2023-2024 Student Health Insurance Form Filing Guidance

Under 45 C.F.R. §§ 144.103 and 147.145, student health insurance is defined as a type of individual market health insurance coverage offered to students and their dependents under a written agreement between an institution of higher education and an issuer. Student health insurance is also considered individual insurance under 40 P.S. §§ 3801.301 et seq.; the Department does not consider student health insurance to be blanket insurance, and it is currently subject to filing.

Therefore, in accordance with state and federal law, the Pennsylvania Insurance Department will review student health insurance forms as individual coverage. Student health insurance must include all required provisions and state mandates that apply to individual coverage and it must comply with applicable federal laws. Student health forms should not contain any language referencing the Employee Retirement Income Security Act (ERISA), as ERISA only applies to group coverage. The federal laws specifically applicable to student health insurance are those described in 45 C.F.R. § 147.145(b). The two provisions pertinent to form filings involve guaranteed availability and guaranteed renewability, in 45 C.F.R. § 147.145(b)(1), as follows:

> (ii) For purposes of section 2702 of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage, and, notwithstanding the requirements of §147.104(b), is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis.
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> (iii) For purposes of section 2703(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students.

Timeline

The form filing should be submitted by February 1, 2023. The Department will endeavor to review and approve the filing in a timely manner. The filing will be made public through SERFF upon approval. The Department expects that a copy of the final executed form will be provided to the Department within 15 business days of finalizing a contract with an institution. Please submit this non-redacted form as a separate filing, linking to the originally approved form via the corresponding filing tracking number on the General Information tab. The submission will be processed as "Informational Only." The institution-specific filing may contain a request for confidentiality. If warranted, the Department will honor this request.

Issuers are reminded that a Group-Specific Named Group Rate Filing must be submitted for the rates for fully insured Student Health Insurance plans, as referenced in the Rate Filing Guidance posted on the Department's website.

SERFF Submission and Necessary Documents

Please use the following Types of Insurance (T.O.I.), Sub-Types of Insurance (Sub-TOI), and Filing Types.. Please submit rate and form filings separately..

Form Filing

- TOI: H22 Student Health Insurance
- Sub-TOI: H22.000 Student Health Insurance
- Filing Type: Form

A **complete filing** is required even if a policy form used in 2023 has no changes from the approved plan filling for 2023. A complete filing includes all forms that will be used to apply for and enroll in coverage and forms issued to the policyholder and insured.

Preventive Schedules, ID Cards, and A Summary of Benefits and Coverage (S.B.C.) are to be uploaded as Supporting Documentation with each SERFF filing.

Please submit with the form filing a current **Compliance Worksheet, Compliance Checklist, and Certification Form**, which are available on the Department's website.. These items should be uploaded to the SERFF submission as Supporting Documentation.

Redlines are 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.

Mental Health Parity Guidance (UPDATE)

To demonstrate compliance with mental health parity laws, the PID requires specific reporting related to quantitative and non-quantitative treatment limitations (QTL/NQTLs) for health insurance policies subject to MHPAEA, listed below. The Department expects that each filing will include an analysis of one plan for each network type (HMO, PPO, and EPO), if offered.

- 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.

An insurer may choose to use the QTL and NQTL templates available on the Department's website.

Note Regarding Annual Dollar Limits and Mental Health Parity

Under the Affordable Care Act, there may be no lifetime or annual limits on essential health benefits (EHB). Additionally, there may be no lifetime or annual dollar limit for non-EHB mental health or substance use disorder (MH/SUD) benefits unless the plan demonstrates that the annual limit applied to non-EHB MH/SUD benefits meets the requirements of MHPAEA.

QTL/FR Testing and Analyses

To demonstrate compliance, for each filing for a health insurance policy offered, issued, or renewed in the Commonwealth to which MHPAEA applies, please include in each form filing quantitative treatment limitations (QTLs) and Financial Requirements (FR) analyses for each plan design. The Department expects that each filing will include an analysis for at least one HMO plan design, one PPO plan design, one EPO plan design, and one POS plan design, as applicable.

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 (Med/Surg) 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 at least one example of non-quantitative treatment limitations (NQTLs) that may apply to Med/Surg services and 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, an insurer 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 may delay the form review process.

Non-Discrimination in Benefit Design (UPDATE)

Under the Affordable Care Act and its regulation at 45 C.F.R. § 156.125, a benefit design and the implementation of a benefit design may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Beginning on the earlier of January 1, 2023 (the start of the 2023 plan year) or upon renewal of any plan subject to this rule, a non-discriminatory benefit design that provides EHB is one that is clinically-based.

The following examples were provided within the PY23 Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP), see 88 Fed. Reg. 27208, 27301-305 (May 6, 2022), as potential areas of non-compliance:

1. Limitation on Hearing Aid Coverage Based on Age
2. Autism Spectrum Disorder (ASD) Coverage Limitations Based on Age
3. Age Limits for Infertility Treatment Coverage When Treatment Is Clinically Effective for the Age Group
4. Limitation on Foot Care Coverage Based on Diagnosis (Whether Diabetes or Another Underlying Medical Condition)
5. Access to Prescription Drugs for Chronic Health Conditions (Adverse Tiering)