Dental • H10G: Group Health – Dental

All major medical health insurance forms should be filed through SERFF, even if those health plans are offered only in the market outside the State-based exchange. General instructions to filers in Pennsylvania will be provided on Pennsylvania's state page in SERFF, including any updates to these instructions. Please check SERFF on a regular basis for important general information, as well as specific information about your company's filings.

Please check the SERFF website for information and instructions about using SERFF. As was the case last year, issuers will work directly with PID to submit all QHP application data in accordance with federal and state guidelines. SERFF will be used by issuers to transmit information to PID, and PID will use SERFF to transmit information to Pennie®.

Guidance to Issuers

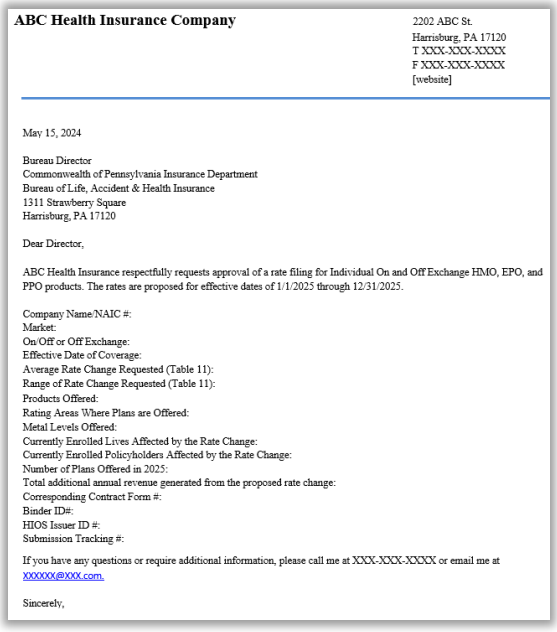
All issuers should carefully review all Pennie® PY 2025 certification guidance. The Pennie® certification guidance document contains important information regarding QHP certification, including details on the process for meeting expectations regarding QHP benefit design, review for non-discrimination, annual maximum out-of-pocket limits, and other topics. PID will review health plans that will be sold on Pennie® (and outside Pennie®, as applicable) according to the requirements of Pennsylvania law and federal law, as explained in the issued guidance. PID seeks to promote a level playing field inside and outside the exchange to the greatest extent possible.

Open Review Period Corrections

PID will conduct the preliminary review for QHP certification and make a recommendation to Pennie®. Pennie® will send all substantive corrections to PID before sending those requested corrections to the issuer. Please do not make corrections without first seeking permission and receiving approval from PID to make those corrections through SERFF.

Content of Form Filings

A separate submission letter, as required by 31 Pa. Code § 89b.5, is to be uploaded as a Supporting Document; reference to the filing description or General Information tab in SERFF does not satisfy this requirement. The submission may be rejected as incomplete if the submission letter is not included. Example submission letter:



ABC Health Insurance Company

2202 ABC St.
Harrisburg, PA 17120
T XXX-XXX-XXXX
F XXX-XXX-XXXX
[website]

May 15, 2024

Bureau Director
Commonwealth of Pennsylvania Insurance Department
Bureau of Life, Accident & Health Insurance
1311 Strawberry Square
Harrisburg, PA 17120

Dear Director,

ABC Health Insurance respectfully requests approval of a rate filing for Individual On and Off Exchange HMO, EPO, and PPO products. The rates are proposed for effective dates of 1/1/2025 through 12/31/2025.

Company Name/NAIC #:
Market:
On/Off or Off Exchange:
Effective Date of Coverage:
Average Rate Change Requested (Table 11):
Range of Rate Change Requested (Table 11):
Products Offered:
Rating Areas Where Plans are Offered:
Metal Levels Offered:
Currently Enrolled Lives Affected by the Rate Change:
Currently Enrolled Policyholders Affected by the Rate Change:
Number of Plans Offered in 2025:
Total additional annual revenue generated from the proposed rate change:
Corresponding Contract Form #:
Binder ID#:
HIOS Issuer ID #:
Submission Tracking #:

If you have any questions or require additional information, please call me at XXX-XXX-XXXX or email me at XXXXX@XXX.com.

Sincerely,

Please submit small group and individual health plans in separate SERFF filings. Please attach all forms submitted for review and approval to the Form Schedule tab in SERFF. Any form appearing on the Form Schedule tab should be submitted in clean final print, as intended for use. Redlines of Forms are also a very important part of the review process for this type of product. Issuers are reminded to use redlines, along with detailed comments in the filing that describe the specific revisions to the form. Forms Redlines, drafting notes, and other tracked changes should be uploaded under the Supporting Documentation tab.

Table A: Materials to be uploaded in SERFF Form Filings	
Federal Forms and Templates	**Format**
Under the Supporting Documentation Tab in SERFF:	
Summary of Benefits and Coverage (SBC) per issuer for PPO/POS/EPO products and one per issuer for HMO products, if the issuer offers both PPO/POS/EPO and HMO products. For products that include plans designed to comply with metal level actuarial value requirements, please submit a Silver level plan SBC.	PDF
Pennsylvania Forms and Templates Refer here for forms and templates: http://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages	**Format**
Under the Supporting Documentation Tab in SERFF:	
Completed Compliance Checklist – The filing may be rejected as incomplete if required documents are not provided within the timeframes identified by PID. Please note that separate Compliance Checklists are provided for major medical and stand-alone dental.	PDF
Compliance Worksheet	PDF
Compliance Certification Form	PDF
Other Documents	**Format**
Under the Form Schedule Tab in SERFF:	
Applications must be filed at the same time as the policy forms for products sold in the **Individual Market**	PDF
Applications and Enrollment forms must be included at the time of submission for the **Small Group Market**	PDF
Outline of Coverage (OOC) documents must be filed at the same time as the policy forms for products sold in the Individual Market	PDF
Policy Forms (examples include the Policy, Schedule of Benefits, Certificate of Coverage, Subscription Certificate, Declaration Page, Subscriber Agreement, Evidence of Coverage, Preventive Benefits Schedule, Summary of Cost Sharing and Benefits, and Preauthorization Schedule)	PDF
Under the Supporting Documentation Tab in SERFF:	
Certificate of Authority	PDF
Forms Redlines, drafting notes, and other tracked changes	PDF
Mental Health Parity Attestation (completed and signed)	PDF
Nonquantitative treatment limitation parity analyses	PDF or Excel
Quantitative treatment limitation parity analyses	Excel
Sample insurance ID Card	PDF
Variability Explanation	PDF

Variability within an ACA-compliant product filing is limited to cost-sharing; benefits may not be variable. Also, all benefits must be embedded in a plan, as explained in the URR Instructions. For example, suppose a company desires to add extraterritorial benefits for employees that live outside of Pennsylvania. In that case, it may amend the policy form to include those benefits, but it may not treat those benefits as optional. Such an amendment should contain language that has been approved by the other jurisdiction. Please also include in the filing a certification stating that the language has been approved by the other jurisdiction, identifying the jurisdiction, and confirming that the extraterritorial benefit does not diminish the benefits provided to an employee pursuant to Pennsylvania law.

Mental Health Parity Guidance

Section 203 of Consolidated Appropriations Act of 2021 (Pub. L. 116-260), codified at 42 U.S.C. § 300gg-26(a)(8), which became effective on February 10, 2021, and Acts 89 and 92 of 2020, codified at 40 Pa. C.S. §§ 4301-4304 and 40 P.S. § 908- 14a-b, which are applicable for health insurance policies beginning on January 1, 2022, impose specific requirements on health insurers. These laws require plans subject to the Paul Wellstone and Pete

Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended (MHPAEA), to document and make available parity analyses that identify limitations, describe the process used to develop, select, or continue those limitations, and define the factors used to determine whether a limitation is applicable to an MH/SUD service. To demonstrate compliance with these requirements, the PID requires specific reporting related to quantitative and non-quantitative treatment limitations (QTL/NQTLs) for health insurance policies subject to MHPAEA. More information about MHPAEA compliance is available at https://www.insurance.pa.gov/Coverage/health-insurance/parity/Pages/default.aspx and the parity analysis templates and product filing instructions are available at https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages/default.aspx

Requirements include:

- Annual Attestations under Acts 89 and 92
- Quantitative Treatment Limitation (QTL) and Financial Requirement (FR) Parity Analysis Submission
- Non-Quantitative Treatment Limitation (NQTL) Parity Analysis Submission

QTL/FR Testing

To demonstrate compliance with these requirements, for each filing for a health insurance policy offered, issued, or renewed in the Commonwealth to which MHPAEA applies, PID expects that each form filing will include quantitative treatment limitations (QTLs) and Financial Requirements (FR) analyses for all metal levels in each plan design. The PID is expecting each form filing to include an analysis for one HMO plan design from each metal level, one PPO plan design from each metal level, and one EPO plan design from each metal level, as applicable. An insurer may choose to use the QTL compliance template available on the PID's website. For purposes of these analyses, QTLs/FRs include, but are not limited to, financial requirements like co-pays and coinsurance, as well as office visit limitations or other limits on how many times a treatment may be covered. The analyses must provide classifications and limitations for ALL covered benefits listed in the analyzed plan; please identify the form number and/or product/plan identification for certificates of coverage and schedules of benefits to which the analysis is being applied. Expected claims dollar amounts must be provided for medical/surgical benefits.

If a health insurer does not use the template provided on the PID's website, the analysis should clearly identify all elements of the analysis as outlined in federal regulations. Such documentation may include a crosswalk or narrative comparison to the PID's template or to each element outlined in 45 C.F.R. § 146.136.

NQTL Analysis

Additionally, for each filing for a health insurance policy offered, issued, or renewed in the Commonwealth to which MHPAEA applies, please provide one example of non-quantitative treatment limitations (NQTLs) that may apply to medical/surgical (Med/Surg) services and mental health or substance use disorder (MH/SUD) services under the policy.

The example should illustrate and reference the baseline parity analysis performed for each limitation while demonstrating how the limitations are compliant with MHPAEA. An insurer may choose to use the NQTL compliance template available on the PID's website. If the NQTL analysis is the same for multiple products/plans, a company should submit the single analysis and reference the products/plans to which it applies. NQTLs include, but are not limited to, medical management standards limiting or excluding benefits based on medical necessity, prior authorization processes, and step therapy; recognizing the importance and prevalence of prior authorization processes, you may wish to include prior authorization as the submitted example. If an insurer previously submitted a prior authorization NQTL analysis to the PID in past review years and no issues were noted, the insurer should submit an analysis for a different type of NQTL in future review years. Additional examples of NQTLs specifically cited under the MHPAEA regulations [45 C.F.R. § 146.136(c)(4)(ii)] include:

- "Medical management standards limiting or excluding benefits based on ... medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;

- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage."

The goal of these QTL/FR analyses and NQTL examples is to facilitate the PID's responsibility to gauge, at the point of policy form review, compliance "as written" with the above-cited provisions. As noted above, an insurer may choose to use the QTL and NQTL compliance templates available on the PID's website. Alternate means of demonstrating compliance are permitted but may delay the form review process.

Network Adequacy

As required in federal law and regulation, a QHP issuer that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. To promote efficiency across network types, PID will review all networks based on the same standards, generally referencing the requirements in Act 68 of 1998, as amended by Act 146 of 2022, 28 Pa. Code Ch. 9, and 45 C.F.R. § 156.230 as amended by the final 2024 Notice of Benefit and Payment Parameters. PID will use an updated version of the network adequacy template introduced during PY2022.

NOTE: network adequacy templates required as part of the QHP certification application must still be filed. While PID continues to explore options to reduce the number of templates required, PID has not yet been able to confirm removal of any templates.

Please submit PID network adequacy templates via company-specific SFTP sites provided by Bureau of Health Care Access, Administration, and Appeals (HCA3) staff (formerly the Bureau of Managed Care). If your company has not received an SFTP link, please send a request for SFTP access to: RA-IN-HCA3@pa.gov Final network reports and additional justification will be uploaded to SERFF by PID staff.

NOTE: PID network adequacy templates do not connect to CMS templates or checkers.

Network Identification Filing Form

In addition to submitting the QHP network templates, please complete the Network Identification Filing Form available on the PID's website. This Form should be submitted within SERFF as Supporting Documentation in the Binder Filing. Please submit a separate form for each Network ID.

No Surprises Act

The No Surprises Act (NSA) applies to all QHPs. Under the NSA, emergency services, including air ambulance, must be covered without prior authorization and regardless of whether the provider or facility is in-network. Emergency services also include any post-stabilization services, unless certain conditions are met. Further, the NSA protections apply if a health plan covers any benefits for non-emergency services related to a visit in an in-network facility. In particular, the NSA seeks to protect patients who have little or no control over who provides their care, which means specified ancillary providers, such as labs, anesthesiologists, radiologists, or doctors involved in a surgery that the patient does not select, and certain diagnostic services that the patient does not select, may not balance bill under any circumstance. In addition, cost-sharing for care by those ancillary providers or services is treated as in-network.

The NSA also protects patients who receive services from an out-of-network provider, other than those specified, in connection with a visit to an in-network facility unless that out-of-network provider gives notice and receives consent in accordance with the Act.

Protections included in the No Surprises Act apply to the following facilities and services: emergency air ambulance, emergency facility and provider services, hospitals, hospital outpatient departments, ambulatory surgical centers, and non- emergency services in connection to a visit at a covered facility. The NSA does not currently apply to Ground Ambulance Services.

PID expects form language and internal policies and procedures to accurately represent and implement these protections. For more information about the No Surprises Act, please visit www.insurance.pa.gov/nosurprises.

Non-discrimination Provisions

The PID recognizes that plans include broad non-discrimination provisions. The PID encourages issuers to explicitly identify its non-discrimination protections for sexual orientation, sex, disability, gender identity, pre-existing conditions, health status, and marital status in addition to the language already included.

Formulary and Prescription Drug Coverage

Prescription Drug Template

As part of the filing, the PID is requesting additional information about coverage of prescription drugs, including those drugs covered under the medical benefit. If an issuer offers drugs under the medical benefit and needs those drugs in order to satisfy the state benchmark drug count or to demonstrate appropriate coverage of services required to be covered under the plan to satisfy federal and state regulations, and the issuer is unable to utilize the seven-tier formulary template to report this information, please complete a Combined Prescription Drug Supporting Documentation and Justification form and include it in the filing as Supporting Documentation in SERFF. For additional guidance, the Centers for Medicare & Medicaid Services (CMS) released the following Prescription Drug FAQ.[2]

Q1: How would an issuer who is already using all of the available seven (7) tier types within the Prescription Drug Template incorporate the drug tier type of Medical Service Drugs?

- The Prescription Drug Template cannot fully accommodate a formulary design that includes more than seven (7) formulary tiers. If the plans associated with the formulary cannot meet the essential health benefit (EHB) count unless medical drugs are included in the drug list, CMS recommends taking the following steps to submit the Qualified Health Plan (QHP) Application:
  - Enter all RXCUIs covered under the plan's prescription drug benefit in the Prescription Drug Template, for each of the issuer's drug lists.
  - Use the Combined Prescription Drug Supporting Documentation and Justification to identify how the drug list meets the requirement and submit the RXCUIs associated with the medical drugs for each drug

Note, drugs without associated RXCUIs should not be included in the Prescription Drug Template, because these drugs are not used in evaluating EHB benchmark or non-discrimination compliance[3]. However, the PID is requesting issuers include a supplemental justification as Supporting Documentation within the filing for those drugs that may be covered by the plan but do not have a RXCUI. Please use the PID's Annual Supplemental Template "PAST" for ACA review, available on the PID's website, for reporting this information.

Prescription Drug Coverage Changes

The PID is monitoring year over year prescription drug coverage changes to be better informed about any potential consumer impact for the upcoming plan year. As Supporting Documentation and as applicable, please provide a list of all drugs that were previously covered under the plan (in PY2024) but will no longer be covered in PY2025, and all drugs that were added as new covered drugs this year (not previously covered by the issuer). Please use the PID's Annual Supplemental Template "PAST" for ACA Review, available on the PID's website, for reporting this information.

Category and Class Drug Count Tool

For the Category and Class Drug Count Tool Results, some issuers indicated certain RXCUIs are "Not on Template", while other issuers listed those same RXCUIs as covered or not covered. To ensure consistency, when the template results in any RXCUI being designated "Not on Template", please submit a supplementary justification as Supporting Documentation in SERFF explaining whether that RXCUI would be covered or not covered by the plan. When submitting this supplementary justification, please use the federal form for combined prescription drug Supporting

[2] https://www.qhpcertification.cms.gov/s/Prescription%20Drug%20FAQs

[3] www.qhpcertification.cms.gov/s/Prescription%20Drugs

Documentation and justification for PY2025.

Essential Drugs (EHBs) versus Non-Essential Drugs (non- EHBs)
The PID expects insurers to cover drugs in any drugs savings program as EHBs when those drugs are also present on the formulary. Cost-sharing limitations and protections should apply to all drugs on the formulary, including those covered by the drug savings program, for all individuals, including those that do not opt into the drug savings program. Other EHB protections should also apply to drugs covered on the plan's formulary.

For drugs covered under the plan formulary's specialty tier or other formulary tier, the PID expects insurers to apply the same financial requirements, if any, as applied to the other drugs available under that same formulary tier regardless of their inclusion in any drug savings program. Please update the policy forms and documents as necessary to reflect this approach.

Contraception Coverage (New for PY2025 Review)
On January 22nd, 2024, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) released *FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 64*, which introduced a therapeutic equivalence approach to comply with the requirements in PHS Act section 2713 and its implementing regulations with respect to FDA-approved contraceptive drugs and drug-led devices. The PID is aware that the therapeutic equivalence approach is one of two options for insurers along with the approach based on previous federal guidance, however, broadening access of contraception drugs, particularly for drugs for which there are no therapeutic equivalents in the market, and removing accessibility hurdles, are considered best practices.

As an example of a best practice in Pennsylvania, one product available in PY2024 covers ***all FDA-approved contraceptive*** drugs and drug-led devices without cost-sharing, including over the counter (OTC) contraception with or without a prescription, and without requiring members to complete the drug exceptions process.

If an insurer does not cover contraception drugs which have no therapeutic equivalents and requires members to seek the drug exceptions process to access those unique drugs, the PID will be requesting additional information regarding the insurer's drug exceptions process to verify compliance.

Moreover, starting in PY2025 review, the PID is requesting additional general information regarding the approach to contraceptives utilized by each insurer. This question is included later in this guidance under "Standard Binder Questions". The PID expects insurers to respond to all the Standard Binder Questions for Plan Year 2025 and submit the responses as Supporting Documentation in the SERFF binder filing. Other specific information on coverage of contraception drugs for which there are no therapeutic equivalents is collected in the PID's Annual Supplemental Template for ACA review (PAST).

PID's Annual Supplemental Template "PAST" for ACA Review (New for PY2025 Review)
The PAST template was created by the PID to supplement information provided within other templates for ACA compliant plans and Qualified Health Plans and will contribute to the efficiency of the PID's review. Each insurer has the opportunity to explain the benefits which may be available within each of their plans, as well as explain other important features of the plan functions (e.g., prior authorization program and transparency in coverage URLs). If an insurer/plan does not cover specific items or services, this template also collects that information to aid the PID in the review process. Instructions for completion are built into the template. The template contains the following sections for insurers to complete:

- Additional Benefit Package Information (new for PY2025 review)
- Additional Formulary Information (new for PY2025 review)
- Additional Act 146 Prior Authorization Program Information and Transparency (new for PY2025 review)
- Transparency in Coverage Disclosures Available to the Public (TiC URLs) (started collecting information in PY2024 review)
- Information on Transitional Plans (new for PY2025 review)
- Prescription Drug Coverage Changes (started collecting information in PY2024 review)
- Covered Drugs Without a RXCUI (started collecting information in PY2024 review)

Content of Binder Filings

A binder is required for each market type (individual or small group). "On-exchange" plans and "off-exchange only" plans should appear within the same binder; do not file separate binders based on exchange intentions. Correspondence related to the binder must be attached to the binder filing.

If an issuer needs to update information that results in a change to any template, the associated QHP Application Review tools must be run, and results submitted each time there is a template revision.

NOTE: Binders, like form filings, must be submitted no later than May 15, 2024, as described in the timeline.

Table B: Materials to be uploaded in SERFF "Binder" Filings	
Federal Forms and Templates As in past years, the QHP data templates must be completed for all individual and small group health plans, regardless of whether plans are being submitted for QHP certification. New templates for 2025 must be filed even if no changes were made to the underlying policy forms. **All QHP/ACA issuers must run all applicable CMS tools; if the tool identifies deficiencies, the issuer must also submit the appropriate justification addressing the identified deficiencies.**	**Format**
Accreditation Certificate	PDF
Adverse Tiering Drug Tool Results	Excel
Adverse Tiering Supporting Documentation and Justification (as needed)	PDF
Business Rules Template – Issuers offering plans in both the individual and small group markets need to complete only one Business Rules Template; it will include both individual and small group plans. However, the Business Rules Template must be submitted in both the individual and small group SERFF filings and binders.	Excel
Category & Class Drug Count Tool Results	Excel
Combined Prescription Drug Supporting Documentation and Justification (as needed) – Fill in this form for each correction identified for the following Formulary Non-Discrimination Reviews: Clinical Appropriateness, Formulary Outlier, and Category/Class Benchmark Count. If there are multiple corrections, use a separate form for each correction. If there is a Treatment Protocol Calculator review correction, complete the Discrimination— Treatment Protocol Supporting Documentation and Justification. Additionally, the detailed explanation should provide a more in-depth explanation of the associated Justification Code.	PDF
Cost Sharing Review Tool Results	Excel
Data Integrity Tool Results	Excel
Discrimination— Treatment Protocol Supporting Documentation and Justification (as needed)	PDF
Essential Community Providers/Network Adequacy Justification Form(s) (as needed)	PDF
Essential Community Providers (ECP) Tool Results	Excel
Essential Community Providers Write-in Worksheet (when applicable)	PDF
Essential Community Providers/Network Adequacy Template	Excel
Essential Health Benefits-Substituted Benefit	PDF
Formulary Review Suite Tool Results (Includes Non-Discrimination Clinical Appropriateness Review Tool Results and Non-Discrimination Formulary Outlier Review Tool Results)	Excel
Master Review Tool Results	Excel
Network Template (Network IDs)	Excel
Plan ID Crosswalk Validation Tool Results	Excel
Plan ID Crosswalk Justification (as needed)	PDF
Plan ID Crosswalk State Authorization	PDF
Plans and Benefit Template – The Plan and Benefits Template does not include entries for Inherited Metabolic Disorder (PKU), Diabetes Care Management and Dental Anesthesia. Please add these as line items to the template as additional EHBs. This will allow the review tools to run properly.	Excel
Prescription Drug Template	Excel
Quality Improvement Strategy and Progress Report forms	PDF

Rates Table Template	Excel
SADP Essential Community Providers Tool Results	Excel
Service Area Template	Excel
Service Area Justification (as needed)	PDF
Service Area Map	PDF
Transparency in Coverage Template	Excel
Unique Plan Design Supporting Documentation	PDF
Pennsylvania Forms and Templates Refer here for forms and templates: http://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages	**Format**
Certificate of Authority	PDF
Network Identification Filing Form	PDF
PID's Annual Supplemental Template (PAST)	Excel
Standard Binder Questions for PY2025 Review	Excel

Standard Binder Questions for PY2025 Review (New for PY2025 Review)
Please respond to all the following Standard Binder Questions for Plan Year 2025 and submit the responses as Supporting Documentation in the SERFF binder filing.

1. Are any benefits or services for this plan administered by a third-party administrator? If so, please provide a list of those services or benefits and the TPA responsible for administration.

2. Which Pharmacy Benefit Manager (PBM) is utilized to administer pharmacy benefits for this plan?

3. Are any pharmacy benefits for this plan not handled by the PBM, if applicable? If so, which benefits (i.e., applicable prescription drugs), and who administers those benefits?

4. Given the PID is ending its nonenforcement of individual transitional plans in October 2024, what steps has the insurer taken to ensure that all individual transitional policies become ACA compliant policies by January 1, 2025?

5. What were the top five (5) utilized prescription drugs in 2023 across all QHP/ACA plans?

6. Based on the following federal guidance, which approach will be utilized by the insurer for PY2025?
"With respect to FDA-approved contraceptive drugs and drug-led devices, a plan or issuer could provide coverage consistent with the PID's prior guidance or*, alternatively, consistent with the therapeutic equivalence approach outlined in these FAQs to comply with the requirements in PHS Act section 2713 and its implementing regulations."* (FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 64 (dol.gov))

7. As it relates to infertility services and in vitro fertilization (IVF) for individuals with conditions that would preclude natural conception, does the insurer have an exception process or some other mechanism to forgo any natural attempt requirements? Please explain.

8. How does the issuer plan to handle any drug shortages in the upcoming plan year should a covered drug become affected? Please explain.

Plan Validation Workspace in the HIOS Marketplace Plan Management System Module
Issuers in all states are required to validate their QHP Application data for compliance with a number of federal standards—including data integrity—prior to submitting this data to their state (via SERFF). The PID strongly encourages insurers utilize the Plan Validation Workspace in the HIOS Marketplace Plan Management System (MPMS) Module.

From CMS's guidance on February 23rd, 2023:

- All issuers will also have access to a new Plan Validation Workspace in this module.
- States and issuers will need to request access to the new MPMS Module in HIOS; additional instructions are forthcoming.
- Validating application data or cross validating an application within the Plan Validation Workspace will allow issuers to access their pre-submission review results.
- Pre-submission review results ("validation results") display as:
    - Validation errors: issuers must correct prior to submitting an application
    - Validation warnings: issuers should review to determine whether a correction needs to be made to an application prior to submitting
- Issuers will not be able to submit their applications to CMS via HIOS or to their state via SERFF until all validation errors are resolved.
- As in previous years, issuers must pass validations within SERFF Validate & Transform in order to submit their QHP Applications to their states.
    - SERFF Validate & Transform has been enhanced to include several new validations, including validations related to data integrity and standardized plan options.
    - SERFF issuers must use the new Plan Validation Workspace in MPMS prior to Validate & Transform.

Stand-Alone Dental Plans and Vision Plans

Qualified stand-alone dental plan (QDP) issuers must file their rates, forms, and plan binders according to the same timelines and instructions that apply to all QHP issuers as outlined above. Pennsylvania's PPO network adequacy requirements also apply to dental plans and vision plans.[4]

Each QDP issuer must specify whether the rates contained in the templates are guaranteed to consumers or will be subject to change (underwriting).

QDP forms, rates, and binders must be filed separately from QHP filings. Dental binders/filings should include all QDPs sold on and off the exchange.

Note: Off-exchange non-certified stand-alone dental plans are not required to be submitted during the same timeframe as for QDPs. An exception to this is a stand-alone dental plan that an issuer wishes to certify but only offer off-exchange. Refer to the Content of Binder Filings section above for details on certifying "off-exchange only" plans.

REMINDER: SADP issuers that wish to certify non-exchange dental plans with CMS must provide a table in the Binder Transmittal Letter or a separate document under Supporting Documentation in the binder that identifies the plans that the issuer would like to certify. This helps facilitate the transfer of those plans to HIOS. It is imperative that SADP issuers provide this information so that all plans can be properly transferred to CMS.

Conclusion

The PID reminds filing entities that all forms and rates used in Pennsylvania remain subject to, and must comply in all respects with, Pennsylvania's insurance laws and regulations. The PID retains its ability to take after-use enforcement action and seek any available remedy for non-compliant forms or rates. An issuer will be responsible for assuring that all of its insureds are provided the full benefits provided by state and federal law, including the ACA, MHPAEA, and the NSA. PID continues to review templates and documentation to try to reduce the number of required documents for any given submission and will accept comment on efficiencies and processes that will help reduce the overall filing burden for all concerned.

Please send any questions on this guidance that cannot be answered through the SERFF process to the following resource account: ra-rateform@pa.gov. As appropriate, we may compile questions and post responses as FAQs on the PID's website.

[4] Pennsylvania's PPO network adequacy requirements apply to vision plans in addition to dental plans.

Appendix

Overview of Binder Submission, Rate Filing Submission and Form Filing Supporting Documents Submission, As Applicable.

Please note: For QHP application materials, CMS templates should be used unless a separate template is provided by the PID or Pennie®.

Qualified Health Plan (QHP) or Plan Certification Criteria	**Submission**
Plan Certification	Memo of Attestation to Pennie® [Submitted prior to participation in Early Plan Preview, and is made available through the individual insurer collaboration SharePoint setup by Pennie®]
Accreditation Certificate	SERFF – Binder Filing/Supporting Documentation
Federal Actuarial Memorandum RRG.2	SERFF – Rate Filing
Adverse Tiering Tool Results	SERFF – Binder Filing/Supporting Documentation
Adverse Tiering Supporting Documentation and Justification (as needed)	SERFF – Binder Filing/Supporting Documentation
Applications and Enrollment Forms	SERFF – Form Filing/Form
Business Rules Template	SERFF- Binder Filing/Binder Template
Category and Class Drug Count Tool Results	SERFF – Binder Filing/Supporting Documentation
Certificate of Authority	SERFF – Binder Filing/Supporting Documentation
Combined Prescription Drug Supporting Documentation and Justification (as needed)	SERFF – Binder Filing/Supporting Documentation
Compliance Certification Form (signature)	SERFF – Form Filing/Supporting Documentation
Compliance Checklist	SERFF – Form Filing/Supporting Documentation
Compliance Worksheet	SERFF – Form Filing/Supporting Documentation
Consumer Friendly Justification (as needed)	SERFF – Rate Filing
Cost Sharing Review Tool Results	SERFF – Binder Filing/Supporting Documentation
Data Integrity Tool Results	SERFF – Binder Filing/Supporting Documentation
Discrimination—Treatment Protocol Supporting Documentation and Justification (as needed)	SERFF – Binder Filing/Supporting Documentation
Essential Community Providers Tools Results	SERFF – Binder Filing/Supporting Documentation
Essential Community Providers Write-in Worksheet (when applicable)	SERFF – Binder Filing/Supporting Documentation
Essential Community Providers/Network Adequacy Justification Form(s) (as needed)	SERFF – Binder Filing/Supporting Documentation
Essential Community Providers/Network Adequacy Template	SERFF- Binder Filing/Binder Template
Essential Health Benefits-Substituted Benefit	SERFF – Binder Filing/Supporting Documentation
Formulary Review Suite Tool Results (Includes Non-Discrimination Clinical Appropriateness Review Tool Results and Non-Discrimination Formulary Outlier Review Tool Results)	SERFF – Binder Filing/Supporting Documentation
Insurer Marketplace Information Administrative Data	HIOS/Marketplace Plan Management System (MPMS) Module
Master Review Tool Results	SERFF – Binder Filing/Supporting Documentation
Mental Health Parity Attestation in compliance with Acts 89 & 92	SERFF – Form Filing/Supporting Documentation
Network Adequacy Template- PID/QUEST	To Quest with Company Specific SFTP
Network Identification Filing Form	SERFF – Binder Filing/Supporting Documentation
Network Template (Network IDs)	SERFF- Binder Filing/Binder Template
Outline of Coverage	SERFF – Form Filing/Form
PA Actuarial Memorandum	SERFF – Rate Filing
PID's Annual Supplemental Template (PAST)	SERFF – Binder Filing/Supporting Documentation
Plan ID Crosswalk Justification (as needed)	SERFF – Binder Filing/Supporting Documentation
Plan ID Crosswalk State Authorization	SERFF – Binder Filing/Supporting Documentation
Plan ID Crosswalk Template	SERFF – Binder Filing/Supporting Documentation
Plan ID Crosswalk Validation Tool Results	SERFF – Binder Filing/Supporting Documentation

Plans & Benefits Template	SERFF- Binder Filing/Binder Template
Policy Forms	SERFF – Form Filing/Form
Prescription Drug Template	SERFF- Binder Filing/Binder Template
Quality Improvement Strategy and/or Progress Report Forms	SERFF – Binder Filing/Supporting Documentation
QTL/NQTL Analysis Templates	SERFF – Form Filing/Supporting Documentation
Rates Table Template	SERFF- Binder Template
Rate Exhibits	SERFF – Rate Filing
Redacted Justification Checklist (reasons companies can redact criteria)	SERFF – Rate Filing
SADP AV Supporting Documentation	SERFF – Rate Filing
SADP Description of EHB Allocation	SERFF – Rate Filing
SADP Essential Community Providers Tool Results	SERFF – Binder Filing/Supporting Documentation
Sample Insurance ID Card	SERFF – Form Filing/Supporting Documentation
Summary of Benefits and Coverage (SBC)	SERFF- Form Filing/Supporting Documentation
Service Area Template	SERFF- Binder Filing/Binder Template
Service Area Justification (as needed)	SERFF – Binder Filing/Supporting Documentation
Service Area Map	SERFF – Binder Filing/Supporting Documentation
Stand-alone AVC screenshot	SERFF – Binder Filing/Supporting Documentation
Stand-alone Dental Plan AV Supporting documentation and justification (as needed)	SERFF – Binder Filing/Supporting Documentation
Transparency in Coverage Template	SERFF- Binder Filing/Binder Template
Unique Plan Design Supporting Documentation	SERFF – Supporting Documentation
Unified Rate Review Template (URRT)	SERFF – Rate Filing/URRT
URL Templates (Formulary, Network, Plan Brochure, SBC)	To Pennie® prior to Plan Preview [Submitted through the individual insurer collaboration SharePoint setup by Pennie® under the "Plan Management Forms & Templates" folder]
Variability Explanation (as needed)	SERFF – Form Filing/Supporting Documentation

RETURN TO TOP OF DOCUMENT