PY2023
ACA-Compliant
Health Insurance Form Filing Guidance

Pennsylvania Insurance Department

As of May 12, 2022

Guidance –PY 2023 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 2023 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 2023. 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 issuers that wish to issue or renew ACA-compliant individual or small group health insurance coverage on or after January 1, 2023, must file their forms (including all required documents for policies, certificates, or membership contracts) and plan binders containing all required templates beginning May 8, 2022, but no later than **June 1, 2022. Late filings will not be accepted.**

A complete filing is required even if a policy form that will be used in 2023 has no changes from the approved form for 2022.

Forms, rates, and binder filings updates and/or corrections should be submitted to the Department by August 12, 2022**.** No exceptions will be permitted.

SERFF Submission and Required Documents

All filings must be submitted through the System for Electronic Rate and Form Filings (SERFF) under the appropriate Type of Insurance (TOI).

Major medical plans should be submitted under the appropriate TOI and corresponding sub-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)

Stand-Alone dental plans should be submitted using the proper TOI.

- H10I: Individual Health – Dental
- H10G: Group Health – Dental

[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 plans and possibly transitional (sometimes called grandmothered) plans. A decision with respect to transitional plans being permitted in 2023 has not yet been announced by the federal government, nor has PID made a determination on whether they will be permitted to continue into 2023 in Pennsylvania.

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.

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.

Applications and Enrollment forms must be included at the time of submission for the Small Group Market.

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 on Pennie™.

Guidance to Issuers

All issuers should carefully review all Pennie™ PY 2023 certification guidance. The Pennie™ certification guidance document contains important guidance 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 guidance issued and the requirements of Pennsylvania law and federal law. 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 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 required; 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.

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. Copies of the forms with redlines, drafting notes, and other tracked changes are encouraged and should be uploaded on the Supporting Documentation tab.

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

REMINDER: Applications and Enrollment forms must be included at the time of submission for the Small Group Market.

Materials to be uploaded under the Supporting Documentation include:

- Completed Compliance Checklist, Worksheet, and Certification. These documents can be found on the Department's website at http://www.insurance.pa.gov/Companies/ProductAndRateRequire/Pages.
- 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.
- Forms with Redlines, drafting notes, and other tracked changes.

- Completed Mental Health Parity Attestation, Nonquantitative parity analyses, and Quantitative parity analyses.
- Sample insurance ID Card.

The filing may be rejected 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.

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/Pages/Parity.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 suggests that each form filing include quantitative treatment limitations (QTLs) and Financial Requirements (FR) analyses for all metal levels in each plan design. For PY23, the Department is suggesting each filing 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 Department'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 Department's website, the analysis must clearly identify all elements of the analysis as outlined in federal regulation. Such documentation may include a crosswalk or narrative comparison to the Department'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 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 the submitted example. 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.

The goal of these QTL/FR analyses and NQTL examples is to facilitate the Department'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 Department'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 finalized 2023 Notice of Benefit and Payment Parameters and requirements found in Act 68 and 28 Pa. Code Ch. 9. 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.

Submit PID network adequacy templates via company-specific SFTP sites provided by Bureau of Managed Care staff. If your company has not received an SFTP link, please send a request for SFTP access to: RA-INBURMNGDCAREPRDR@pa.gov. Final network reports and additional justification will be uploaded to SERFF by PID staff.

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 a 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.

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.

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 2023 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 PID's 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. As this problem has not been corrected for PY 2023, please add these as line items to the template as additional EHBs. This will allow the review tools to run properly. NOTE: PID network adequacy templates do not connect to CMS templates or checkers.

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 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.

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 June 1st, 2022** 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 plans[2]. The benefits template will be modified for dental plans as described in the 2023 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

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

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 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 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 Lars Thorne at rlthorne@pa.gov. As appropriate, we may compile them and post responses as FAQs on the Department's website.

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 Department or Pennie™.

Qualified Health Plan (QHP) or Plan Certification Criteria	**Submission**
Plan Certification	Memo of Attestation to Pennie™
Accreditation Questions	SERFF
Federal Actuarial Memorandum RRG.2	SERFF
Category and Class Drug Count Tool Results	SERFF – Supporting Documentation
Combined Prescription Drug Supporting Documentation and Justification	SERFF
Compliance Certification (signature)	SERFF – Supporting Documentation
Compliance Checklist	SERFF – Supporting Documentation
Compliance Worksheet	SERFF – Supporting Documentation
Consumer Friendly Justification	SERFF
Cost Share Tool Results	SERFF
Essential Community Providers Tools Results	SERFF
Essential Community Providers Write-in Worksheet (when applicable)	SERFF
Essential Community Providers/Network Adequacy Attestation	SERFF
Essential Community Providers/Network Adequacy Template	SERFF
Essential Health Benefits-Substituted Benefit	SERFF – Supporting Documentation
Formulary Review Suite Tool Results	SERFF – Supporting Documentation
Insurer Marketplace Information Administrative Data	SERFF

Master Review Tool	SERFF
Mental Health Parity Attestation in compliance with Acts 89 & 92	SERFF
Network Template (Network IDs)	SERFF
PA Actuarial Memorandum	SERFF
Plan ID Crosswalk Justification	SERFF
Plan ID Crosswalk State Authorization	SERFF
Plan ID Crosswalk Template	SERFF
Plans & Benefits Template	SERFF
Prescription Drug Template	SERFF
Quality Improvement Strategy Form	SERFF
QTL/NQTL Templates	SERFF – Supporting Documentation
Rates Table Template	SERFF
Rate Exhibits	SERFF
Rating Business Rules Template	SERFF
Redacted Justification Checklist (reasons companies can redact criteria)	SERFF
SADP AV Supporting Documentation	SERFF
SADP Description of EHB Allocation	SERFF
Summary of Benefits and Coverage (SBC) Schedule Benefit	SERFF
Service Area Template	SERFF
Service Area Map	SERFF – Supporting Documentation
Stand-alone AVC screenshot	SERFF – Supporting Documentation
Stand-alone Dental Plan AV Supporting documentation and justification	SERFF – Supporting Documentation
State Partnership Exchange Issuer Program Attestation Response Forms	SERFF – Supporting Documentation
Transparency in Coverage Template	SERFF
Unique Plan Design Supporting Documentation	SERFF – Supporting Documentation
Unified Rate Review Template (URRT)	SERFF - URRT
URL Templates (Formulary, Network, Payment, Plan Brochure, SBC)	To Pennie™ during Plan Preview