2022
ACA-Compliant
Health Insurance Form Filing Guidance

Pennsylvania Insurance Department

March 2021

Guidance –2022 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 the plan year 2022 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 State-based exchange (Pennie) for Plan Year 2022. 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/**.****

Timeline for Form and Binder Filings

All health insurers that wish to issue or renew ACA-compliant individual or small group health insurance coverage on or after January 1, 2022, must file their forms (including all required documents for policies, certificates, or membership contracts) and plan binders containing all required templates beginning May 8, 2021, but no later than **May 18, 2021. Late filings will not be accepted.**

A complete filing is required even if a policy form that will be used in 2022 has no changes from the approved form for 2021.

Forms, rates, and binder filings must be fully and finally approved by the Department by August 10, 2021**.** No exceptions will be permitted.

Use of SERFF Required

All filings must be submitted through the System for Electronic Rate and Form Filings (SERFF). Please check the SERFF website for information and instructions about how to use 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.

All major medical health insurance forms must 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.

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[1] By "ACA-compliant individual and small group plans," the Department means major medical (also known as comprehensive medical) plans that are fully compliant with the 2014 ACA market reforms. This excludes grandfathered and transitional (sometimes called grandmothered) plans.

DO NOT submit QHP application data through HIOS. Submitting QHP application data through HIOS will result in system malfunctions that could cause plan data to fail to display or to display incorrectly on healthcare.gov. NOTE: The one exception to this relates to Unified Rate Review (URR) submissions. Issuers should continue to file Parts I, II, and III of the URR submission in both the URR HIOS Module and in SERFF, as has been required in previous years. For more information, see the separate PID rate filing guidance.

Guidance to Issuers

All filers should carefully review the 2022 Plan year Certification guidance issued by Pennie through the SharePoint portal. That document contains important guidance regarding QHP certification, including details on the process for meeting Pennie's expectations regarding QHP benefit design, review for non-discrimination, annual maximum out-of-pocket, and other topics. The PID will review health plans that will be sold on the State-Based Exchange (and outside the SBE, as applicable) according to the guidance issued in that letter and the requirements of Pennsylvania law and federal law. The PID seeks to promote a level playing field inside and outside the exchange to the greatest extent possible.

PID will conduct the preliminary review for QHP certification and make a recommendation to the 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

Small group and individual health plans must be submitted in separate SERFF filings. All forms submitted for review and approval must be attached to the Form Schedule tab in SERFF. Any form appearing on the Form Schedule tab must be submitted in clean final print, as intended for use. Forms with redlines, drafting notes and other tracked changes should be submitted on the Supporting Documentation tab.

Each submission must include a Compliance Checklist, Worksheet, and Certification as Supporting Documentation; these forms must be completed in their entirety. The filing may be rejected if these required documents are not provided in a timely manner. These documents can be found on SERFF as well as on the Department's website at http://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages. Please note that separate Compliance Checklists are provided for major medical and stand-alone dental.

A separate submission letter (as required by 31 Pa. Code § 89b.5) is required; reference to the filing description or General Information tab in SERFF does not satisfy this requirement and the submission may be rejected as incomplete if the submission letter is not included.

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 at page 6. For example, if a company desires to add extraterritorial benefits for employees that live outside of Pennsylvania, 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.

Submit one 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.

Outline of Coverage (OOC) documents must be filed at the same time as the policy forms for products sold in the Individual Market.

Mental Health Parity Guidance

Section 203 of Consolidated Appropriations Act of 2021 (Pub. L. 116-260), codified in 42 U.S.C. § 300gg-26(a)(8), which became effective on February 10, 2021, and Act 92 of 2020, codified in 40 P.S. § 908-14a-b, which is applicable for health insurance policies beginning on January 1, 2022, impose new 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, there are new filing expectations related to quantitative and non-quantitative treatment limitations (NQTLs) for health insurance policies subject to MHPAEA.

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, we suggest that each form filing include quantitative treatment limitations (QTLs) analyses for three plans. An insurer may choose to use the QTL compliance template available on the Department's website. For purposes of these analyses, QTLs 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.

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

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

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.

Please note that the Compliance Checklist, Worksheet and Certification are no longer required to be submitted in the binder as Supporting Documentation. These forms are still required to be submitted within each form filing as noted above.

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 2022 must be filed even if no changes were made to the underlying policy forms. 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.

It came to our attention during plan year 2018 that 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.

For the Formulary - Inadequate Category/Class Count Supporting Documentation and Justification: Provide a detailed explanation at the time of binder submission of any inadequate Category/Class Count. The detailed explanation should provide a more in-depth explanation of the associated Justification Code.

If an issuer resubmits a revised template, the associated QHP Application Review tools must be submitted each time there is a template revision.

All QHP issuers must run all applicable CMS tools, including the Data Integrity Tool, the Plan ID Crosswalk Tool, the ECP Tool, the SADP ECP Tool, the Cost Sharing Tool, the Category & Class Drug Count Tool, and the Non-Discrimination Clinical Appropriateness Review, and submit the results as supporting documentation. If the tool identifies deficiencies, the issuer must submit the appropriate justification addressing the identified deficiencies.

Submit the Quality Implementation Plan and Progress Report forms through SERFF since Pennsylvania performs plan management.

NOTE: Binders, like form filings, must be submitted **no later than May 18, 2021** as described in the timeline.

Stand-Alone Dental 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 and vision plans. The benefits template will be modified for dental plans as described in the 2022 Letter to Issuers in the Federally-facilitated Marketplaces. 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 Filing section above for details on certifying off-exchange stand-alone dental plans.

REMINDER: SADP issuers who 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 Department 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 Department retains its ability to take after-use enforcement action and seek any available remedy for non-compliant forms or rates. An insurer will be responsible for assuring that all of its insureds are provided the full benefits provided by state and federal law, including the ACA.

Please send any questions on this guidance that cannot be answered through the SERFF process to Lars Thorne at rlthorne@pa.gov. As appropriate, we may compile them and post responses as FAQs on the Department's website.