Large Group Major Medical Health Insurance Form Filing Guidance

To monitor and assure compliance with the ACA and State law requirements, major medical accident and health insurance forms sold only to large groups for plan years beginning on or after January 1, 2018, should be submitted annually to the Department via SERFF on a 'rolling' basis, based on renewal date. See: 40 P.S. § 3801.303. See also: Notice 2016-01, published in the PA Bulletin on January 23, 2016

Deadline
To help foster the Department's timely review, insurers should submit their annual forms at least **90 days** prior to the requested effective date of the coverage.

SERFF Submission and Necessary Documents

SERFF Submission
Please submit all filings through the System for Electronic Rate and Form Filings (SERFF) under the appropriate Type of Insurance (TOI). Please use the following Types of Insurance (TOI), Sub-Types of Insurance (Sub-TOI), and Filing Types.

TOI Options	SubTOI Options	Filing Type
• **H15G Group Health - Hospital/Surgical/Medical Expense** • **H16G Group Health - Major Medical** • **HOrg02G Group Health Organizations - Health Maintenance (HMO)**	• **Large Group Only - PPO** • **Large Group Only - POS** • **Large Group Only - HMO** • **Large Group Only - Other**	• **Form** including Guaranteed Issue, Medically Underwritten, Medically Underwritten High-Deductible Health Plan, or Other (Not M.U. or G.I. Product)

Required Documents
A complete filing is required even if a policy form used has no changes from the previously-approved 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, and all of the **supporting documentation**.

The Department expects that each product type (EPO, PPO, HMO, and POS) will be submitted separately.

Forms: The following forms are examples of what is to be uploaded as 'Forms' within each SERFF filing as applicable:

- **Benefits Booklet**
- **Contract**
- **Group Policy**
- **Certificate of Coverage**
- **Subscription Certificate**
- **Schedule of Benefits**
- **Policy Declaration Page**
- **Subscriber Agreement**
- **Group Agreement**
- **Preventive Schedule**
- **Application Form(s)**
- **Enrollment Form(s)**
- **Rider(s)**
- **Health Reimbursement Arrangement Administration Addendum**
- **Preauthorization Program**

A master policy is an insurance contract issued to the policyholder that combines the policy provisions and exclusions, certificate of coverage, schedule of benefits, riders, and other forms issued to the policyholder into one

policy document. The master policy should be 'standardized' (i.e., include all ACA and state mandates, as well as all mandatory provisions). These items cannot be variable and must appear in every contract issued. Customization of benefits is permitted and should be denoted by brackets with an Explanation of Variability (EOV) that provides basic information of what may appear in this variability.

Supporting Documentation: The SERFF filing should also include as 'Supporting Documentation' the following as applicable:

- **Transmittal Letter**
- **Summary of Benefits and Coverage (S.B.C.)**
- **Variability Explanation**
- **Plan Options Grid**
- **Compliance Certification Form** (available here: Product and Rate Require (pa.gov))
- **Compliance Checklist (Major Medical)** (available here: Product and Rate Require (pa.gov))
- **Replacement Form with Highlighted Changes**
- **Quantitative Treatment Limitation Analyses**
- **Nonquantitative Treatment Limitation Analysis**
- **Mental Health Parity Compliance Attestation**
- **ID cards**
- **Certificate of Authority & Network Approval**
- **Certification for Variable/Customized Benefits-** A certification that any variable and/or customized benefit changes not appearing in the form will not reduce or eliminate any federal or state mandates or mandatory provisions. This certification should be signed by an authorized representative of the company
- **Redlines of Forms** 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.
- **PID Annual Supplemental Template for Large Group Major Medical Plans (PAST for LG)** should be submitted with every large group major medical form/product filing. See filing guidance section "PID Annual Supplemental Template for Large Group Major Medical Plans" later in this document. The template is available on the website under *Large Group Major Medical Health Insurance Filing Guidance*. **(ADDED NOVEMBER 2024)**

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 at least one plan, so the Department can confirm the parity analyses performed by the insurers meet the requirements of the law. However, insurers are not limited to submitting only one plan's parity analysis and may submit additional analyses for other plan designs in the filing.**

- 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.

PID's Annual Supplemental Template "PAST" for Large Group Major Medical Plans (NEW starting November 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 large group 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 November 2024)
Starting November 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.

Please send any questions on this guidance that cannot be answered through the SERFF process to ra-rateform@pa.gov. As appropriate, we may compile them and post responses as FAQs on the Department's website or within future guidance.

Frequently Asked Questions

1. **Are copies of the final executed forms required to be submitted after issue?**
   Due to volume, the PID currently does not expect issuers to file copies of each final executed policy. However, the Department may request copies of final executed forms, and anticipates collecting a limited number of final executed policies that meet specific criteria (e.g., largest employer groups) at a later date. These executed contracts will be considered informational only and may be marked confidential. Insurers will be given reasonable notice prior to any filing request.

2. **If any group accepts the approved standard form, does this mean it will not require a further submission?**
   Yes.

3. **Is the intent of the reference to 'rolling' basis on page one, in paragraph one, to have any forms customized by group customers submitted prior to the time of each group's renewal?**
   The "rolling" basis reference is in recognition of the flexibility in plan year start dates in the large group market. Customization of benefits is permitted via variability.

4. **For further clarification, is the intent of this guidance document that there will be one annual filing of a standardized form, plus additional filings upon their applicable renewal for any groups that customize benefits?**
   No. There would be one annual filing per form type (i.e., HMO, PPO, etc.). No additional filings are required except as noted in Q1. Customized benefits are permitted via variability.

5. **Often, large group customers are determining their benefits right up to the effective date of coverage. Given this, the forms may not be 'final' until shortly before or on the coverage effective date. What are the expectations for these situations so as to satisfy the requirement to allow sufficient time for review?**
   Variability in benefits is permissible; PID may request final executed forms as noted in FAQ1.

6. **What sub-TOI should be used for Gatekeeper PPO and EPO plans? Should they use the same SubTOI as 'Large Group Only-PPO' or instead use 'Large Group Only – Other'?**
   Please use "Large Group Only – PPO" for a Gatekeeper PPO and "Large Group – Other" for an EPO plan.

7. **Are examples of Performance Guarantees required to be included with the Large Group filings?**
   No.

8. **The terms and conditions relating to the funding requirements and payment of premiums for large groups are customized and provided separately in a financial arrangement as an exhibit to the group contract. Are financial arrangements required to be filed for the large group segment? If so, will the Department accept a basic format for the financial arrangement, or will insurers be required to submit each potential financial arrangement?**
   Please file a basic format of the financial arrangement with each form type.

9. **We do not anticipate making any changes to the forms that were previously submitted. Are we still required to submit a filing?**
   Yes. To maintain consistency with individual and small group ACA comprehensive major medical products, as well as student health products, please make an annual submission. A complete filing is required even if a policy form that will be used in the next benefit year has no changes from the approved form for the previous year. The submission must contain the forms (on the Form Schedule) with a new form number. This can be facilitated by use of a revision/version date (i.e., the form number itself can remain the same but a year should be added). The certifications and transmittal letter should be on the Supporting Documentation tab, and an additional certification stating that no changes other than the form number have been made should be included. The SERFF tracking number of the previously approved submission should be identified in the transmittal letter to allow an expedited review by the Department.