IDOI FINAL LETTER TO ISSUERS – PLAN YEAR 2024

This notice is for all carriers writing ACA individual and small group major medical plans and stand-alone dental plans for Plan Year 2024. 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 be reviewing CAA information in the form filings.
- CMS will be reviewing 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 is requiring health insurance issuers in Indiana to submit form filings for the following all 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, 2023** is the deadline for filing forms for all products in the individual and small group 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 12, 2023.***
  - CMS is requiring that forms for student health insurance products and products offered in the large group market are due 60 days prior to marketing.
  - CMS has issued the document, *"Frequently Asked Questions regarding Plan Year 2024 Form Filing Submissions from Health Insurance Issuers in States where CMS Directly Enforces the No Surprises Act or Transparency Provisions of the Consolidated Appropriations Act, 2021 (CAA) and/or the Affordable Care Act"*, which we emailed to Indiana major medical insurers on May 5, 2023.
- Please refer to CMS document regarding the specific form and manner documents should be filed. Please refer to attachment 3.

Timeline For Plan Year 2024

- Single Risk Pool Form(s) Filings (Individual and Small Group) are due **no later than 12:00 p.m. EST on May 12, 2023**.
  - Rate filings are due **no later than 12:00 p.m. on June 13, 2023**.
  - Filings need to be 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 forms and rates (refer SERFF plan management instructions document).
- 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 9, 2023.**
  - All QHP issuers MUST have final and active URLs completed by this date.
  - An attestation will be required as part of your final changes that a thorough plan preview has been completed.
- IDOI will complete its review of single risk pool filings by August 16, 2023.

- Qualified Dental Plan (QDP) Forms filings are due **no later than 12:00 p.m. on May 12, 2023.**
  - Rate filings are due **no later than 12:00 p.m. EST on June 13, 2023.**
  - Filings need to be concurrent into **BOTH** HIOS and SERFF.
  - Filings must include all forms and rates and all applicable templates (refer 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 9, 2023.**
    - All QDP issuers MUST have final and active URLs completed by this date.
    - An attestation will be required as part of your final changes that a thorough plan preview has been completed.
  - IDOI will complete its review of QDP filings by August 16, 2023.
- SERFF Response Requirement from Carriers
  - 10 days: before June 30, 2023.
  - 4 days: July 1, 2023 to July 14, 2023
  - 2 days: July 15, 2023 to August 9, 2023
- **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 2024

- Indiana will be retaining the current 2017 essential health benefit benchmark plan for the 2024 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 is 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.

Maximum Annual Limitation on Cost Sharing for Plan Year 2024

- HHS proposes to make the 2024 maximum annual limitation on cost sharing would be $9,450 for self-only coverage and $18,900 for other than self-only coverage.

Maximum Annual Limitation on Cost Sharing for 2024

Category	Self-Only Plans	Other Than Self-Only
100-150 percent of FPL	$3,150	$6,300
151-200 percent of FPL	$3,150	$6,300
201-250 percent of FPL	$7,550	$15,100

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 Stand Alone Dental Plans (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 (RRD) in SERFF, carriers should report the min, max, and weighted average for the annualized PMPM as premiums to cover one month of coverage.

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 2023.
    - 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 2024, CMS has established two additional stand-alone ECP categories: Mental Health Facilities and SUD Treatment Centers, and the addition of Rural Emergency Hospitals (REHs) as a provider type in the Other ECP Providers category.

- CMS has delayed the application of the appointment wait time standards until PY 2025.

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 will update the IDOI Clinical Appropriateness Tool's drug lists for Plan Year 2024 on or about May 15. Because of the late availability, the IDOI will extend the due date for submission of the tool to **June 30th.**
    - 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.
    - When the tool is available, it will be found here: http://www.in.gov/idoi/2813.htm

Nondiscrimination Standards

- Sexual Orientation and Gender Identity-Nondiscrimination protections would 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 2024 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 before 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

Definition of Guaranteed Availability (Past Debt)

- HHS is proposing to revise interpretation of the guaranteed availability requirement to prohibit issuers from applying a premium payment to an individual's or employer's past debt owed for coverage and refusing to effectuate enrollment in new coverage.

Exchange Reenrollment Hierarchy

- HHS is proposing to incorporate the net premium, maximum out-of-pocket (MOOP), deductible, and annual out-of-pocket costs (OOPC) of a plan into the Exchange re-enrollment hierarchy.

Exchange User Fees

- Federal-facilitated Exchange user fee 2.2%

Standardized Plan Options (for QHP Issuers Only)

- CMS Proposes 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.

State Legislative Considerations

- The IDOI will provide later guidance as to any changes needed to be made to forms by way of an objection to your SERFF filing.

Reference Documents

- The IDOI Rate and Form Review will encompass information contained within the following reference documents/rules:
  - 2024 Final Notice of Benefit and Payment Parameters
  - 2024 Final Letter to Issuers
  - 2024 Plan Management/CMS Templates
  - No Surprises Act

IDOI Network Adequacy Standards for Plan Year 2024

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 2024 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 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 Letter to Issuers and Notice 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. All carriers may attest to compliance with the wait-time standards, but this attestation is not required for PY 2024.

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 or 2023.
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 (but not time) standards defined by CMS in their final 2024 Letter 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 with CMS's network adequacy requirements as defined in the Letter to Issuers and Notice of Benefit and Payment Parameters for both their on-exchange plans as well as for their off-exchange plans.
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 may attest to compliance with the wait-time standards, but this attestation is not required for PY 2024.

Submissions that Contain On-Exchange Major Medical Plans:

1. Carriers will need to demonstrate compliance with CMS's network adequacy requirements as defined in the Letter to Issuers and Notice of Benefit and Payment Parameters for both their on-exchange plans as well as for their off-exchange plans.
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 may attest to compliance with the wait-time standards, but this attestation is not required for PY 2024.

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 and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: December 20, 2022

From: Samara Lorenz, Director, Oversight Group

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

Subject: Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) for Plan Year 2024

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 amended or extended 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 of a product or plan. 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

CAA Enforcement

The CAA imposed new requirements related to surprise medical bills and transparency in health care applicable to health insurance issuers, generally for plan years beginning on or after January 1, 2022.[3] In order to ensure compliance with the provisions of the CAA, CMS is requiring health insurance issuers in American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, Nevada, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Texas, Utah, 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 "grandmothered" plans,[4] to the CMS Direct Enforcement instance in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rates and Forms Filing (SERFF) at https://login.serff.com/serff/.[5]

Issuers in these states and territories must submit a full and complete form for CMS's review, not just the portions of the contract that are changing from the prior year. Issuers must submit forms for each product in a separate submission in SERFF, which must include all plans to be offered for that product.[6] Instructions for form filing submissions to CMS are also provided in the SERFF submission General Instructions Tab. Table 1, below, lists the documents that must be submitted in SERFF and indicates the appropriate tab for each form.

Table 1 – Required Documents for Form Filings in American Samoa, Arizona, Arkansas, Connecticut, Delaware, Florida, Guam, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Missouri, Nevada, New Hampshire, Northern Mariana Islands, Oklahoma, Rhode Island, Texas, Utah, Virginia, and Wyoming for the Purpose of CAA Compliance Review

Form Schedule Tab

[2] The combination of the service areas for all plans offered within a product constitutes the total service area of the product.

[3] For more information see FAQS about ACA and CAA, 2021 Implementation Part 49 (August 20, 2021) at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FAQs%20About%20ACA%20%26%20CAA%20Implementation%20Part%2049_MM%20508_08-20-21.pdf.

[4] The term "grandmothered" plans refers to plans subject to a non-enforcement policy under which CMS will not take enforcement action against certain non-grandfathered health insurance coverage in the individual and small group market that is out of compliance with certain specified market reforms. See https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.

[5] Issuers submitting forms for CAA compliance only are not required to submit forms for excepted benefits, account-based plans and short-term, limited-duration insurance. Excepted benefits and short-term, limited duration insurance are defined at 45 CFR 144.103. Also see 45 CFR 149.20(b).

[6] A single product submission may include qualified health plans (QHPs) and non-QHPs.

Group master policy[7]
Evidence of coverage or individual policy
Riders, endorsements, and amendments[8]

For issuers in CAA Enforcement states and territories:

- Include the associated Health Insurance and Oversight System (HIOS) number and Product ID(s) on the General Description tab of the submission. Issuers offering products in the territories do not need HIOS Issuer or Product IDs.
- Identify whether each product submission will include any plans submitted for QHP certification, and, if applicable, identify the coverage level for each plan within a product (i.e., bronze, silver, gold, platinum, or catastrophic).
- If a form is used for multiple products or plans, indicate which form(s) belong with which products or plans.
- A separate filing is required for each product network type (e.g., PPO, POS, EPO and HMO). If you are submitting more than one filing for a single product network type, provide a high-level explanation of the benefit differences between the filings.
- Do not file optional benefit riders for plans that are subject to the single risk pool requirement.
- Do not include plan documents within SERFF Reviewer notes. Only the submission of new and revised forms, submitted in the Forms Schedule Tab and Supporting Documentation Tab are accepted.
- Upload redlined versions of forms that reflect changes from prior product submissions, or changes made to the product submission as a result of an issuer notice. We ask that issuers upload the redline document under the **Supporting Documentation Tab** and the clean version of the revised document under the **Form Schedule Tab**.
- Do not submit scanned documents.
- Microsoft Word documents cannot be uploaded to SERFF.
- All text files should be in Adobe Acrobat PDF format. Spreadsheets should be attached in Excel format. BMP, PNG, and JPG are acceptable formats for screenshots.
- Do not submit locked or password protected PDFs. The locking of documents slows down the review process.
- Forms must be submitted in SERFF in final form. Plan documents must be submitted as they will be offered to enrollees. A submission of 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 and must be submitted in the Supporting Documentation Tab.
- The maximum file size limit for uploads to SERFF is 5 MB.
- When filing forms in SERFF, select both the state and CMS instances so that information goes to both state and federal regulators.

For additional information about SERFF, including participation details and how to sign up, call (816)

[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.

783-8990 or email serffhelp@naic.org.

ACA Enforcement

In addition to reviewing form filings for CAA compliance, CMS will also review form filings in Missouri, Oklahoma, Texas, and Wyoming for compliance with applicable ACA requirements that CMS is responsible for enforcing. Issuers in those four states must submit documents for all non-grandfathered health insurance products in the individual[9] and group markets, to the CMS Direct Enforcement instance in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rates and Forms Filing (SERFF) at https://login.serff.com/serff/.[10]

Table 2 below lists documents that issuers in Missouri, Oklahoma, Texas and Wyoming must submit in SERFF.

As stated in the 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges, there are additional documents specific to Qualified Health Plan (QHP) certification that CMS proposed to require be submitted.[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. The requirements specific to QHP certification in the 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges are subject to change. Please refer to the Final 2024 Letter to Issuers in the Federally-facilitated Exchanges for complete and final instructions for submitting QHP templates and justifications.[13] Additionally, issuers in all states must submit rate filing information to CMS.[14] For more information on the submission of rate information please email ratereview@cms.hhs.gov.

Table 2 – Required Documents for Form Filings in Missouri, Oklahoma, Texas, and Wyoming for the Purpose of ACA Compliance Review

Form Schedule Tab

[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] Issuers submitting forms for ACA compliance are not required to submit forms for excepted benefits, account-based plans and short-term, limited-duration insurance, or grandmothered plans. Excepted benefits and short-term, limited duration insurance are defined at 45 CFR 144.103. Also see 45 CFR 146.145(b), 148.102 and 148.220.
[11] The 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges is available at: https://www.cms.gov/files/document/2024-draft-letter-issuers-508.pdf.
[12] Templates are available at https://www.qhpcertification.cms.gov/s/QHP.
[13] Once published, the Final 2024 Letter to Issuers in the Federally-facilitated Exchanges will be available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2024-Letter-to-Issuers.pdf.
[14] See Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2023 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2024, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Proposed-Key-Dates-Tables-For-CY2023.

Group master policy[15]
Evidence of coverage or individual policy
Schedule of benefits for each plan and CSR plan variation
Notice of appeals and external review rights
Riders, endorsements, and amendments[16]
Supporting Documentation Tab
Summary of Benefits and Coverage (SBC)[17]
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
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
Explanation of variability

For issuers in ACA Enforcement states:

- Identify whether each product submission will include any plans submitted for QHP certification, and, if applicable, identify the coverage level for each plan within a product (i.e., bronze, silver, gold, platinum, or catastrophic) in the Filing Description under the General Information tab in SERFF.
- Submit 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 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.
- Include the activation date of SBC weblinks in the Filing Description under the General Information tab in SERFF for non-QHPs only. Weblink activation dates must be prior to open enrollment.

[15] For group market product submissions only.
[16] Optional benefits riders are not permitted for plans that are subject to the single risk pool requirements.
[17] 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.

- Identify whether multiple product submissions use identical CMS Prescription Drug Templates and indicate which CMS Prescription Drug Template belongs with which product or plan.
- Issuers can run their CMS Prescription Drug Template through the plan year 2024 RX Tool to ensure there are no CMS Prescription Drug Template errors and also 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.
- If a form is used for multiple products or plans, indicate which form(s) belong with which products or plans.
- A separate filing is required for each product network type (e.g. PPO, POS, EPO and HMO). If you are submitting more than one filing for a single product network type, provide a high-level explanation of the benefit differences between the filings.
- Do not file optional benefit riders for plans that are subject to the single risk pool requirement.
- Do not include plan documents within SERFF Reviewer notes. Only the submission of new and revised forms, submitted in the Forms Schedule Tab and Supporting Documentation Tab are accepted.
- Upload redlined versions of forms that reflect changes from prior product submissions, or changes made to the product submission as a result of an issuer notice. We ask that issuers upload the redline document under the **Supporting Documentation Tab** and the clean version of the revised document under the **Form Schedule Tab**.
- Do not submit scanned documents.
- All text files should be in Adobe Acrobat PDF format. Spreadsheets should be attached in Excel format. BMP, PNG, and JPG are acceptable formats for screenshots.
- Do not submit locked or password protected PDFs. The locking of documents slows down the review process.
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- Microsoft Word documents cannot be uploaded to SERFF.
- The maximum file size limit for uploads to SERFF is 5 MB.
- When filing forms in SERFF, select both the state and CMS instances so that information goes to both state and federal regulators.

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IV. Deadlines

May 15, 2023 is the deadline for filing forms for all products subject to ACA and CAA compliance review, with the exception of forms for student health insurance products and products offered in the large group market, which are due 60 days prior to marketing.[18]

[18] States and territories that are substantially enforcing provisions of the CAA and/or ACA are permitted to establish different submission deadlines for form filings as long as the deadline is no later than the federal deadline.

Prior to the QHP Application finalization deadline, issuers may make changes to their PY 2024 QHP Application data without state or CMS authorization. After the submission finalization deadline,[19] 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 certified by CMS that will require re-review for QHP certification. QHP Issuers in Missouri, Oklahoma, 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.[20] CMS will not be reviewing Data Change Requests in states where it is only reviewing form filings for CAA compliance.

Please note that failure to comply with these dates may result in the submitted forms not being reviewed on time and potential QHP plan suppression during Open Enrollment.[21] 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.[22]

[19] See Proposed Plan Year 2024 QHP Data Submission and Certification Timeline available at: https://www.cms.gov/files/document/proposed-py2024-qhp-data-submission-and-certification-timeline-bulletin.pdf. All dates are subject to change. Once published, the Final Plan Year 2024 QHP Data Submission and Certification Timeline will be available at: https://www.cms.gov/files/document/py2024-qhp-data-submission-and-certification-timeline-bulletin.pdf.
[20] Additional information and instructions on QHP Data Change Request is available at https://www.qhpcertification.cms.gov/s/Data%20Change%20Windows.
[21] See 45 CFR 156.815(b).
[22] See 45 CFR 150.303 and 150.313(b).