IDOI FINAL LETTER TO ISSUERS – PLAN YEAR 2025

This notice is for all carriers writing ACA individual and small group major medical plans and stand-alone dental plans (SADPs) for Plan Year 2025. All questions should be directed to compliance@idoi.IN.gov.

Form Filing Requirements QHP/Non-QHP Consolidated Appropriations Act (CAA)/No Surprises Act

- Indiana will not review CAA information in the form filings.
- CMS will review for compliance the following four (4) provisions of the CAA:
    - **24a-42 USC §300gg-111(b)(1)**-Patient Protections: Surprise Billing-Non-Emergency Services;
    - **24b-42 USC §300gg-112**-Patient Protections: Surprise Billing-Air Ambulance;
    - **25-42 USC §300gg-113**-Patient Protections-Continuity of Care; ***and***
    - **24-PHS §2719A**-Patient Protections: Emergency Services-Prohibition on Prior Authorization and Cost-Sharing Restrictions.
- CMS requires health insurance issuers in Indiana to submit form filings for the following health insurance products in CMS Direct Enforcement module in SERFF
    - Individual market;
    - Group markets, including fully insured small group and large group market plans;
    - Student health insurance coverage;
    - Grandfathered plans; ***and***
    - Grandmothered plans.
- CMS has outlined the requirements for how/where filings should be remitted
    - **May 15, 2024** is the federal deadline for filing forms for all products in the individual and small group major medical markets subject to ACA and CAA compliance review.
    - ***However, Indiana requires filings to be submitted no later than 12:00 p.m. EST on May 13, 2024.***
    - CMS requires that forms for student health insurance products and products offered in the large group market are due 60 days prior to marketing.
    - Please refer to the CMS document, "**Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2025,**" which is included as Attachment 4 of this document.

Timeline For Plan Year 2025

- Single Risk Pool Form(s) Filings (Individual and Small Group) are due **no later than 12:00 p.m. EST on May 13, 2024**.
    - Rate filings are due **no later than 12:00 p.m. on June 11, 2024**.
    - Filings need to be made concurrent into **BOTH** HIOS and SERFF
        - Please note that there will be a gateway between SERFF and the Unified Rate Review (HIOS URR) module.
        - This applies only to the URR module.
        - All other templates must appear in both databases and any updates must

be made at the same time.
    - Filings must include all required forms and rates (refer to SERFF plan management instructions document for further instruction).
    - Refer to plan management instruction in SERFF.
    - All updates to rates and forms from carriers are due **no later than 5:00 p.m. EST on August 7, 2024.**
        - All QHP issuers **MUST** have final and active URLs completed by this date.
        - An attestation is required as part of your final changes that a thorough plan preview has been completed.
    - The IDOI will complete its review of single risk pool filings by August 14, 2024.
- Qualified Dental Plan (QDP) Forms filings are due **no later than 12:00 p.m. on June 11, 2024.**
    - Rate filings are due **no later than 12:00 p.m. EST on June 11, 2024.**
    - Filings need to be made concurrent into **BOTH** HIOS and SERFF.
    - Filings must include all forms and rates and all applicable templates (refer to SERFF plan management instructions document).
    - Please refer to plan management instruction in SERFF.
    - All updates to rates and forms from carriers are due **no later than 5:00 p.m. EST on August 7, 2024.**
        - All QDP issuers **MUST** have final and active URLs completed by this date.
        - An attestation is required as part of your final changes that a thorough plan preview has been completed.
    - The IDOI will complete its review of QDP filings by August 16, 2024.
- SERFF Response Requirement from Carriers
    - **10 days**: before June 29, 2024
    - **4 days**: June 30, 2024, to July 13, 2024
    - **2 days**: July 14, 2024, to August 7, 2024
- **ALL** data change requests must be provided to the IDOI two (2) days **PRIOR** to the due date of the submission.
    - Change requests must be emailed to the following email addresses with the subject line "Data Change Request from Issuer XXXX HIOS ID XXXX."
        - Sshover@idoi.in.gov
        - Ccooper@idoi.in.gov
        - Compliance@idoi.in.gov

Essential Health Benefits 2025

- Indiana will retain the current 2017 essential health benefit benchmark plan for the 2025 calendar year:
    - Anthem BCBS Blue 5 Blue Access PPO Medical Option 6 Rx Option G
    - Pediatric Oral (FEDVIP)
    - Pediatric Vision (FEDVIP)
- Substitutions between benefit categories are not permitted.

- Additional information may be obtained by visiting http://www.in.gov/idoi/2812.htm.

Actuarial Value (AV) De Minimis Ranges

- The de minimis ranges at §156.140(c) are +2/-2 percentage points for all individual and small group plans subject to the AV requirements under the EHB package.
- For expanded bronze plans, the de minimis range is +5/-2 percentage points.
- For QHP certification, the de minimis range is +2/0 percentage points for individual market silver QHPs and +1/0 percentage points for income-based CSR plan variations.

CSR Loading

- For Plan Year 2025, loading for CSRs will continue to be applied to all metal levels, for both on and off exchange plans.
- This topic may be addressed again for future policy years.

SERFF Plan Management Instructions

- Binder submissions and Form/Rate filing submissions are required by Indiana for all ACA compliant non-grandfathered plans that are part of the single risk pool as well as SADPs.
    - Additional information on submission requirements can be found by reviewing the SERFF Plan Management Instructions found at http://www.in.gov/idoi/2812.htm.
- Form/Rate Filing Changes
    - On the Rate Review Detail in SERFF, carriers should report the min, max, and weighted average for the annualized PMPM as premiums to cover one month of coverage.
- Rate Filing Timelines
    - Timing of Submission of Rate Filing Justifications for the 2024 Filing Year for Single Risk Pool Coverage are located in Attachment 3.

Network Adequacy Review Updates

- The IDOI has decided to largely defer to CMS regarding network adequacy review for on-exchange and dental submissions.
    - Requirements for Individual or Small Group Major Medical submissions that are completely Off-Exchange are similar to those used for PY 2024.
- Additional information can be found by visiting Attachment 1 of this document.
- The ECP provider participation standard is set at 35 percent of available ECPs based on the applicable PY HHS ECP list, including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the 35 percent threshold.
- For PY 2025, CMS has added guidance for time and distance standards, appointment wait times, and the network adequacy justification process, and the IDOI encourages you to review the 2025 Federal Final Letter to Issuers.
    - QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers).

- Here is a table of Provider Specialty Types and Appointment Wait Time Standards:

Provider Specialty Type	**Appointments Must Be Available Within**
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-urgent)	30 business days

- CMS requires medical QHP issuers offering QHPs in the FFEs to contract with a third-party entity to administer secret shopper surveys to meet appointment wait time standards.
  - To demonstrate compliance with these standards, medical QHP issuers must contract with a third-party entity to conduct a secret shopper survey, with surveying beginning on or shortly after January 1st and completed by May 31 of each plan year, and report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities.
  - Please see the 2025 Federal Final Letter to Issuers for further information.
- Also, please see this link for Appointment Wait Time Secret Shopper Survey Technical Guidance: **(**https://www.qhpcertification.cms.gov/s/AWT-SSS-Tech-Guide-QHP-FFE-508.pdf?v=1**).**
- The IDOI will require that the secret shopper surveys be completed for both Individual and Small Group Major Medical off exchange submissions.

Formulary Review Updates

- Major medical formularies must comply with all federal review requirements using all of the federal review tools available at https://www.qhpcertification.cms.gov/s/Review%20Tools.
- In addition to the federal templates, Indiana conducts the state specific IDOI Clinical Appropriateness Review. The IDOI Clinical Appropriateness Tool will be used for Plan Year 2025.
  - This is an Indiana specific formulary review for all single risk pool major medical plans and is in addition to all formulary reviews done using the Plan Management Tools designed by CMS.
  - The tool can be found here: http://www.in.gov/idoi/2813.htm.

Treatment of Drug Coupons Towards Out-of Pocket Costs

In response to the 2021 NBPP Final Rule, Indiana enacted Senate Bill 8 in 2023. Senate Bill 8 added new chapters to the Indiana Code regarding the handling of prescription drug rebates.[1] For individual health plans, cost-sharing for a prescription drug must be calculated at the point of sale and based on a reduced price equal to 85% of available rebates connected to dispensing or administering the drug.[2] Senate Bill 8 also specifies that it will only apply to plans issued,

[1] See Ind. Code 27-1-49-1, *et seq*. (Individual plans) and 27-1-50-1, *et seq*. (Group plans).
[2] IC 27-1-49-7.

delivered, amended, or renewed after December 31, 2024.[3] In the absence of further guidance from the U.S. Department of Health and Human Services, Indiana will enforce Senate Bill 8 and expects plans to comply with its requirements.

- For the 2025 benefit year, the IDOI requests each insurer indicate in your form filing how copayment accumulators will be treated.

Nondiscrimination Standards

- **Sexual Orientation and Gender Identity**: Nondiscrimination protections explicitly prohibit discrimination based on sexual orientation and gender identity.
- **Benefit Design**: The design should be clinically based, that incorporates evidence-based guidelines into coverage and programmatic decisions.
- **Rx Tiers**: Issuers may not place most or all drugs that treat a specific condition on highest cost tiers.

MHPAEA

- MHPAEA tab of the EHB Verification Template
    - The IDOI requires that the classifications be listed separately on the template and must remain separate for the determination of "substantially all" and "predominant" level tests.
    - It is now IDOI policy that Outpatient Office Visits (In-Network) for Medical/Surgical must use the same cost-sharing type (copay/coinsurance) as Mental Health/Substance Use Disorder.
    - Plans that do not comply with this standard will not be approved.
- The IDOI will require completion of the federal Self-Compliance Toolkit.
- Additional information on expectations for Plan Year 2025 may be found in Attachment 2 of this document.

Product Discontinuance/Renewal Notifications

- Notification must be sent to policyholders at least 90 calendar days in advance of the date the coverage will be discontinued.
    - Carriers should also send written notice of the product discontinuance to the Commissioner.
    - Notification to policyholders should be approved by the IDOI prior to sending to policyholders.
- Notification requirements are applicable for both grandfathered and non-grandfathered coverage in the large group, small group and individual market on and off Marketplace.
- Additional information regarding notice requirements may be found at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Federal-Standard-Notices-and-Enforcement-Safe-Harbor-for-Discontinuation-Notices-PY2020.pdf.

[3] IC 27-1-49-0.5 and IC 27-1-50-0.5.

Exchange User Fees

- Federal-facilitated Exchange user fee 1.5%.

Standardized and Non-Standardized Plan Options (for QHP Issuers Only)

- For PY 2025, CMS will continue to require standardized QHP options in FFE at every product network type to include:
  - One bronze plan;
  - One bronze plan that meets the requirements to have an AV up to 5 points above the 60 percent standard as specified in §156.140 (c) (known as expanded bronze plan);
  - One silver plan;
  - One version of each of the three income-based silver CSR plan variations;
  - One gold plan; *and*
  - One platinum plan.
- CMS has made a minor change requiring plans to be within the allowable de minimis range for the metal level.
- Non-standardized plan option exceptions-An issuer may offer additional non-standardized plan options beyond the limit of two for each product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area. Please refer to the 2025 Federal Final Letter to Issuers.

State Legislative Considerations

Below is a list of bills passed this legislative session that insurers should be aware of and review for new regulatory requirements or reporting requirements. Insurers should monitor Indiana legislation that impacts them and should review any new legislation with counsel to determine impact.

- SEA 9: Notice of health care entity merger
- SEA 132: Professions and professional services
- SEA 215: Medicare supplement insurance
- SEA 273: Biomarker testing coverage
- HEA 1034: Insurance and transfer on death deeds
- HEA 1058: Breast cancer screening and services
- HEA 1259: Health care matters
- HEA 1332: Insurance matters
- HEA 1385: Emergency medical services

Reference Documents

- The IDOI Rate and Form Review will encompass information contained within the following reference documents/rules:
  - 2025 Final Notice of Benefit and Payment Parameters
  - 2025 Final Letter to Issuers
  - 2025 Plan Management/CMS Templates
  - No Surprises Act

IDOI Network Adequacy Standards for Plan Year 2025

Finalized Standards:

The IDOI has decided to largely defer to CMS regarding network adequacy review for on-exchange and dental submissions. With this in mind, the proposed IDOI Network Adequacy Standards for Plan Year 2025 are finalized:

Individual or Small Group Major Medical Submissions that Are Completely Off-Exchange:

1. Carriers may choose to use either the 3 county designations proposed by the IDOI (Large Metro, Metro, and Rural) or all 5 as defined by CMS in their Letter to Issuers.
2. Carriers may demonstrate network adequacy using distance only maps as described in the IDOI Network Adequacy Standards, or carriers may choose to submit tables that demonstrate both time and distance in accordance with CMS's network adequacy requirements as defined in the 2023 through 2025 Final Letters to Issuers and Notices of Benefit and Payment Parameters.
3. Carriers will be responsible for designing and submitting exhibits that clearly demonstrate how all criteria are met. Most criteria are evaluated at the network/county level. For this reason, the information entered into ECP/Network Adequacy template must be complete and accurate, especially regarding the county that is listed. A provider/facility/pharmacy must be in network in order to be listed in the ECP/Network Adequacy template and be counted towards satisfying network adequacy standards.
4. Indiana requires that Outpatient Dialysis be covered in-network and satisfy a distance standard of 45 miles. This can be demonstrated in the carrier's format in a document separate from the ECP/Network Adequacy template.
5. Carriers will need to submit:
   i. the ECP/Network Adequacy template,
   ii. the IDOI Active Individual Providers Template (major medical only),
   iii. a table showing the count of unique providers (facilities and individual) by specialty and network, and
   iv. justifications where any standard has not been met.
6. The IDOI is requiring all Off-Exchange submissions to comply with CMS wait-time standards starting with Plan Year 2025:
   a. QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers).
   b. Here is a table of Provider Specialty Types and Appointment Wait Time Standards:

Provider Specialty Type	**Appointments Must Be Available Within**
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-urgent)	30 business days

c. CMS requires medical QHP issuers offering QHPs in the FFEs to contract with a third-party entity to administer secret shopper surveys to meet appointment wait time standards.
   - To demonstrate compliance with these standards, medical QHP issuers must contract with a third-party entity to conduct a secret shopper survey, with surveying beginning on or shortly after January 1st and completed by May 31 of each plan year, and report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities.
   - For Plan Year 2025, CMS is requiring that secret shopper surveys be conducted for a QHP issuer's primary care (routine) and behavioral health providers. CMS expects to require secret shopper surveys to be administered with respect to specialty care (non-urgent) providers in future plan years.
   - Please see the 2025 Federal Final Letter to Issuers for further information.

d. Also, please see this link for Appointment Wait Time Secret Shopper Survey Technical Guidance: (https://www.qhpcertification.cms.gov/s/AWT-SSS-Tech-Guide-QHP-FFE-508.pdf?v=1).

IDOI Active Individual Providers Template:

This is an Excel workbook, separate from the ECP/Network Adequacy template that lists active individual providers at locations that meet the following additional criteria:

1. By default, individual providers may only be listed at a single primary location. However, providers may be listed at additional locations if the carrier has paid major medical claims for care provided in-person at that location for that specialty during or after 2022. The goals for this restriction are as follows:
   a. To reduce the number of outdated or incorrect entries,
   b. To account for the fact that an individual can only provide a limited amount of care, and
   c. To more accurately identify where care is being provided.
2. The IDOI may provide additional leniency for carriers that are entering the market and thus would not have any claims in 2022, 2023, or 2024.
3. The layout and fields in this workbook match the layout and fields of the "IndividualProviders" tabs in the ECP/Network Adequacy template but have the addition of two final columns labeled "Default/Active" and "Date of Recent Service".

Count of Unique Providers by Specialty and Network:

For each network, carriers should provide the total number of unique providers of each specialty. These counts must only include providers listed in the ECP/Network Adequacy template on the non-ECP tabs. There should also be a column indicating the percentage of providers in each specialty and for each network that has billed the carrier for care they provided in that specialty at that location since 1/1/2022.

Distance Standards and Maps:

County Designations:

The IDOI uses the three county type designations of Large Metro (Marion County only), Metro (combines CMS's Metro and Micro), and Rural (combines CMS's Rural and CEAC).

County Designation	Population
Large Metro	> 900,000
Metro	50,000 – 900,000
Rural	< 50,000

Distance Standards:

The IDOI will be using the specialties and distance standards defined by CMS in their 2023 through 2025 Final Letters to Issuers.

For Carriers that Submit Maps:

For each network and for each specialty, carriers will need to provide 3 maps (Large Metro, Metro, and Rural). The maps should demonstrate that all policy holders will have access to at least one provider of each specialty within the distance standard of their county's designation by plotting each provider location in that network of that specialty type statewide and drawing semi-transparent circles, centered at the provider locations, with radii equal to the map's distance standard. For each map, all providers of that specialty and in that network should be plotted and should have their circles drawn, even if they are in counties of a different county designation than the map. Counties that have the same county designation as what is being shown on the map should be colored in a way to make them easy to identify. It must also be easy to identify which counties do not have plans with the map's network. Each of these counties are expected to be fully covered. Counties that have a less stringent distance standard than that being shown on the map are not expected to be fully covered.
Maps should include the following:

1. All Indiana county boundaries,
2. All county names,
3. County Designation being mapped,
4. The distance standard in miles,
5. The Network ID,
6. The provider specialty,
7. The date made,
8. Colorings of counties that make it easy to identify which counties match the county designation of the map and which counties offer plans with the map's network.

Justifications:

Carriers will need to demonstrate a sufficient number of each provider type, in each network, for each county in which that network is used. If a carrier is unable to meet this requirement, then the carrier must supply a justification of why the carrier was unable to meet this

requirement. This justification will need to be reviewed and found adequate by the IDOI for the carrier to receive credit for meeting that standard for that network/county.

SADPs:

1. Carriers will need to demonstrate compliance, for both their on-exchange plans and off-exchange plans, with CMS's network adequacy requirements as defined in the 2023 through 2025 Final Letters to Issuers and Notices of Benefit and Payment Parameters.
2. Dental plans will NOT need to submit:
   i. the IDOI Active Individual Providers Template,
   ii. a table showing the count of unique providers (facilities and individual) by specialty and network.
3. All carriers must comply with wait-time standards starting with Plan Year 2025:
   a. QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers).
   b. Here is a table of Provider Specialty Types and Appointment Wait Time Standards:

Provider Specialty Type	**Appointments Must Be Available Within**
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-urgent)	30 business days

   c. As SADP issuers would generally contract with specialty care (non-urgent) providers, SADP issuers would not be required to contract with a third-party entity to conduct secret shopper surveys for the 2025 plan year. Please see the 2025 Federal Final Letter to Issuers for further information.
   d. Also, please see this link for Appointment Wait Time Secret Shopper Survey Technical Guidance: (https://www.qhpcertification.cms.gov/s/AWT-SSS-Tech-Guide-QHP-FFE-508.pdf?v=1).

Submissions that Contain On-Exchange Major Medical Plans:

1. Carriers will need to demonstrate compliance, for both their on-exchange plans and off-exchange plans, with CMS's network adequacy requirements as defined in the 2023 through 2025 Final Letters to Issuers and Notices of Benefit and Payment Parameters.
2. Indiana requires that Outpatient Dialysis be covered in-network and satisfy a distance standard of 45 miles. This can be demonstrated in the carrier's format in a document separate from the ECP/Network Adequacy template.
3. Submissions containing on-exchange plans will not need to submit:
   I. the IDOI Active Individual Providers Template,
   II. a table showing the count of unique providers (facilities and individual) by specialty and network.

4. All carriers must comply with wait-time standards starting with Plan Year 2025:
   a. QHP issuers, including SADP issuers, are required to ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time (particularly concerned with the ability of new patients to schedule appointments with in-network providers).
   b. Here is a table of Provider Specialty Types and Appointment Wait Time Standards:

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   c. CMS requires medical QHP issuers offering QHPs in the FFEs to contract with a third-party entity to administer secret shopper surveys to meet appointment wait time standards.
      - To demonstrate compliance with these standards, medical QHP issuers must contract with a third-party entity to conduct a secret shopper survey, with surveying beginning on or shortly after January 1st and completed by May 31 of each plan year, and report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities.
      - For Plan Year 2025, CMS is requiring that secret shopper surveys be conducted for a QHP issuer's primary care (routine) and behavioral health providers. CMS expects to require secret shopper surveys to be administered with respect to specialty care (non-urgent) providers in future plan years.
      - Please see the 2025 Federal Final Letter to Issuers for further information.

   d. Also, please see this link for Appointment Wait Time Secret Shopper Survey Technical Guidance: (https://www.qhpcertification.cms.gov/s/AWT-SSS-Tech-Guide-QHP-FFE-508.pdf?v=1).

Attachment 2 Consolidated Appropriations Act MHPAEA Guidance

The Consolidated Appropriations Act "CAA" amended MHPAEA to require certain plans to perform and document an analysis that demonstrates compliance with the non-quantitative treatment limitations (NQTLs) requirements of the MHPAEA (i.e., the requirement that the application of NQTLs to mental health and substance use benefits are "in parity" with the application of NQTLs to medical/surgical benefits). As of February 10, 2021, plans and issuers must provide a comparative analysis if requested by plan participants, the Departments, or relevant state agencies.

What information must a NQTL comparative analysis contain?

The comparative analysis must contain a written detailed explanation of whether processes, strategies, evidentiary standards, or other factors that apply a NQLT to MU/SUD benefits are comparable and are not applied more stringently than to medical/surgical benefits. The CAA requires, at a minimum, that the comparative analysis contain a robust discussion of 9 elements:

- A clear description of the specific NQTL, plan terms, and policies at issue;
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies;
- Identification of any factors, evidentiary standards, or processes considered in the application of the NQTL to MH/SUD and medical/surgical benefits;
- If any factors, evidentiary standards, strategies, or processes are defined in a quantitative manner, the precise definitions used;
- Explanation of whether there is any variation in the application of a guideline or standard between MH/SUD and medical/surgical benefits;
- If the application of the NQTL turns on specific decisions, the nature of the decisions, the decision makers, the timing of the decisions, and the qualifications of the decision makers;
- If the plan relies on experts, the experts' qualifications and the extent to which the plan relies on the experts' evaluations when setting recommendations for MH/SUD and medical/surgical benefits;
- A discussion of the plan's findings and conclusions as to the comparability of the process, strategies, evidentiary standards, and factors of the above categories and the plan's compliance with MHPAEA; and
- The date of the analysis and the name, title, and position of the persons who performed the comparative analysis.

What documentation may be requested from the Departments to support the comparative analysis?

Plans and carriers should be prepared to provide documents that support the conclusions of the NQTL comparative analysis. The DOL highlights the following documents that it may request from a plan to support a comparative analysis:

- Records documenting NQTL processes and how NQTLs are applied to medical/surgical and MH/SUD benefits;
- Any materials that have been prepared for compliance with any applicable reporting requirements under state law;

- Documentation (e.g., guidelines, claims processing policies and procedures) the plan or issuer relied upon in determining the NQTLs are applied no more stringently to MH/SUD benefits that medical/surgical benefits;
- Samples of covered and denied MU/SUD and medical/surgical claims; and
- Documents related to MHPAEA compliance from the plan's service providers/vendors (if the plan delegates management of some or all MU/SUD benefits to another entity).

What enforcement action may be taken for parity violations?
Civil monetary penalties may be levied for MHPAEA violations.

Additional Resources
https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf

https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

Indiana Department of Insurance
Mental Health Parity MHPAEA Issuer Compliance Certification Tool

Updated 4/29/2019

Background

The Patient Protection and Affordable Care Act generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits (parity). The goal of the compliance attestation is to ensure compliance with the requirements set forth the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements that apply to group health plans, group health insurance issuers, and individual market health insurance issuers. MHPAEA set forth requirements for determining parity with respect to financial aspects and treatment limitations which limit the scope or duration of benefits for treatment. Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment.

I. Non-quantitative Treatment Limitations

MHPAEA forbids a plan from imposing an NQTL on MH/SUD benefits unless, under the plan's written terms and day-to-day operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable to, and apply no more strictly than, those used in applying the limit to medical and surgical benefits. Non-quantitative treatment limitations (NQTLs) on MH/SUD benefits are reviewed for compliance with federal mental health parity requirements. 45 C.F.R. § 146.136(c)(4). Please complete the tables below and submit the requested documentation to enable the Department to determine NQTL parity compliance in each plan. 45 C.F.R. § 146.136(d)(1);

- Formulary design for prescription drugs;
- Network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- 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.

Examples of NQTLs are as follows:

Preauthorization & Pre-service Notification Requirements

- Plan requires preauthorization for all mental health and substance use disorder services.
- Plan states that if the insured is admitted to a mental health or substance abuse facility for nonemergency treatment without prior authorization, insured will be responsible for the cost of services received.
- Plan states that inpatient mental health services require precertification.
- Plan requires pre-notification (or notification as soon as possible) for unscheduled MH/SUD admissions, and reduces benefits 50% for failing to provide pre-notification.
- Plan requires preauthorization for all inpatient and outpatient treatment of chemical dependency and all inpatient and outpatient treatment of serious mental illness and mental health conditions.
- Plan requires preauthorization or concurrent care review every 10 days for MH/SUD services but not for medical and surgical services.
- Plan's medical management program (precertification and concurrent review) delegates its review authority to attending physicians for medical and surgical services but conducts its own reviews for MH/SUD services.
- Plan requires preauthorization every three months for pain medications prescribed in connection with MH/SUD conditions.
- Plan requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes.

Fail-first Protocols

- For coverage of intensive outpatient treatment for MH/SUD, the plan requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.
- For inpatient SUD rehabilitation treatment plan requires a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care.
- For any inpatient MH/SUD services, the plan requires that an individual first complete partial hospitalization treatment program.

Probability of Improvement

- For residential treatment of MH/SUD, the plan requires the likelihood that inpatient treatment will result in improvement.
- Plan covers only services that result in measurable and substantial improvement in mental health status within 90 days.

Written Treatment Plan Required

- For MH/SUD benefits, plan requires a written treatment plan prescribed and supervised by a behavioral health provider. Plan requires that within seven days, an individualized problem-focused treatment plan be completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex biopsychosocial evaluation. Plan needs to be reviewed at least once a week for progress.
- Plan requires that an individual-specific treatment plan will be updated and submitted, in general, every six months.

Other

- Plan excludes services for chemical dependency in the event the covered person fails to comply with the plan of treatment, including excluding benefits for MH/SUD services if a covered individual ends treatment for chemical dependency against the medical advice of the provider.
- Plan excludes residential level of treatment for chemical dependency.
- Plan imposes a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on medical and surgical benefits.
- Plan requires that MH/SUD facilities be licensed by a state but does not impose the same requirement on medical and surgical facilities.

MH/SUD NQTL List

- **Benefit/Service Column:** Please list all MH/SUD benefits in each classification that are subject to NQTLs as defined in § 146.136(a) and (c)(4)(ii).Ensure that the list of benefits is comprehensive and consistent with the policy. In each table, insert additional rows as needed and delete any unnecessary rows.
- **NQTL(s) Column:** For each listed MH/SUD benefit, describe all non-quantitative treatment limitations (e.g., prior authorization, step therapy, continued stay review) that apply to that benefit. Ensure that all applicable NQTLs are listed here.
- **Policy Form/Page No. Column:** Indicate the form and page numbers on which each NQTL appears. If a NQTL is not stated in the policy forms, please write "N/A" with additional explanation of how benefit is covered.

- **Out-of-Network Tables:** If the product imposes the same NQTL requirements on in-network and out-of-network benefits in a given classification, you do not need to repeat the NQTL list; instead, in the out-of-network table please reference the in-network list and delete any unnecessary blank rows (e.g., "Inpatient OON: NQTL requirements for MH/SUD are identical to Inpatient INN").

MH/SUD NQTL List: Inpatient, in-network		
Benefit/Service	**NQTL(s)**	**Policy Form/Page No.**

Additional explanation of NQTL Coverage not part of form filing:

NQTL List: Inpatient, out-of-network (if applicable)		
Benefit/Service	**NQTL(s)**	**Policy Form/Page No.**

Additional explanation of NQTL Coverage not part of form filing:

NQTL List: Outpatient, in-network		
Benefit/Service	**NQTL(s)**	**Policy Form/Page No.**

Additional explanation of NQTL Coverage not part of form filing:

NQTL List: Outpatient, out-of-network (if applicable)		
Benefit/Service	**NQTL(s)**	**Policy Form/Page No.**

Additional explanation of NQTL Coverage not part of form filing:

NQTL List: Emergency Care		
Benefit/Service	**NQTL(s)**	**Policy Form/Page No.**

NQTL List: Emergency Care		
Benefit/Service	**NQTL(s)**	**Policy Form/Page No.**

Additional explanation of NQTL Coverage not part of form filing:

NQTL List: Prescription Drugs		
Benefit/Service	**NQTL(s)**	**Policy Form/Page No.**

Additional explanation of NQTL Coverage not part of form filing:

II. Disclosure Requirements

Please attest to your compliance with the following MHPAEA disclosure requirements:

Federal Requirement	Attestation
The health insurance issuer must make available the criteria for medical necessity determinations made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary,	

enrollee, or contracting provider upon request. See 29 CFR 2590.712(d)(1), 45 CFR 146.136(d)(1).	
The plan administrator (or health insurance issuer) must make available the reason for any denial under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, enrollee, , and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).	
Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including mental health/substance use disorder) are eligible for external review. The internal claims and appeals rules include the right of claimants (or their authorized representative) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan. See 26 CFR 54.9	
With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, medical necessity criteria for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided within 30 days of the request to the participant, beneficiary, or provider or other individual if acting as an authorized representative of the beneficiary or participant. See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).	
45 CFR § 146.136 states the following: Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage **and** in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition **must** be defined to be consistent	

with generally recognized independent standards of current medical practice (for example, the most current version of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**, the most current version of the **ICD**, or State guidelines).	
If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to $110 a day from the date of failure to provide these documents.	

Name of individual(s) completing form

Title/job description

Date

Indiana Department of Insurance Mental Health Parity and Addiction Equity Act (MHPAEA) Internal Compliance Checklist Form Review

Introduction:

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for mental health or substance use disorder and benefits in addition to medical/surgical benefits.

Definitions:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but not including mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health

condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

Applicability:

Small and Large Group Health Plans:

Most group health plans that provide MH/SUD benefits must provide such benefits "in parity" with medical/surgical benefits. Any combination of benefits under which coverage for medical/surgical and MH/SUD benefits may be received simultaneously is a single group health plan subject to parity requirements.

Individual Health Plans:

Individual health plans which are required to provide MH/SUD benefits as part of the "essential health benefits" under the ACA.

Exemptions:

- Group health plans that provide MH/SUD benefits only to meet preventive coverage requirements
- Excepted benefits (e.g. health FSAs, limited-scope vision or dental, hospital indemnity policies or specified disease/illness policies)
- Small employer plans (50 or less employees) 100 and under for non-federal governmental plans
- Retiree-only plans
- Self-funded state and local governmental plans (non-federal) that choose to opt out and follow required procedures
- Employers who experience significant cost increases (at least 1% due to coverage for such benefits)

Insurance Company Name:			
Type of Insurance:			
NAIC SERFF Tracking Number:			
Section A. Lifetime and Annual limits			
	YES	NO	N/A
Q1. Does the plan comply with the mental health parity requirements regarding lifetime dollar limits on mental health/substance use disorder benefits? A plan generally may not impose a lifetime dollar limit on mental health/ substance use disorder benefits that is lower than the lifetime dollar limit imposed on medical/ surgical benefits. If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes on that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits (See IDOI EHB Verification template MHPAEA tab). 26 C.F.R. § 9812-1(b), 29 C.F.R. § 2590.712(b), 45 C.F.R. § 146.136(b) **Q2. Does the plan comply with the mental health parity requirements regarding annual dollar limits on mental health/substance use disorder benefits?** A plan generally may not impose an annual dollar limit on mental health/ substance use disorder benefits that is lower than the annual dollar limit imposed on medical/surgical benefits. 29 CFR 2590.712(b)			
Section B. Financial Requirements and Quantitative Treatment limitations			
	YES	NO	N/A
Q1. Does the plan comply with the mental health parity requirements for parity in financial requirements and quantitative treatment limitations?			

A plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type that is applied to substantially all medical/surgical benefits in the same classification. 29 CFR 2590.712(c)(2) Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. 29 CFR 2590.712(c)(1)(ii) Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. 29 CFR 2590.712(c)(1)(ii) The six classifications* of benefits are: **1)** Inpatient, in-network; **2)** Inpatient, out-of-network; **3)** Outpatient, in-network; **4)** Outpatient, out-of-network; **5)** Emergency care; and **6)** Prescription drugs. 29 CFR 2590.712(c)(2)(ii) *See IDOI EHB Verification Template MHPAEA tab			
Section C. Coverage in all Classifications			
	YES	NO	N/A
Q1. Does the plan comply with the mental health parity requirements for coverage in all classifications? If a plan provides mental health/substance use disorder benefits in any classification of benefits, mental health/substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. 29 CFR 2590.712(c)(2)(ii)(A)			

In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health/substance use disorder benefits. 29 CFR 2590.712(c)(2)(ii)(A) This rule also applies to intermediate services provided under the plan or coverage. Plans must assign covered intermediate mental health and substance use disorder benefits (such as residential treatment, partial hospitalization and intensive outpatient treatment) to the existing six classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan classifies skilled nursing and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify residential treatment facilities for mental health and substance use disorder benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient mental health/substance use disorder services and partial hospitalization must be considered outpatient benefits as well. A plan must also comply with MHPAEA's NQTL rules, discussed in the following section, in assigning any benefits to a particular classification. 29 CFR 2590.712(c)(4) **Q2. Are there any impermissible quantitative treatment limitations (i.e. visit limits) or Non-quantitative treatment limits (i.e. dosage or duration) that apply to Medication assistance treatment (MAT)?** **Q3. Does the plan adequately provide treatment for the coverage of eating disorders including residential treatment in accordance with MHPAEA?**			
Section D. Cumulative Financial Requirements and Treatment limitations			
	YES	NO	N/A
I. Financial Requirements			

Q1. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirement regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits? **Q2. Is the deductible for mental health and/or substance use treatment higher than the deductible for most medical/surgical care?** **Q3. Are the plan's copayment requirements for mental health and substance use treatment higher than those for most medical/surgical benefits?** **Q4. Are copayments for medications used to treat mental health and substance use conditions higher than the copayments for most medications used to treat other conditions?** **Q5. Does the plan set a higher out of pocket maximum or limit for mental health and/or substance use disorder treatment beyond which more comprehensive coverage applies?** ***II. Treatment Limitations*** **Q6. Does the plan impose more restrictive limits on how often treatment for mental health and/or substance use treatment will be covered compared to treatment for medical and surgical care?** **Q7. Does the plan set a lower limit on the number of visits allowed for mental health and/or substance use treatment compared to the number of visits covered for most medical or surgical care?** **Q8. Does the plan set a lower limit on the number of days covered mental health and/or substance use treatment than are covered for most medical and surgical care?** **III. Out-of-Network Coverage**			

Q9. Does the plan cover out-of-network medical or surgical care, but not out-of-network mental health and substance use disorder treatment? **Q10. Does the plan apply higher financial requirements or stricter treatment limitations for out-of-network medical and surgical benefits?** A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v) Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a) Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a)			

Section E. Non-quantitative Treatment Limitations (NQTL)			
	YES	NO	N/A
MHPAEA forbids a plan from imposing a NQTL on MH/SUD benefits unless, under the plan's written terms and day-to-day operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable to, and apply no more strictly than, those used in applying the limit to medical and surgical benefits. List of NQTLs:			

• Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review); • Formulary design for prescription drugs; • Network tier design; • Standards for provider admission to participate in a network, including reimbursement rates; • Plan methods for determining usual, customary, and reasonable charges; • 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. ***I. Preauthorization and Pre-service notification requirements*** **Q1. A. Does the plan requires preauthorization for all mental health and substance use disorder services?** **Q2. Does the plan states that if the insured is admitted to a mental health or substance abuse facility for non-emergency treatment without prior authorization, insured will be responsible for the cost of services received.** **Q3. Does the plan state that inpatient mental health services require pre-certification?** **Q4. Does the Plan requires pre-notification (or notification as soon as possible) for unscheduled MH/SUD admissions, and reduces benefits 50% for failing to provide pre-notification?** **Q5. Does the plan requires preauthorization for all inpatient and outpatient treatment of chemical dependency and all inpatient and outpatient treatment of serious mental illness and mental health conditions?**			

Q6. Does the plan requires preauthorization or concurrent care review every 10 days for MH/SUD services but not for medical and surgical services? **Q7. Does the plan's medical management program (precertification and concurrent review) delegates its review authority to attending physicians for medical and surgical services but conducts its own reviews for MH/SUD services?** **Q8. Does the plan requires preauthorization every three months for pain medications prescribed in connection with MH/SUD conditions?** **Q9. Does the plan requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes?** ***II. Fail-first Protocols*** **Q10. Does the coverage of intensive outpatient treatment for MH/SUD require that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency?** **Q11. Does inpatient SUD rehabilitation treatment plan require a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care?** **Q12. For any inpatient MH/SUD services, does the plan require that an individual first complete partial hospitalization treatment program?** ***III. Probability of Improvement*** **Q13. For residential treatment of MH/SUD, does the plan require the likelihood that inpatient treatment will result in improvement?** **Q14. Does the plan only cover services that result in measurable and substantial improvement in mental health status within 90 days?**			

IV. Written Treatment Plan Required **Q15. For MH/SUD benefits, does the plan require a written treatment plan prescribed and supervised by a behavioral health provider?** **Q16. Does the plan require that within seven days, an individualized problem-focused treatment plan be completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex biopsychosocial evaluation. Plan needs to be reviewed at least once a week for progress?** **Q17. Does the plan require that an individual-specific treatment plan will be updated and submitted, in general, every six months?** *V. Other* **Q18. Does the plan exclude services for chemical dependency in the event the covered person fails to comply with the plan of treatment, including excluding benefits for MH/SUD services if a covered individual ends treatment for chemical dependency against the medical advice of the provider?** **Q19. Does the plan excludes residential level of treatment for chemical dependency?** **Q20. Does the plan impose a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on medical and surgical benefits?** **Q21. Does the plan require that MH/SUD facilities be licensed by a state but does not impose the same requirement on medical and surgical facilities?**			

Section F. Disclosure Requirements			
	YES	NO	N/A
Q1. Does the plan comply with the mental health parity			

disclosure requirements? See Issuer attestation document. • The plan administrator (or the health insurance issuer) must make available the criteria for medical necessity determinations made under a group health plan with respect to mental health/substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) to any current or potential participant, beneficiary, or contracting provider upon request 29 CFR 2590.712(d)(1) • The plan administrator (or health insurance issuer) must make available the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health/substance use disorder benefits to any participant or beneficiary in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719. (internal claims and appeals and external review processes). • Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act, applicable to all non-grandfathered group health plans, claims related to medical judgment (including mental health/substance use disorder) are eligible for external review. The internal claims and appeals rules include the right of claimants (or their authorized representative) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and mental health/substance use disorder benefits under the plan. 29 CFR 2590.712(d)(3) • If coverage is denied based on medical necessity, medical necessity criteria for the mental health/substance use disorder benefits at issue and for medical/ surgical benefits			

in the same classification must be provided within 30 days of the request to the participant, beneficiary, or provider or other individual if acting as an authorized representative of the beneficiary or participant 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1)			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: April 15, 2024

From: Samara Lorenz, Director, Oversight Group

Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: Bulletin: Timing of Submission of Rate Filing Justifications for the 2024 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2025

I. Purpose

The Centers for Medicare & Medicaid Services (CMS) is releasing this bulletin for purposes of establishing the submission deadlines under 45 CFR 154.220 for Rate Filing Justifications for single risk pool coverage in the individual and small group (or merged) markets effective on or after January 1, 2025.[1]

This bulletin also establishes the dates on which CMS will provide public access to information regarding proposed rate changes and final rate changes for single risk pool coverage, as well as the deadline for States with an Effective Rate Review Program[2] to post proposed rate increases subject to review. It also provides the CMS web address that States with an Effective Rate Review Program can use if they elect to provide public access to information regarding proposed rate changes and final rate changes for single risk pool coverage from their websites through a link to the CMS website.

II. Rate Review Timelines for the 2024 filing year for single risk pool coverage effective on or after January 1, 2025

The timelines specified below will apply to the rate filings submitted in 2024 (2024 filing year) for single risk pool coverage (including both qualified health plans (QHPs) and non-QHPs) in the individual and small group (or merged) markets for plan or policy years beginning on or after January 1, 2025.

[1] The term "single risk pool coverage" is used to describe non-grandfathered health insurance coverage in the individual or small group (or merged) markets that is subject to the single risk pool provisions at 45 CFR 156.80 and for which issuers are required to file rate information using the Unified Rate Review Template (URRT).
[2] See 45 CFR 154.301 for the list of criteria CMS considers when evaluating whether a State has an Effective Rate Review Program.

Proposed Rate Filings - Submission Deadlines

The deadlines for submission of a Rate Filing Justification to CMS and the applicable State for single risk pool coverage are listed below.[3] Pursuant to 45 CFR 154.215(a), in addition to rate increases, these deadlines also apply to single risk pool coverage that experience no rate changes, rate decreases, and rates for new single risk pool coverage.

- In a State ***without an Effective Rate Review Program,*** proposed rate filings for all single risk pool coverage, regardless of whether or not the filing contains a QHP, must be submitted to CMS in the Unified Rate Review (URR) module of HIOS for review by June 3, 2024.
- In a State ***with an Effective Rate Review Program,*** proposed rate filings for all single risk pool coverage, regardless of whether or not the filing contains a QHP, must be submitted to both CMS and the State by a date set by the State, as long as the date is no later than July 17, 2024.[4]

In addition to submitting the Rate Filing Justification, issuers submitting QHP applications to participate in Exchanges served by the HealthCare.gov platform are required to submit their QHP Rates Table Templates by July 17, 2024. We note that there will be opportunities during the QHP certification process for an issuer to update, correct, or change the QHP Rates Table Template (as may be necessary).

Proposed Rate Filings – Posting by CMS

CMS will post all applicable parts of the Rate Filing Justification for all single risk pool coverage with rate changes (including both QHPs and non-QHPs), regardless of whether the product includes a plan with a rate increase that is subject to review under 45 CFR 154.210.[5] CMS will conduct a data refresh prior to posting, in order to capture the most recent rate filing information, and then will post proposed rate information for all issuers at one time. The data will not be refreshed again by CMS until final rate information is posted.

- All changes to proposed rate filings must be made by July 17, 2024.

- CMS intends to post information on proposed rate filings for consumers to review on

[3] 45 CFR 154.220(b) requires issuers to submit rate information for single risk pool coverage by the earlier of: (a) the State's deadline or (b) the date specified by the Secretary of the Department of Health and Human Services (HHS) in guidance.

[4] States with an Effective Rate Review Program are permitted to establish a different submission deadline for non-QHP-only rate filings as long as that deadline is no later than July 17, 2024. In states with an Effective Rate Review Program, a rate filing that is filed through the National Association of Insurance Commissioners (NAIC) System For Electronic Rates & Forms Filing (SERFF) and automatically uploaded to the URR module of HIOS will be considered to be filed with CMS once the upload is successful. This functionality does not apply to states that do not participate in SERFF. Issuers in those states will need to continue to submit the rate filing justification directly in the URR module in HIOS.

[5] CMS will not post information that is a trade secret or confidential commercial or financial information as defined in HHS' Freedom of Information Act regulations at 45 CFR 5.31(d).

August 1, 2024 at https://ratereview.healthcare.gov.[6]

Final Rate Filings – Determination Deadlines

States with an Effective Rate Review Program that participate in SERFF must enter in SERFF the applicable final determination status, as detailed further below, which will then be automatically uploaded to the URR module of HIOS. States with an Effective Rate Review Program that do not participate in SERFF must enter the applicable final determination status directly in the URR module of HIOS.

There are three final determination statuses. All submissions that do not have any rate increases subject to review (rate increases less than 15 percent)[7] must be in a status of "Rate Filing Accepted." For submissions with rate increases that are subject to review (rate increase of 15 percent or greater), the submission must be in a status of "Review Complete" if the rate increase received a determination of "not unreasonable," or in a status of "Final Justification Submitted" if the rate increase received a determination of "unreasonable" and the issuer has submitted the final justification.

- Rate filings *that contain a QHP* in States with Exchanges served by the HealthCare.gov platform must be finalized by the State or CMS by August 14, 2024.
- Rate filings *that contain a QHP* in States with a State-based Exchange that does not use the HealthCare.gov platform must be finalized by the State by a date set by the State, as long as the date is no later than October 15, 2024.
- All rate filings *that contain only non-QHPs* must be finalized by the State or CMS by October 15, 2024.

Final Rate Filings – Posting by CMS

For all single risk pool coverage (including both QHP and non-QHPs) with rate changes, CMS will post all applicable parts of the Rate Filing Justification for all final rate filings, regardless of whether the product includes a plan with a rate increase that is subject to review under 45 CFR 154.210.[8] CMS will conduct a data refresh prior to posting, in order to capture the most recent rate filing information, and then will post final rate filing information for all issuers at one time.

- CMS intends to post final rate information for single risk pool coverage (including

[6] Consistent with 45 CFR 154.301(b)(1)(i), States with an Effective Rate Review Program must post proposed rate increases subject to review by August 1, 2024. States with an Effective Rate Review Program must post the required rate filing information at a uniform time and not on a rolling basis. This requirement applies to rate information for all single risk pool coverage (including both QHP and non-QHPs) offered inside and outside of Exchanges. See 45 CFR 154.301(b)(3).

[7] See 45 CFR 154.200.

[8] CMS will not post information that is a trade secret or confidential commercial or financial information as defined in HHS' Freedom of Information Act regulations at 45 CFR 5.31(d).

both QHPs and non-QHPs) no later than November 1, 2024.[9]

III. CMS Web Address

States with an Effective Rate Review Program that elect to provide public access via a link to the rate information made available on the CMS website should use: https://ratereview.healthcare.gov.

IV. Notification to CMS

Pursuant to 45 CFR 154.301(b)(2), if a State intends to release information about proposed rate increases subject to review or final rate increases (including those not subject to review) *earlier* than the date on which CMS will be posting information publicly, the State must notify CMS in writing at least 5 business days prior to the date it intends to make the information public. The State should notify CMS by sending an email to RateReview@cms.hhs.gov. The email must indicate the date that the State intends to make the information public.

V. Where to Get More Information

If you have questions about this bulletin, please contact CMS at RateReview@cms.hhs.gov.

[9] Consistent with 45 CFR 154.301(b)(1)(ii), States with an Effective Rate Review Program must post all final rate increases (including those not subject to review) no later than November 1, 2024. States with an Effective Rate Review Program must post the required rate filing information at a uniform time and not on a rolling basis. This applies to rate information for all single risk pool coverage (including both QHP and non-QHPs) offered inside and outside of Exchanges. See 45 CFR 154.301(b)(3).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: April 29, 2024

From: Samara Lorenz, Director, Oversight Group

To: Health Insurance Issuers in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wyoming

Subject: Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2025

I. Purpose

The Centers for Medicare & Medicaid Services (CMS) is responsible for enforcing provisions of title XXVII of the Public Health Service Act (PHS Act), as amended or extended by the Patient Protection and Affordable Care Act (ACA) and the Consolidated Appropriations Act, 2021 (CAA), among other laws, with respect to health insurance issuers in the individual and group markets when a state or territory informs CMS that it does not have authority to enforce or is not otherwise enforcing one or more of the applicable provisions of that title, or when CMS determines that a state or territory is not substantially enforcing one or more of the applicable provisions of that title.

The states and territories listed above have informed CMS that they are not enforcing certain provisions of the PHS Act, as added or amended by the ACA and the CAA.[1] In situations where CMS is responsible for enforcement, one of the ways CMS enforces these provisions is through the review of policy forms for compliance prior to sale. Within CMS, the Oversight Group in the Center for Consumer Information & Insurance Oversight (CCIIO) is primarily tasked with these duties.

II. Difference Between a Product and a Plan

All form filing submissions to CMS must be made at the "product" level. This means that there may be more than one filing per issuer per market. The terms "product" and "plan" are defined in regulations at 45 CFR 144.103. A product is a discrete package of health insurance coverage benefits that are offered using a particular product network type (e.g., HMO, PPO, EPO, POS or indemnity) within a service area.

A plan is the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area. Plans within a product may vary with respect to

[1] See https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA for letters from CCIIO to states that are not enforcing provisions of the CAA.

cost-sharing structure, provider network, and service area.[2] Plans within a product may not vary with respect to which benefits are offered, meaning the product's covered items and services must be consistent, including any visit or other frequency limits on the same covered benefits.

III. Form Filing Instructions

- Issuers must submit forms to the CMS Instance in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rates and Forms Filing (SERFF) at https://login.serff.com/serff/
- Issuers must submit forms for each product in a separate submission in SERFF, which must include all plans to be offered for that product.[3]
- If you are submitting more than one filing for a single product network type (e.g., PPO, POS, EPO and HMO), provide a high-level explanation of the benefit differences between the filings.
- Issuers are required to submit products that contain a plan or plans that will be submitted for certification as a qualified health plan (QHP) to be offered through the Federally-Facilitated Exchange or a State-Based Exchange.
- Issuers are not required to resubmit a product that contains only non-QHPs if the product was previously reviewed and acknowledged by CMS Form Filing in a prior filing year, unless there is a material change to any plan within the product.
    - A material change is any change to the coverage offered that independently or in conjunction with other contemporaneous changes would be considered by the typical enrollee to be an important change, including changes that enhance or reduce benefits, increase premiums or cost-sharing, or impose new referral requirements.
- Issuers must submit a full and complete filing for each product. It is not sufficient to submit updated versions of only some required documents or portions of documents. Insert pages and matrix filings are not acceptable.
- QHPs generally must be available off-Exchange, but issuers are not required to submit a separate form filing for the off-Exchange offering of the same plan.
- Issuers are not required to submit forms for excepted benefits, account-based plans and short-term, limited-duration insurance.[4]
- In the **Filing Description Section** under the **General Information Tab**:
    - Enter the associated Health Insurance and Oversight System (HIOS) number and Product ID. Issuers offering products in the territories do not need HIOS Issuer or Product IDs.
    - If applicable, enter the coverage level for each plan within the product (i.e., bronze, silver, gold, platinum, or catastrophic).
- Under the **State Specific Tab**:
    - State whether the product will be offered in the individual, small group, large group, or student health market.
    - State whether the product is grandmothered,[5] grandfathered, or neither.
    - If the product will be offered in the small group or large group market, provide the group

[2] The combination of the service areas for all plans offered within a product constitutes the total service area of the product.
[3] A single product submission may include qualified health plans (QHPs) and non-QHPs.
[4] Excepted benefits are defined at 45 CFR 146.145 and 148.220. Also see 45 CFR 149.20(b). Short-term, limited duration insurance in defined at 45 CFR 144.103. Also see 45 CFR 149.20(b).
[5] "Grandmothered" or "transitional" plans refers to coverage that has been renewed under CMS's non-enforcement policy continually since 2014. See https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.

market type (Employer, Association, Blanket, Discretionary, Trust, Non Employer Group, or Other). If "Other," specify the market type.
    - State whether the product includes a plan(s) that will be submitted for certification as a QHP (regardless of whether the plan will be offered on the Federally-Facilitated Exchange or a State-Based Exchange).
- Under the **Companies and Contact Tab**, provide company contacts who can timely respond to inquiries and objection letters regarding the filing, and ensure such contact information is complete, correct, and current.
- Submit all forms and plan documents in the **Form Schedule Tab** or **Supporting Documentation Tab**, as applicable. Do not use the **Note to Reviewer** function to submit forms or plan documents.
- Only file ONE form or plan document per line item.
- Forms must be submitted in SERFF in final form. Plan documents must be submitted as they will be offered to enrollees. A drafted document or a redlined marked up document submitted under the **Form Schedule Tab**, will not be accepted. Redline documents are used only to reference changes from previous versions submitted during the current filing season and must be submitted in the **Supporting Documentation Tab**. The associated clean version of the revised document must be submitted under the **Form Schedule Tab**.
- Microsoft Word documents cannot be uploaded to SERFF. All text files must be in Adobe Acrobat PDF format. Spreadsheets must be attached in Excel format. BMP, PNG, and JPG are acceptable formats for screenshots. File names cannot include a comma(s).
- The maximum file size limit for uploads to SERFF is 5MB.
- Scanned documents must be converted to a readable format using the optical character recognition (OCR) feature in Adobe Acrobat prior to uploading in SERFF.
- Do not submit locked or password protected PDFs. The locking of documents slows down the review process.
- The information submitted in SERFF must be the same information submitted to CMS Plan Management in HIOS. If the information is different, use the **Note to Reviewer** function in SERFF to request that CMS Form Filing reopen the filing. Once the filing is reopened, upload in SERFF the new documents that correspond to the documents submitted to HIOS.
- If you require an extension, use the **Note to Reviewer** function in SERFF to submit a request stating the reason you need the extension and the requested extension length (1 to 3 business days), at least 24 hours prior to the given deadline. Requests will be considered on a case-by-case basis. You will be notified that the request has been approved or denied, and the length of the extension, via a **Note to Filer** under the **Filing Correspondence Tab** in SERFF. CMS will not grant an extension beyond 3 business days.
- If you need to withdraw a plan, notify CMS immediately via the **Note to Reviewer** function in SERFF, stating your intention to withdraw. If the filing is still open, CMS will send its disposition that the filing has been withdrawn. If the filing is closed, CMS will reopen the filing and then send the withdrawn disposition.

For additional information about SERFF, including participation details and how to sign up, call (816) 783-8990 or email serffhelp@naic.org.

IV. CAA Submission Instructions

The CAA imposed requirements related to surprise medical bills and transparency in health care for

health insurance issuers, generally for plan years beginning on or after January 1, 2022.[6] In order to ensure compliance with certain provisions of the CAA, CMS is requiring health insurance issuers in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wyoming to submit form filings for all health insurance products in the individual and group markets, including fully insured small group and large group market plans, student health insurance coverage, grandfathered plans, and transitional ("grandmothered") plans, to the CMS instance in SERFF at https://login.serff.com/serff/.

CMS will be reviewing form filings for compliance with the following provisions of the Public Health Service Act (PHS Act), as added by the CAA, in states where CMS directly enforces such provisions:

- PHS Act section 2799A-1(a)(1) and (a)(3) – Preventing Surprise Medical Bills – Emergency services;
- PHS Act section 2799A-1(b) – Preventing Surprise Medical Bills – Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities;
- PHS Act section 2799A-1(e) – Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations;
- PHS Act section 2799A-2(a) – Ending Surprise Air Ambulance Bills; and
- PHS Act section 2799A-3 – Continuity of Care.

Table 1, below, lists the forms that issuers in the specified states and territories must submit in SERFF and indicates the appropriate tab for each form.

Table 1 – Required Forms and Documents for All Form Filing Submissions in Alabama, American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, and Wyoming

Form Schedule Tab
Group master policy[7]
Evidence of coverage or individual policy
Riders, endorsements, and amendments[8]
Schedule of benefits for each plan and CSR plan variation
Supporting Documentation Tab

[6] For more information see FAQS about ACA and CAA, 2021 Implementation Part 49 (August 20, 2021) at: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

[7] For group market product submissions only.

[8] Optional benefit riders are not permitted for plans that are subject to the single risk pool requirements.

Explanation of variability
Sample plan or insurance identification (ID) card
Grandfathered plans excel spreadsheet
Grandfathered plans attestation

For issuers in CAA Enforcement states and territories:

- Under the **Form Schedule Tab** in SERFF:
    - Upload the following documents, as applicable: Group Master Policy (for group market product submissions only); Evidence of Coverage or Individual Policy; riders, endorsements, and amendments; and the Schedule of Benefits for each plan and CSR plan variation.
    - Do not file optional benefit riders for plans that are subject to the single risk pool requirement.
- Under the **Supporting Documentation Tab** in SERFF**:**
    - Upload the following documents, as applicable: Explanation of Variability, Sample Plan or Insurance Identification (ID) Card, Grandfathered Plans Excel Spreadsheet, Grandfathered Plans Attestation.
        - Issuers may submit forms with bracketed text for all applicable benefit design options and cost sharing ranges to account for variability of student health and large group market product options. Issuers that submit forms with such text bracketed must also provide an accompanying Explanation of Variability. The Explanation of Variability should include the relevant page number, section number and header (as applicable), bracketed text, and an explanation of when specific text or cost sharing applies.
    - Upload a sample plan or insurance ID card. If you submitted a sample Summary of Benefits and Coverage as instructed by *Section V* of these instructions for ACA form filing submissions, the sample ID card must correspond to the submitted Summary of Benefits and Coverage.
        - Use the Comment function to enter the title of the document that contains the Schedule of Benefits and Coverage for the plan that corresponds to the sample ID card.
        - Use the Comment function to input the form schedule line item for the plan document that contains the Statement of Benefits for the plan that corresponds to the sample ID card.
    - Upload a Grandfathered Plans Excel Spreadsheet and Grandfathered Plans Attestation as directed in S*ection VI Grandfathered Plans* of these instructions, if applicable.

V. ACA Enforcement

In addition to reviewing form filings for CAA compliance, CMS will also review form filings in Missouri, Oklahoma, Tennessee, Texas, and Wyoming for compliance with applicable ACA requirements that CMS is responsible for enforcing. Issuers in these five states must submit documents for all non-

grandfathered health insurance products in the individual[9] and group markets, to the CMS instance in SERFF at https://login.serff.com/serff/.

In addition to the required forms in Table 1, issuers in Missouri, Oklahoma, Tennessee, Texas and Wyoming must submit in SERFF the documents in Table 2 for all non-grandfathered products in the individual and group markets.[10]

As stated in the 2025 Final Letter to Issuers in the Federally-facilitated Exchanges, there are additional documents specific to QHP certification that CMS requires issuers submit.[11] For QHPs, completed templates and justifications must be uploaded into the HIOS Plan Management and Market Wide Functions Module[12] and should not be submitted through the SERFF **Supporting Documentation Tab**. Please refer to the 2025 Final Letter to Issuers in the Federally-facilitated Exchanges for complete and final instructions for submitting QHP templates and justifications. Additionally, issuers in all states must submit rate filing information to CMS.[13] For more information on the submission of rate information, please email ratereview@cms.hhs.gov.

Table 2 – Additional Required Documents for Form Filing Submissions for Non-Grandfathered Products in Missouri, Oklahoma, Tennessee, Texas, and Wyoming

Form Schedule Tab
Notice of appeals and external review rights
Supporting Documentation Tab
Summary of Benefits and Coverage (SBC)[14]
Plans & Benefits Template, in .xlsx format, for non-QHPs only
CMS Prescription Drug Template (one per product in Excel format) for non-QHPs only, except large group market
Results of the Actuarial Value Calculator (screen shot or in Excel format) for non-QHPs only

[9] Student health insurance plans are defined as individual market plans, and are generally subject to the individual market requirements under title XXVII of the PHS Act.
[10] The additional documents listed in Table 2 are not required for grandmothered products.
[11] The 2025 Final Letter to Issuers in the Federally-facilitated Exchanges is available at: https://www.cms.gov/files/document/2025-letter-issuers.pdf.
[12] Templates are available at: https://www.qhpcertification.cms.gov/s/QHP.
[13] See Bulletin: Timing of Submission of Rate Filing Justifications for the 2024 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2025, available at: https://www.cms.gov/files/document/2024-final-rate-review-bulletin.pdf.
[14] One SBC is required per network type. For a product submission that includes plans designed to comply with metal level actuarial value requirements, issuers should submit an SBC for a silver level plan. Additionally, one American Indian/Alaska Native zero cost share and one American Indian/Alaska Native limited cost share SBC should be included if applicable.

Unique Plan Design Supporting Documentation and Justification for non-QHPs only
Essential Health Benefit (EHB) Substituted Benefit (Actuarial Equivalent) Justification for non-QHPs only
Formulary—Inadequate Category/Class Count Supporting Documentation and Justification for non-QHPs only

For issuers submitting non-grandfathered coverage only submissions in ACA Enforcement states:

- In the **Filing Description Section** under the **General Information Tab:**
  - Identify the name of and line item for the plan documents that correspond to the AI/AN no cost sharing option SBC and the limited cost sharing option SBC.
  - Include the activation date of SBC weblinks for non-QHPs only. Weblink activation dates must be prior to open enrollment.
  - Issuers that utilize a single document, such as the Plans & Benefits Template or the CMS Prescription Drug Template, for multiple products must include the corresponding SERFF tracking numbers for the other products listed. For example, if an issuer lists products A, B, and C on the Plans & Benefits Template, the issuer must write "Plans & Benefits Template" and provide the SERFF tracking numbers for products B and C in the **Filing Description Section** under the **General Information Tab** for the product A filing. Additionally, the issuer must write "Plans & Benefits Template" and provide the SERFF tracking numbers for products A and C in the **Filing Description Section** under the **General Information Tab** for the product B filing, and the issuer must write "Plans & Benefits Template" and provide the SERFF tracking numbers for products A and B in the **Filing Description Section** under the **General Information Tab** for the product C filing.
- Under the **Form Schedule Tab** in SERFF, upload the Notice of Appeals and External Review Rights.
- Under the **Supporting Documentation Tab** in SERFF**:**
  - Upload the following documents for non-QHPs only: Plans & Benefits Template, in .xlsx format; CMS Prescription Drug Template (one per product in Excel format), except for large group market; Results of the Actuarial Value Calculator (screenshot or in Excel format); Unique Plan Design Supporting Documentation and Justification; Essential Health Benefit (EHB) Substituted Benefit (Actuarial Equivalent) Justification; Formulary—Inadequate Category/Class Count Supporting Documentation and Justification.
    - Run your CMS Prescription Drug Template through the plan year 2025 RX Tool to ensure that there are no CMS Prescription Drug Template errors and to provide CMS with the Combined Prescription Drug Supporting Documentation and Justification for any deficiencies identified as part of this process. This will reduce the number of Prescription Drug Template review issues.
  - Upload one SBC for a QHP offered to individuals who are recognized as American Indian or Alaska Native (AI/ANs) for the no cost sharing option and one SBC for the limited cost sharing option.
  - In addition, submit one SBC for each product network type for one of your plans. We encourage issuers to provide a silver-level plan SBC if possible.

VI. Grandfathered Plans

CMS is permitting issuers with more than 30 grandfathered plans in a market(s) (individual, small group, and/or large group) to submit form filings for only 20 percent of the grandfathered plans in that market(s) to CMS for review for compliance with the CAA. Issuers that use this accommodation to submit only 20 percent of the grandfathered plans for each respective market in which they have more than 30 grandfathered plans, must submit the plans with the highest enrollment, in the manner prescribed in these instructions. The plan filings that an issuer submits as part of its 20 percent sample of plans for plan year 2025 cannot be the same as the plans that were submitted as part of the 10 percent sample for plan year 2024. Notwithstanding this accommodation, if an issuer has made a material change that would not otherwise cause a loss of grandfather status to any of its grandfathered plans that were submitted to CMS for plan year 2024, it must resubmit form filings for those plans with material changes for CMS review for plan year 2025. These filings will not count towards the 20 percent sample requirement for plans that are using the accommodation but will be in addition to the plan filings that are included in the 20 percent sample for plan year 2025.

If 20 percent of an issuer's grandfathered plans, for each market type, does not equal a whole number, the issuer must round up and submit the next whole number of plans. For example, for an issuer that has 112 grandfathered plans in the individual market, 20 percent of 112 is 22.4, which is not a whole number. In this case, the issuer would round up and submit the 23 grandfathered plans with the highest enrollment in the individual market.

Issuers are responsible for ensuring all grandfathered plans are in compliance with the applicable CAA requirements, implementing regulations, and guidance. To verify CAA compliance, at any time, CMS may request and review the form filings for the grandfathered plans that issuers did not previously submit for review.

An issuer with 30 or fewer grandfathered plans, per market type, must submit form filings for all of its grandfathered plans, for each market, for CMS's review for compliance with CAA requirements.

A. Grandfathered Plans Excel Spreadsheet

All issuers of grandfathered plans must submit an Excel spreadsheet listing all of the issuer's grandfathered plans, including those submitted to CMS in a prior filing year, those submitted this filing year, and those submitted not submitted to CMS for review, in addition to the documentation required in these instructions. The spreadsheet must have eight columns that indicate for each grandfathered plan the plan name; market type; number of enrollees; the earliest date on which the 2025 plan or policy year will start; whether the plan's form filings have been or are being submitted to CMS for review; the plan year(s) for which the plan has been submitted to CMS, if applicable; whether there was a material change from the plan year 2024 submission, if applicable; and the SERFF filing number for grandfathered plans that are now being submitted for review for plan year 2025. The plans should be listed in descending order based on the number of enrollees. The spreadsheet must also indicate whether the issuer is electing to submit only 20 percent of its grandfathered plans for CMS review.

For example:

Issuer X elects to submit only 20 percent of its grandfathered plans for CMS review.							
Plan Name	**Market Type**	**Number of Enrollees**	**Earliest 2025 Plan or Policy**	**Submitted to CMS**	**Plan Year of**	**Material Change from Plan**	**SERFF Tracking Number**

		Per Market Type	Year Start Date		Submission to CMS	Year 2024 Submission	
Plan A	Small Group	134	06/01/2025	Yes	2024	No	N/A
Plan B	Small Group	48	03/15/2025	Yes	2024 and 2025	Yes	X1234567
Plan C	Individual	17	02/01/2025	Yes	2025	N/A	X7654321
Plan D	Small Group	27	03/01/2025	No	N/A	N/A	N/A

The spreadsheet should be saved under the following naming convention: IssuerName_State_GrandfatheredPlans.xlsx. The spreadsheet must be uploaded once under the **Supporting Documentation Tab** within the SERFF filing for the plan with the highest enrollment.

B. Grandfathered Plans Attestation

CMS is collecting an attestation from issuers with more than 30 grandfathered plans that elect to use this accommodation. Such issuers must attest that:

1. The Excel spreadsheet listing all the issuer's grandfathered plans is complete and accurate;
2. All grandfathered plans listed in the Excel spreadsheet are in compliance or will be brought into compliance with the CAA requirements, implementing regulations, and guidance after CMS's review of the submitted grandfathered plans is complete and;
3. The issuer will ensure all necessary conforming revisions are made to the non-submitted grandfathered plans based on CMS's review of and feedback on the submitted plans before the start of the 2025 plan or policy year.

An issuer may authorize any appropriate individual within the organization, such as the compliance officer, to attest on its behalf.

The attestation should be saved in Adobe Acrobat PDF format and under the following naming convention: IssuerName_State_Attestation_CAA_Compliance.pdf. The attestation must be uploaded once under the **Supporting Documentation Tab** within the SERFF filing for the plan with the highest enrollment.

VII. Deadlines

May 15, 2024, is the deadline for filing forms for all products subject to ACA and/or CAA compliance review, with the exception of forms for student health insurance products and products offered in the large group market, which are both due 60 days prior to the coverage effective or renewal date. Issuers must submit to CMS forms for student health insurance products with a policy year that begins in 2025 (e.g., the 2025-2026 school year). CMS reminds issuers subject to the *Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2024*[15] to submit forms for student health insurance products with a policy year that begins in 2024 (e.g., the 2024 – 2025 school

[15] See Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2024 available at: https://www.cms.gov/files/document/py2024-form-filing-instructions.pdf.

year).

All communication regarding form filing submissions will be conducted through the SERFF **Filing Correspondence Tab**. Issuers should frequently monitor the **Filing Correspondence Tab** for Objection Letters and Notes to Filers, to ensure that they are responding to any and all CMS communications or requests within the given deadlines.

Please note that failure to comply with deadlines may result in submitted forms not being reviewed on time and potential QHP plan suppression during Open Enrollment.[16] If an issuer sells a plan without submitting forms for review, or prior to the completion of form review, the issuer may be referred to the appropriate state or CMS market conduct team for further investigation.[17]

VIII. Qualified Health Plans

Prior to the QHP Application finalization deadline, issuers may make changes to their PY 2025 QHP Application data without state or CMS authorization. After the submission finalization deadline,[18] issuers may not add new plans to a QHP Application. CMS may allow issuers to make critical data corrections in order to correct data display errors on HealthCare.gov and align QHP data display with products and plans approved by the state. CMS will not allow substantive data changes that would alter the QHPs approved by CMS that will require re-review for QHP certification. QHP Issuers in Missouri, Oklahoma, Tennessee, Texas and Wyoming that wish to make data change requests after the finalization deadline must submit a State Authorization of QHP Data Change Request form to CMS Form Filing team for authorization before completing a data change request in the Plan Management Community.[19] CMS will not be reviewing Data Change Requests in states where it is only reviewing form filings for CAA compliance.

Failure to properly identify and make any necessary QHP application revisions may result in suppression, decertification, or a QHP compliance review.

IX. Coordination with State Reviewers

Open/Pending Filings

If a filing is open or pending review with CMS, and an issuer needs to revise a document in response to a state objection or a change in state law, the issuer must use the Amendment Filing Function within SERFF to upload the clean and redlined versions of the revised document. Issuers can find the Amendment Filing Function under the **Filing Correspondence Tab**. Issuers should refer to the SERFF Industry Manual, PDF pgs. 175 – 182, for step-by-step instructions.

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[16] See 45 CFR 156.815(b).
[17] See 45 CFR 150.313(b).
[18] See Final Key Dates for Calendar Year 2024: Qualified Health Plan (QHP) Data Submission and Certification; Rate Review; Form Review; and Risk Adjustment available at: https://www.cms.gov/files/document/final-cy24-key-dates-tables.pdf.
[19] Additional information and instructions on QHP Data Change Request is available at: https://www.qhpcertification.cms.gov/s/Data%20Change%20Windows.

The issuer must provide the following information in the comment field of the Amendment Filing Function when they upload the revised document(s):
(a) A description of the changes made, including the corresponding document names, impacted sections, and their respective page numbers;
(b) Reason for the changes (e.g., state regulatory authority objection, or change in state law);
(c) If applicable, contact information of the State Reviewer who required the change(s) described under (a);
(d) Citation of the applicable state law that supports the changes described under (a); and
(e) A note as to whether the change affects other documents filed with CMS, such as rate filings or templates for QHP certification, and whether the applicable sections of CMS have been notified of the change.

If applicable, the issuer must also upload, in Adobe Acrobat Reader PDF format, a copy of the objection letter from the State Reviewer who required the change(s).

CMS will issue an Objection Letter and work directly with the State Reviewer and the issuer if any compliance issues are identified.

Acknowledged/Closed Filings

If an issuer received a Disposition from CMS for an acknowledged or closed filing, and the issuer needs to revise a document in response to a state objection or a change in state law, the issuer must send CMS a request to reopen the filing, via SERFF, using the Note to Reviewer function, under the **Filing Correspondence Tab**.

When an issuer submits such a request, the issuer should include the reason for the changes (e.g., state regulatory authority objection, or a change in state law).

CMS will review the issuer's request to reopen the filing, and will notify the issuer, via SERFF, using the Note to Filer Function, when the filing has been reopened.

The issuer will need to follow the same steps described above for open/pending filings and use the Amendment Filing Function to upload the clean and redlined revised document and, if applicable a copy of the state Objection Letter, as well as use the comment field within the Amendment Filing Function, to provide the same information listed in (a) through (e).

At the conclusion of CMS's review of the revised document, CMS will notify the issuer of its determination by issuing, via SERFF, either an Objection Letter or a Disposition to confirm the previous Acknowledgement remains in effect. CMS will work directly with the State Reviewer and the issuer on any compliance issues identified.