



To: Health Insurance Issuers in Missouri, Oklahoma, Texas, and Wyoming

RE: Rate Filing Instructions for Plan Year 2022; Form Filing Instructions for System for Electronic Rates and Forms Filing (SERFF) Technical Assistance for Plan Year 2022

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 by the Patient Protection and Affordable Care Act (ACA), with respect to health insurance issuers in the group and individual markets when a state informs CMS that it does not have authority to enforce or is not otherwise substantially enforcing one or more of the provisions of that title. In addition, if a state does not have an Effective Rate Review Program, CMS will review individual and small group rate increases subject to review to determine whether the increase is unreasonable, as required by 45 C.F.R. Part 154. Within CMS, the Oversight Group in the Center for Consumer Information & Insurance Oversight (CCIO) is primarily tasked with these duties.

Form Filing Instructions

1. Who must submit form filings to CMS for Plan Year 2022 and how must these form filings be submitted?

For plan year 2022, health insurance issuers in Missouri, Oklahoma, Texas, and Wyoming must submit form filings for all non-grandfathered health insurance products¹ in the individual² and group markets to the CMS Direct Enforcement instance in the National Association of Insurance Commissioners' (NAIC) SERFF at <https://login.serff.com/serff/>.

Issuers in these states offering products that do not contain any plans for which the issuer is applying for Qualified Health Plan (QHP) certification must submit form filings for CMS

¹ Health insurance issuers are not required to submit forms for coverage that has been renewed under CMS's non-enforcement policy continually since 2014. See Bulletin: Extended Non-Enforcement of Affordable Care Act-Compliance With Respect to Certain Policies, available at <https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2022.pdf>.

² 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.

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review only if the forms associated with the product were changed from prior plan years in a manner that requires the re-filing of forms with the State Department of Insurance under applicable state requirements.

One product submission in SERFF comprises all of the plans offered with the same product network type and identical benefits. Each product must be submitted separately. Each product submission must include all plans to be offered for that product.³

Instructions for form filing submissions to CMS are also provided in the SERFF submission General Instructions Tab.

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

2. What is the difference between a product and a plan?

The terms “product” and “plan” are defined in the regulations at 45 C.F.R. § 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 cost-sharing structure, provider network, and service area.⁴ 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.

3. What other information should issuers know when preparing their plan documents?

- a. The Consolidated Appropriations Act, 2021 (P.L. 116-260) imposes new requirements for coverage of emergency services, applicable to health insurance issuers, including requirements related to air ambulance services, non-emergency services furnished by nonparticipating providers at certain participating facilities, and for continuity of care. Be sure to review this new law and the requirements applicable to issuers and ensure your plan document language meets the new requirements.
- b. Oklahoma issuers only: CMS will identify Mental Healthy Parity and Addiction

³ A product submission may include QHPs and non-QHPs.

⁴ The combination of the service areas for all plans offered within a product constitutes the total service area of the product.

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Equity Act (MHPAEA) concerns in your plan year 2022 plan documents and share those concerns with the Oklahoma Insurance Department (OID). OID will include any identified MHPAEA concerns as part of their plan document review process. You are to work with the Oklahoma Insurance Department regulators to resolve such issues

4. When are the plan year 2022 form filing submission deadlines?

- April 22, 2021: Form filing window opens.
- June 16, 2021: Deadline for filing forms for all non-grandfathered products, except for student health insurance products and products offered in the large group market.⁵ This deadline aligns with the initial QHP application deadline contained in Final Key Dates for Calendar Year 2021: Qualified Health Plan (QHP) Data Submission and Certification; Rate Review; and Risk Adjustment.⁶
- 60 days prior to marketing: Deadline for filing forms for student health insurance products and products offered in the large group market.

5. What documents must be submitted in SERFF for plan year 2022 form filings?

Please reference the table below to determine under which tab forms must be filed in SERFF. As stated in the 2022 Draft Letter to Issuers in the Federally-facilitated Exchanges, there are additional proposed requirements specific to QHP certification that CCIIO requires, such as the Plans & Benefits Templates and prescription drug templates.⁷ For QHPs, completed templates and justifications must be uploaded into the HIOS Plan Management and Market Wide Functions Module⁸ and should not be submitted through the SERFF Supporting Documentation Tab. The requirements specific to QHP certification in the 2022 Draft Letter to Issuers in the Federally-facilitated Exchanges are subject to change. Please refer to the Final 2022 Letter to Issuers in the Federally-facilitated Exchanges for complete and final instructions for submitting QHP templates and justifications.

⁵ See, *supra* note 1.

⁶ The document is available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Key-Dates-Table-for-CY2021.pdf>.

⁷ The 2022 Draft Letter to Issuers in the Federally-facilitated Exchanges is available at <https://www.cms.gov/files/document/2022-draft-letter-issuers.pdf>.

⁸ Templates are available at <https://www.qhpcertification.cms.gov/s/QHP>.

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Form Schedule Tab
Group master policy ⁹
Evidence of coverage or individual policy
Schedule of benefits for each plan and CSR plan variations
Notices of appeals and external review rights
Riders, endorsements, and amendments ¹⁰
Supporting Documentation Tab
Summary of Benefits and Coverage (SBC) ¹¹
Plans & Benefits Template, in .xlsx format, for non-qualified health plans only
CMS Prescription Drug Template (one per product in Excel format) for non-qualified health plans only, except large group market
Results of the Actuarial Value Calculator (screen shot or in Excel format) for non-qualified health plans only
Unique Plan Design Supporting Documentation and Justification for non-qualified health plans only
EHB Substituted Benefit (Actuarial Equivalent) Justification for non-qualified health plans only
Formulary—Inadequate Category/Class Count Supporting Documentation and Justification for non-qualified health plans only
Explanation of Variability

6. What are some general tips for submitting forms?

- a. 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).
- b. Include the associated HIOS number and Product ID(s) on the General Description tab of the submission.
- c. Issuers can run their Plans & Benefits Template through the plan year 2022 Master Review tool to ensure all the data is included and there are no errors to avoid

⁹ For group market product submissions only.

¹⁰ Optional benefits riders are not permitted for plans that are subject to the single risk pool requirements.

¹¹ 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.

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- delays in our review of submitted documents.
- d. Submit one Summary of Benefits and Coverage (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.
 - e. If a form is used for multiple products or plans, indicate which form(s) belong with which products or plans. This includes identifying whether multiple product submissions use identical RX templates as other product submissions.
 - f. Issuers can run their RX template through the plan year 2022 RX Tool to ensure there are no RX template errors and also to provide us with the RX justification for any deficiencies identified as part of this process. This will reduce the number of RX review issues.
 - g. Issuers are encouraged to 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 **Support Documentation Tab** and the clean version of the revised document under the **Form Schedule Tab**.
 - h. Issuers submitting products with variable language or data must include any explanations of variability as part of the submission.
 - i. All text files should be an Adobe Acrobat PDF. Spreadsheets should be attached in Excel format. BMP, PNG, and JPG are acceptable formats for screenshots.
 - j. Microsoft Word documents cannot be uploaded to SERFF.
 - k. The maximum file size limit for uploads to SERFF is 5 MB.

7. Is CMS offering additional opportunities to ask questions about form filing?

The Oversight Group will host a conference call on April 15, 2021 at 2:00 pm eastern time to provide issuers with an opportunity to ask questions pertaining to filing forms and rates with CMS for review. No registration is required. Issuers may submit questions in advance to formfiling@cms.hhs.gov.

Please call 1-877-267-1577 with conference ID number 997 695 309 to access the conference call.

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Rate Filing Instructions

1. For which plans must rate filings be submitted?

Health insurance issuers in all states and the District of Columbia are required to submit rate filings for new or renewed coverage effective on or after January 1, 2022, for all non-grandfathered plans in the individual and small group markets, except for student health insurance coverage, for monitoring purposes.¹² If the state does not have an Effective Rate Review Program,¹³ CMS will review rate increases subject to review in the state to determine whether they are unreasonable, as required by 45 C.F.R. Part 154. CMS will also review all rate filings in these states for compliance with the market reform rules under the PHS Act and ACA, including rating rules and the single risk pool requirements, as applicable.

2. What documents need to be submitted?

Issuers of single risk pool coverage¹⁴ in all states and the District of Columbia must submit a Rate Filing Justification into the HIOS Unified Rate Review (URR) Module which generally consists of Part I – Unified Rate Review Template (required for all rate filings, regardless of whether there is any change to rates), Part II – Written Description Justifying the Rate Increase (required for filings which include a plan with a rate increase of 15% or more), and Part III – Rate Filing Documentation (Actuarial Memorandum, required for rate increases of any size).

Issuers of plans subject to the CMS non-enforcement policy¹⁵ must submit a Preliminary Justification for any rate increases of 10% or more into the HIOS Rate Review Justification (RRJ) Module, which generally consists of Part I – Rate Increase Summary Form, Part II – Written Explanation of the Rate Increase, and Part III – Rate Filing Documentation.

¹² CMS finalized an exemption for student health insurance coverage from the Federal rate review process beginning with rate filings that have an effective date on or after July 1, 2018. See the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; Final Rule; 83 FR 16930 at 16972 (April 17, 2018), available at: <https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf>. This exemption applies to rate filings for student health insurance coverage, as defined in 45 C.F.R. § 147.145, with an effective date on or after July 1, 2018.

¹³ States that do not have an Effective Rate Review Program for the 2022 plan year are Oklahoma, Texas, and Wyoming. See 45 C.F.R. § 154.301 for the list of criteria CMS considers when evaluating whether a State has an Effective Rate Review Program.

¹⁴ For purposes of the requirements established in 45 C.F.R. Part 154, “single risk pool coverage” is used to refer to non-grandfathered health insurance coverage in the individual or small group (or merged) market that is subject to all of the single risk pool provisions at 45 C.F.R. § 156.80.

¹⁵ See, *supra* note 1.

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3. When do required documents need to be submitted?

Issuers in states without an Effective Rate Review Program are required to submit proposed rate filings for all single risk pool coverage (QHP and non-QHP) to CMS no later than June 4, 2021.¹⁶ Proposed rate filings for single risk pool plans for all other states must be submitted into the HIOS URR Module no later than July 21, 2021, but states may have earlier deadlines.

Issuers in states with an Exchange served by the HealthCare.gov platform are required to submit final rate filings that include a QHP in the URR module of HIOS no later than 3:00 p.m. EDT on August 18, 2021. Issuers in states with a State-based Exchange that does not use the HealthCare.gov platform are required to submit final rate filings that include a QHP to both CMS and the state by a date set by the state, as long as the date is no later than October 15, 2021. Issuers submitting final rate filings that only contain non-QHPs must submit them in the URR module of HIOS no later than 3:00 p.m. EDT on October 15, 2021.

For quarterly rate update submissions in the small group market, the submission deadline is 105 days prior to the effective date of the quarterly change. If the submission includes a QHP offered in a Federally-facilitated SHOP, issuers should be mindful of the data correction windows when a revised Rates Table Template must be submitted. Data correction windows will be announced in advance, and CMS will provide detailed information on timelines and required submissions at that time.

Rate filing documents for plans subject to the CMS non-enforcement policy must be submitted into the HIOS RRJ Module. Issuers are encouraged to submit the Preliminary Justification¹⁷ at least 60 days in advance of implementation of any rate increase which is subject to review.

4. When will CMS publish rate filing information for single risk pool coverage for the 2022 plan year?

CMS intends to publish all applicable parts of the Rate Filing Justification¹⁸ for all proposed rate changes for single risk pool coverage (including both QHPs and non-

¹⁶ See Bulletin: Timing of Submission of Rate Filing Justifications for the 2021 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2022, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Rate-Review-Bulletin-for-CY2021>.

¹⁷ Parts I, II, and III of the Preliminary Justification are required for plans subject to the CMS non-enforcement policy with rate increases of 10 percent or more.

¹⁸ CMS will not post information that is a trade secret, or privileged or confidential commercial or financial information consistent with HHS' Freedom of Information Act regulations at 45 C.F.R. § 5.31(d).

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QHPs), regardless of whether the product includes a plan with a rate increase that is subject to review under 45 C.F.R. § 154.210, on July 30, 2021 at <https://ratereview.healthcare.gov>.¹⁹ CMS intends to post final rate information for single risk pool coverage (including both QHPs and non-QHPs) no later than November 1, 2021.

5. What if issuers have questions about rate filing submissions?

For questions regarding submission of rate filing documents, please contact the rate review team by email at RateReview@cms.hhs.gov.

¹⁹ See, *supra* note 16.

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