2025-2026 Student Health Insurance Form Filing Guidance

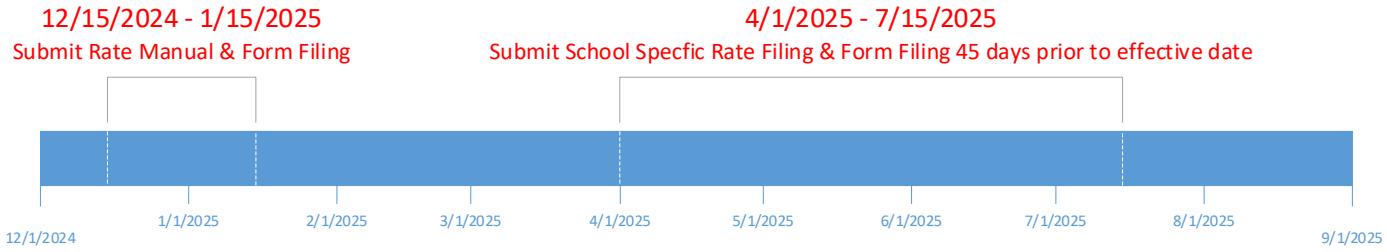
Under 45 C.F.R. §§ 144.103 and 147.145, student health insurance is defined as a type of individual market health insurance coverage offered to students and their dependents under a written agreement between an institution of higher education and an issuer. Student health insurance is also considered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

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

(ii) For purposes of section 2702 of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage, and, notwithstanding the requirements of §147.104(b), is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis.

(iii) For purposes of section 2703(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students.

Timeline and Key Form Filing Dates



November 1st	PID posts Student Health Guidance on Website for upcoming Academic Year	PID Activity
December 15th – January 15th	Insurers may begin submitting their rate manual (methodologies) and generic form filing in SERFF (non-school specific)	Insurer Activity
January 15th	**Deadline to submit Student Health rate manual (methodologies) and generic form filing in SERFF (non-school specific)**	Insurer Activity
December 15th – April 1st	PID reviews SERFF filings and submits objections as necessary	PID Activity
December 15th – March 15th	Insurers respond to PID requests and submit corrected/updated forms and/or rating information, as necessary	Insurer Activity
April 1st	PID Dispositions Rate and Form Filings in SERFF (non-school specific)	PID Activity
April 1st – July 15th	**Within 15 days of executing the contract, insurers file the executed contract in a new SERFF filing as a form filing referencing the approved form and rate filing(s)**	Insurer Activity
April 30th – September 1st	PID Dispositions School Specific Rate and Form Filings in SERFF. The school specific form filing will not be dispositioned until the school specific rate filing review is complete.	PID Activity

Form Review Phase One: **The form filing (non-school specific) should be submitted by January 15th, 2025, but no earlier than December 15th, 2024.** The Department will endeavor to review and approve the filing in a timely manner. The filing will be made public through SERFF upon approval. The corresponding Rate Filing SERFF tracking number should be referenced in the filing.

Form Review Phase Two: **The Department expects that a copy of the final executed form will be filed in SERFF within 15 business days of finalizing a contract with an institution and at least 45 days prior to the requested effective date.** Please submit this non-redacted form as a separate filing, linking to the originally approved form via the corresponding filing tracking number on the General Information tab. The submission will be processed as "Informational Only." The institution-specific filing may contain a request for confidentiality. If warranted, the Department will honor this request.

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

SERFF Submission and Necessary Documents

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

Form Filing

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

A **complete filing** is required even if a policy form used has no changes from the previously approved plan filling. A complete filing includes all forms that will be used to apply for and enroll in coverage and all forms issued to the policyholder and insured. It is expected that each network type (EPO, PPO, HMO, and POS) be submitted separately.

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

The form filing should include as Supporting Documentation a current **Compliance Worksheet, Compliance Checklist, and Certification Form**, which are available on the Department's website.

Redlines are a very important part of the review process for this type of product. Issuers are reminded to use redlines, along with detailed comments in the filing that describe the specific revisions to the form.

Mental Health Parity Guidance

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

- Annual Attestations under Acts 89 and 92 of 2020.
- Quantitative Treatment Limitation (QTL) and Financial Requirement (FR) Parity Analysis Submission.
- Non-Quantitative Treatment Limitation (NQTL) Parity Analysis Submission.

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

Note Regarding Annual Dollar Limits and Mental Health Parity

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

QTL/FR Testing and Analyses

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

For purposes of these analyses, QTLs/FRs include, but are not limited to, financial requirements like co-pays and coinsurance, as well as office visit limitations or other limits on how many times a treatment may be covered. The analyses must provide classifications and limitations for ALL covered benefits listed in the analyzed plan; please identify the form number and/or product/plan identification for certificates of coverage and schedules of benefits to which the analysis is being applied. Expected claims dollar amounts must be provided for medical/surgical (Med/Surg) benefits. If a health insurer does not use the template provided on the Department's website, the analysis must clearly identify all elements of the analysis as outlined in federal regulation. Such documentation may include a crosswalk or narrative comparison to the Department's template or to each element outlined in 45 C.F.R. § 146.136.

NQTL Analysis

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

The example should illustrate and reference the baseline parity analysis performed for each limitation while demonstrating how the limitations are compliant with MHPAEA. An insurer may choose to use the NQTL compliance template available on the PID's website. If the NQTL analysis is the same for multiple products/plans, a company should submit the single analysis and reference the products/plans to which it applies. NQTLs include, but are not limited to, medical management standards limiting or excluding benefits based on medical necessity, prior authorization processes, and step therapy; recognizing the importance and prevalence of prior authorization processes, you may wish to include prior authorization as the submitted example. If an insurer previously submitted a prior authorization NQTL analysis to the PID in past review years and no issues were noted, the insurer should submit an analysis for a different type of NQTL in future review years. Additional examples of NQTLs specifically cited under the MHPAEA regulations [45 C.F.R. § 146.136(c)(4)(ii)] include:

- "Medical management standards limiting or excluding benefits based on … medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as 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."

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

Non-Discrimination in Benefit Design

Under the Affordable Care Act and its regulation at 45 C.F.R. § 156.125, a benefit design and the implementation of a benefit design may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Beginning on the earlier of January 1, 2023 (the

start of the 2023 plan year) or upon renewal of any plan subject to this rule, a non-discriminatory benefit design that provides EHB is one that is clinically-based.

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

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

PID's Annual Supplemental Template "PAST" for Student Health Major Medical Plans

(NEW starting December 2024)

The PAST template was created by the PID to supplement information provided within major medical health insurance filings and will be utilized to better understand and review coverages in the fully insured commercial student health market, which will contribute to the efficiency of the PID's review. Each insurer has the opportunity to explain the benefits which may be available within each of their plans/products, as well as explain other important features of the plan functions (e.g., prior authorization program URLs). If an insurer/plan does not cover specific items or services, this template also collects that information to aid the PID in the review process.

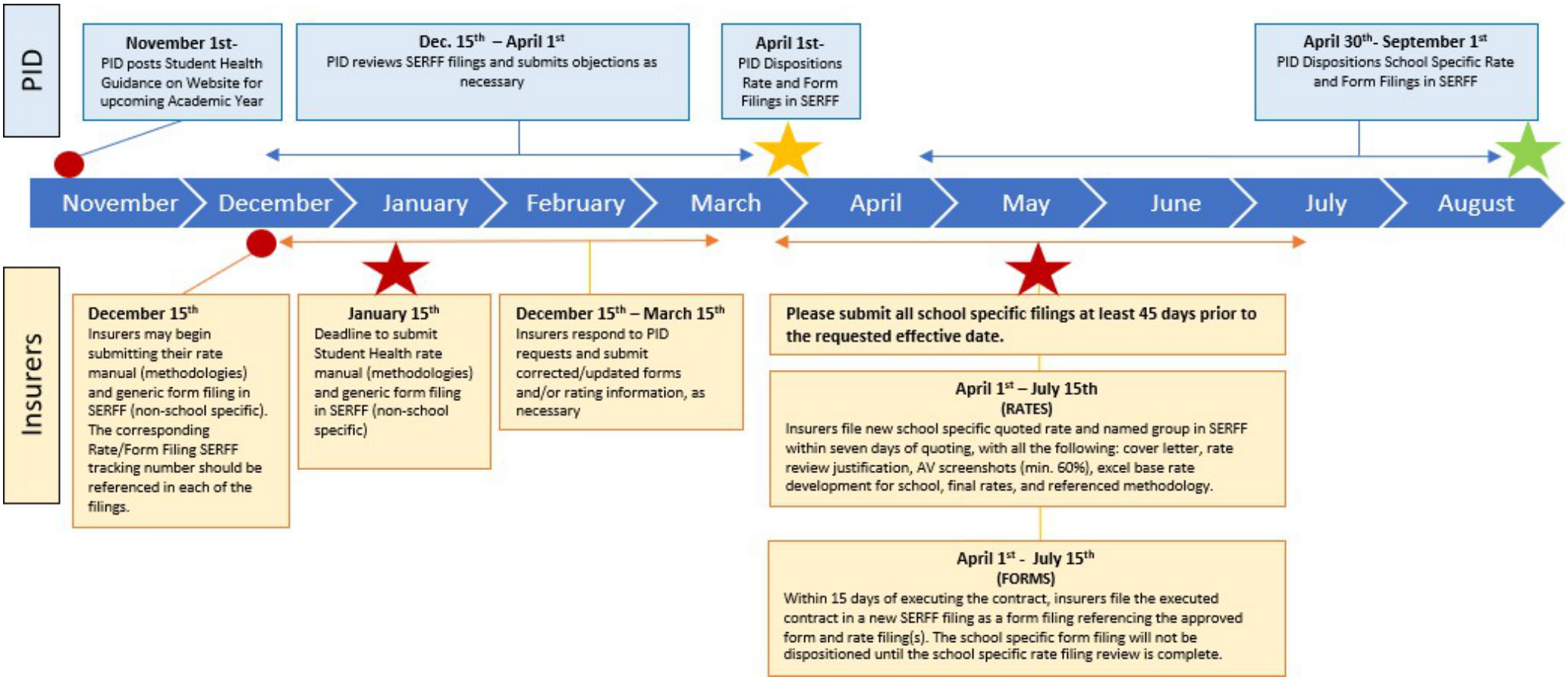
Instructions for completion are built into the template. The template contains the following sections for insurers to complete:

- Additional Benefit Package Information
- Additional Formulary Information
- Additional Act 146 Prior Authorization Program Information and Transparency
- Rx List of All Covered Drugs
- Prescription Drug Coverage Changes
- Covered Drugs Without a RXCUI

PA Act 77 of 2024 and Collection of Formulary Information From All Filed Major Medical Health Insurance Plans (NEW starting December 2024)

Starting December of 2024, every filed major medical health insurance plan/product will need to include a list of all covered drugs under the plan/product, including specific tiering information, limitations, and whether the drug is considered a specialty drug under the plan. PID anticipates publishing soon guidance to effectuate section 901(c) of Act 77, relating to the review of specialty drugs. That guidance will be available on the PID website, and this guidance will be updated to alert filers of that posting.

Pennsylvania's Student Health Insurance Filing Timeline



Last updated on 11/1/2023