Department of Insurance

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ACA Compliant Form Filing Guidance

For Individual, Non-Employer Group and Small Group Products

Prepared by

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Ohio Department of Insurance

INTRODUCTION

The Ohio Department of Insurance has developed this manual to provide guidance for the development of Affordable Care Act compliant filings in the individual, non-employer group, and small group markets. The manual identifies important terms and provides filing instructions and information about document development. Failure to follow the instructions in this manual may result in delay or disapproval of a filing.

This manual provides the following information to help you with your form filings:

- Definitions of important terms
- Instructions on completing SERFF fields
- Identification of appropriate checklists
- Instructions on preparing acceptable forms
- Instructions on responding to objections

ONLINE RESOURCES

Additional information is available on the Department's website under "Plan Management Toolkit" including:

- Ohio Essential Health Benefit Benchmark Plan
- Ohio Essential Health Benefit Resource Document
- Required Supporting Documentation for Form Filings
- QHP Binder and Rate Submission Guidance
- Frequently Asked Questions

FILING DEADLINES – Refer to the Plan Management Tool Kit on the Department's website.

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IMPORTANT TERMS

OHIO ESSENTIAL HEALTH BENEFIT (EHB) BENCHMARK PLAN

The plan selected for Ohio that is the model for all Standard Benchmark Plans.

ESSENTIAL HEALTH BENEFIT RESOURCE DOCUMENT

A chart that identifies the essential health benefits required in Ohio. This chart should be used in conjunction with the Ohio EHB Benchmark Plan for complete descriptions of the Ohio EHBs.

ESSENTIAL HEALTH BENEFITS LOCATOR

A form completed by insurers and submitted with individual and small group filings that confirms the inclusion of required EHBs, provides the page numbers of required EHBs, and identifies benefits that are Substantially Equal to the Benchmark Plan, Actuarially Equivalent Substitutions, or above the EHB. Insurers also list any optional benefits that have been added to plans.

STANDARD BENCHMARK PLAN

The insurer's policy or certificate that includes all the EHBs required in Ohio. This plan must be consistent with the Ohio EHB Benchmark Plan and meet all the requirements of the Affordable Care Act (ACA). Standard Benchmark Plans may include benefits that are not included in the Ohio EHB Benchmark Plan; however, this would mean the Standard Benchmark Plan exceeds the Ohio EHB Benchmark Plan.

Policies and certificates must be one complete form; they may not consist of matrix elements.

STANDARD PLAN VARIATION

A complete policy or certificate that is a unique variation of the Standard Benchmark Plan. Each unique Standard Plan Variation must have a unique form number. Standard Plan Variations may:

- Increase the benefit level by increasing quantitative (*e.g.* visit) limits.
- Increase the benefit level by revising or deleting exclusions.
- Substitute actuarially equivalent essential health benefits.
- Exclude contraceptives for eligible religious groups. Contraceptives may be bracketed, and a new plan variation would not be required.

STANDARD PLAN RIDER

Standard Plan Riders are used to add new benefit provisions that will be used to construct one or more additional plans (each having unique Plan Identification Numbers). More than one new optional provision may be included with a filing, but each must be on a separate form with unique form numbers unless the intent is to always sell them together.
Except for the contraceptive exemption, Standard Plan Riders must add coverage rather than reduce coverage.

Standard Plan Riders may:

- Increase the benefit level by increasing quantitative (*e.g.* visit) limits.
- Increase the benefit level by revising or deleting exclusions.
- Add optional benefits including stand-alone benefits such as dental coverage.
- Exclude contraceptives for eligible religious groups.

AMENDMENT OR ENDORSEMENT (AMENDATORY FORMS)

A separate form, with a unique form number, used to revise previously approved Standard Benchmark Plans and Standard Plan Variations forms.

Amendments and endorsements may not reduce coverage unless the issuer is excluding contraceptive benefits for eligible religious groups.

WHAT SUPPORTING DOCUMENTS DO I NEED TO FILE?

MAJOR MEDICAL

Scenario	*Form Filing Checklist*	*EHB Locator*	*Are Rates Required?*[1]
I plan NO changes to my existing ACA compliant forms (no form filing required)	No	No	Yes
I want to use an Amendment, Endorsement, or Standard Plan Rider to make changes to my existing Standard Benchmark Plan or Standard Plan Variation	No	Yes	Yes
I want to create a new plan or make changes by creating a new Standard Benchmark Plan or Standard Plan Variation	Yes	Yes	Yes

DENTAL

Scenario	*Form Filing Checklist*	*Are Rates Required?*[1]
I plan NO changes to my existing ACA compliant forms (no form filing required)	No	Yes
I want to use an Amendment, Endorsement, or Standard Plan Rider to make changes to my existing ACA compliant forms	No	Yes
I want to create a new ACA compliant form	Yes	Yes

Please review the checklist for any changes or new requirements even if you are only submitting an amendment/endorsement or rider.

[1] All rates are filed under the Rate filing type. Rates are not required if trend was not used in developing rates, and there are no changes to currently approved rates. See the "Plan Management Toolkit," located on the Department's website, for rate filing instructions.

SERFF FILING INSTRUCTIONS

TOI/SUB TOI

- Use the Type of Insurance Code (TOI) and Sub-TOI specified in Appendix A. Filings submitted under the incorrect TOI or Sub-TOI will be rejected.
- Do not combine small and large group forms in one filing.
- The any size group code may be used only for non-employer group plans.

FILING TYPE

The filing type must accurately describe the submitted forms.

- Use the Filing Type, ***Form***, for policy/certificate forms.
- Use the Filing Type, ***Rate***, for the rate filing.
- Policy/certificate forms and rates filed separately.
- The ***Advertising/Solicitation*** filing type should be used for HIC solicitation filings only.

PPACA INDICATOR

- All products that must comply with the ACA will include the PPACA indicator.
- The "Not PPACA Related" option may be used only for applications, amendments to applications, name changes, and assumption filings.
- Identify the filing as either grandfathered or non-grandfathered. Do not combine grandfathered forms and non-grandfathered ACA forms in one filing.

EXCHANGE INTENTIONS INDICATOR

Select YES if any portion of the filing is intended to be sold through the federal health insurance exchange. Include additional information, if any, in the text box that is provided.

IMPLEMENTATION DATE

Indicate January 1ST and the year for any plan to be used for the upcoming open enrollment period.

SUBMISSION TYPE

Indicate whether the filing is a new submission or a resubmission of a previously disapproved or withdrawn form. If it is a resubmission, please see the additional requirements under "Filing Description" section below.

MARKET TYPE

Select the appropriate market type. Please refer to Appendix A for guidance in identifying the correct market type.

CORRESPONDING FILING TRACKING NUMBER

Provide the SERFF Tracking Numbers for the corresponding rate filing and other related form filings (*e.g.* Standard Plan Variations, Standard Plan Riders, and Amendatory Forms) in this field.

FILING DESCRIPTION

Provide a complete and accurate description of the filing in the Filing Description section of the General Information tab. Required information is specified below.

- Indicate if this is a new form or a revision of an existing form; revisions must include the SERFF tracking number and approval date of the previous form.
- Indicate if this filing represents a new use of an existing form.
- Indicate if the form will be offered to existing insureds, new applicants, or both.
- Describe in detail how the Amendatory Forms and Standard Plan Riders will be used with the underlying base form. Examples of necessary information are shown below:
    - Indicate if the Amendatory Form will always be used with the base form.
    - Indicate if the base form will remain unchanged and the Amendatory Form will be issued attached to the base form.
- Describe how the form will be marketed (*e.g.* direct sales or sales agent).
- Indicate if the form is a resubmission of a previously disapproved or withdrawn ACA compliant form; include the SERFF tracking number(s), disposition date(s) of the previous form, and responses to all outstanding issues (as a supporting document)
- Identify all forms to be used with the submitted forms; include SERFF tracking number(s) and approval dates.
- Provide SERFF tracking numbers not included in Corresponding Filing Tracking Number Field for any related form or rate filings.
- For Health Insuring Corporation (HIC) advertising/solicitation filings describe the form related to the advertisement/solicitation and include the SERFF tracking number(s) and approval date(s). Please note, advertising and solicitation documents may be submitted only with the base form or after the base form has been approved.

DOCUMENT FORMAT

All attachments to the Form Schedule and Supporting Document tabs must be provided in a searchable PDF format. For the EHB Locator, submit the locator in both its original Excel format and in a searchable PDF format.

FORM DESIGN

FORMAT

Forms must comply with the following requirements:

- Policies and Certificates must be complete documents.
- Matrix formats are not permitted.
- Each form must include a unique form number on the lower left-hand corner of the first page of the form. The form number must be identical to the form number shown on the Form Schedule tab in SERFF.
- Amendatory Forms and Riders content cannot be embedded into a previously approved form. Changing language within a previously approved form can only be done by submitting the revised form with a new form number.

FORM ORGANIZATION

The form must be organized in a logical, reasonable, and rational order and presented in a manner that is clear and easy to understand for the average consumer. Specific requirements are identified below:

- The format must be consistent throughout the form.
- A table of contents must be included in all policies and certificates.
- Covered benefits must be clearly explained.
- There must be a clear distinction between what is covered and what is not covered.
- All important terms must be defined and when used, must be differentiated from the remaining text in some way (*e.g.* capitalized, bolded).
- Definitions may not be used to describe limits or exclusions of benefits.
- Benefit specific limitations and exclusions must be provided directly after description of the covered benefit. General limitations that apply to the entire form should be located in a separate, clearly identified section.
- Limitations and exclusions must be labeled appropriately. For example, exclusions should be listed under the heading, ***Exclusions***, while limitations should be listed under the heading, ***Limitations***.
- Covered benefits must be described in the benefit section and not included as an exception in the exclusion section.

USE OF VARIABLE CONTENT

Alternative provisions are not permitted in individual policies.

Permitted variable content is limited to:

- Cost sharing options including deductibles, coinsurance, and copayments.
- Contraceptive coverage alternatives for groups eligible for the ACA religious exemption.
- Options in a group policy/certificate that have been added by rider or amendatory form may be bracketed in the Schedule of Benefits.
- Alternative language that does not affect covered benefits (*e.g.* eligibility options, addresses, websites).

To ensure that the use of variability is clear, please adhere to the following:

- Bracket each variable.
- Include a statement of variability in the Forms Schedule as a separate form identified by a unique form number. Please use the Form Type "OTH."

The statement of variability must:

- Clearly describe the use of each bracketed item.
- Include specific options; vague statements such as "variables will always comply with applicable laws" are not acceptable.
- Include all alternative language with an explanation of why and when the language will be substituted.
- Include all values and ranges of values; value ranges must be reasonable and consistent with filed rates.

Any changes to an approved statement of variability must be filed and approved before use.

Requirements For Revisions to the Standard Benchmark Plan or a Standard Plan Variation

Insurers may update Standard Benchmark Plans by revising the previously approved policy or certificate or by submitting an amendment to be used in conjunction with the previously approved form. If insurers want to submit an amendment to be used for current insureds and a new policy or certificate for new insureds, they must submit both the amendment and the policy or certificate for review. These forms should be filed in the same SERFF filing.

The following requirements apply to the submission of revisions to previously approved forms:

- Assign a new unique form number for each filed form.
- Attach the previously approved form under Supporting Documentation tab on SERFF.
- Attach a redlined version of the new form showing all revisions under Supporting Documentation tab. Include a certification that all changes are identified in the redlined version under the Supporting Documentation tab.

Please note that if the Department determines that an amendment or endorsement contains too many changes, we may request an entirely new version of the base form.

Requirements For Adding Optional Benefits

The following requirements apply to adding optional benefits:

- Add new benefits via a Standard Plan Rider.
- Specify in the filing if the optional benefits will always be sold as a package or if each optional benefit may be sold separately. If optional benefits are to be sold as a package they may be included in one Standard Plan Rider. If optional benefits are to be sold separately, each benefit must be on a separate Standard Plan Rider.
- Assign a unique form number to each Standard Plan Rider. The form number must be located in the lower left-hand corner of the first page.

Requirements For Contraceptive Coverage Exemption

Contraceptive coverage may be excluded only for eligible groups in accordance with Federal law. To provide this exemption:

- Use a Standard Plan Variation, Standard Plan Rider or Amendment or Endorsement.
- Clearly state exactly what contraceptive benefit is removed from coverage.
- Explain any variability in a statement of variability as described under USE OF VARIABLE CONTENT section.

Note: The ACA religious exemption does not apply to coverage of therapeutic abortions. Coverage for therapeutic abortions is required for consistency with the Ohio EHB Benchmark Plan.

Form Filing Checklist and EHB Locator

The Department has developed form filing checklists and an EHB Locator for use with certain filings. See the *What Supporting Documents Do I Need to File* section. The applicable checklist and EHB Locator will be populated in SERFF under the Supporting Documentation tab and are available on the Department's website: www.insurance.ohio.gov under "***Plan Management Toolkit***". **Please review the checklist for any changes or new requirements even if you are only submitting an amendment/endorsement or rider.**

FILING TIPS

Please adhere to the following:

- Include all forms for one market type (individual, non-employer group, or small group) in one filing.
- Provide a redlined version of each revised form. The initial redline must be based on a prior **approved** form. Include the SERFF filing number for the prior approved form and a certification that the redlined version is accurate and shows *all* changes made to the original form. See *How to Prepare Redline Versions* for more information.
- Submit all Standard Benchmark Plan and Standard Plan Variation filings as complete policies, certificates, and riders (i.e. not matrix type filings).

HOW TO RESPOND TO OBJECTION LETTERS

- **Respond to each objection individually** using the response format in SERFF.
- Do not respond in a separate letter attached as a supporting document.
- If an objection has multiple parts, address all parts of the objection.
- Call the reviewer if you need clarification of any of the objections.
- Include (as a supporting document) a redline copy of each form showing changes only from the most recent form submitted and a certification that all changes have been redlined. Do not replace an old redline with a new redline.

HOW TO PREPARE REDLINE VERSIONS

- Compare only two forms, the newest version to the last version. Redlines may not include accumulated changes from several versions of a form.
- Use a contrasting color such as red or blue. Underlines, gray or black print are not acceptable.
- Provide a complete form and include all of the changes that have been made. The redline version must match the newest version of the form.
- Review the redline version to ensure it is easy to understand.

SELECTED COVERAGE AND FILING ISSUES

UNDERSTANDING THE ESSENTIAL HEALTH BENEFITS IN OHIO PLANS

- Essential health benefits are outlined in the Essential Health Benefit Resource Document and the Ohio EHB Benchmark Plan. These can be found on the Department's website: www.insurance.ohio.gov in the "Plan Management Toolkit" under the "Services for Companies" tab.
- All EHBs included in the benchmark plan must be covered.
- No annual or lifetime dollar maximums are permitted. Some benchmark benefits have visit limitations or per service dollar maximums.

The Ohio EHB Benchmark Plan is not a HIC plan and does not meet all of the Ohio HIC requirements. Please refer to the section titled *Specific issues for HICs (HMOs) only*.

Some of the benefits in the Ohio EHB Benchmark Plan must be revised and other benefits added to comply with current state and federal requirements. These revisions are identified below:

- Dental Services for accidental injury: limited to $3000 per accident.
- Private duty nursing: limited to 90–110 visits per year.
- Unrelated donor searches for bone marrow/stem cell transplants for a covered transplant: limited to $30,000 per transplant.
- Residential treatment centers must be covered for mental health and substance abuse treatment.

Please refer to the Ohio Essential Health Benefit Resource Document, located in the "Plan Management Toolkit" on the Department's website. Note that a few EHB benefits are no longer listed separately but referenced in the "Explanations" column text of a more general EHB benefit category. It is important to carefully review the "Explanations" column text for important EHB details.

EXCLUSIONS AND LIMITATIONS

- Exclusions and limitations must be consistent with the Ohio EHB Benchmark Plan; benefits not excluded in the Ohio EHB Benchmark Plan may not be excluded in a Standard Benchmark Plan
- Exclusions or limitations broader than those in the Ohio EHB Benchmark Plan are not permitted.

NEW ISSUES AND REQUIREMENTS

TELEHEALTH SERVICES (EXPANDED)

Beginning in 2021, Health Benefit Plans were required to provide telehealth services on the same basis and to the same extent that the plan provides coverage for in-person health care services. No annual or lifetime benefit maximums are permitted. ORC 3902.30 The requirements in ORC 3902.30 were expanded effective March 23, 2022, and include a broader list of providers and description of covered services. (Ohio HB 122, 134th General Assembly).

ADDITIONAL CONTINUITY OF CARE REQUIREMENT

The contracts must provide extended coverage for Continuing Care Patients after a provider terminates its network contract. (PHSA §§ 2799A-3 and 2799B-8, as added by section 113 of division BB of the Consolidated Appropriations Act, 2021).

NO SURPRISES ACT (FEDERAL AND STATE)

Forms must comply with State and Federal restrictions on charging out-of-network cost shares and balance billing for certain services. ORC §§3902.50 et. seq., OAC 3901-08-17; PHSA § § 2799A-1, 2799A-2, added by division BB of the Consolidated Appropriations Act, 2021.

APPENDIX A

CODING INSTRUCTIONS (TOI, SUB-TOI, MARKET TYPE) FOR ACA COMPLIANT FILINGS

The tables below identify the appropriate TOIs, Sub-TOIs, and Market Types for ACA compliant filings.

OHIO TITLE 39 INDEMNITY ISSUERS

MAJOR MEDICAL/DENTAL

TOI	*SUB-TOI*	*Description and Use*
H16G Group Health - **Major Medical** Any Size Group (For Non-Employer Group Plans only)[2]	H16G.001A	Any Size Group - PPO
	H16G.001B	Any Size Group - POS
	H16G.001C	Any Size Group - Other (for plans without networks)
H16G Group Health - **Major Medical** Large Group Only	H16G.002A	Large Group Only - PPO
	H16G.002B	Large Group Only - POS
	H16G.002C	Large Group Only - Other (for plans without networks)
H16G Group Health - **Major Medical** Small Group Only	H16G.003A	Small Group Only - PPO
	H16G.003D	Small Group Only - POS
	H16G.003G	Small Group Only - Other (for plans without networks)
H16I Individual Health - **Major Medical** Individual Only[3]	H16I.005A	Individual - PPO
	H16I.005B	Individual - POS
	H16I.005C	Individual - Other (for plans without networks)
H22 **Student Health** Insurance	H22.000	Student Health Insurance
H10G Group Health - **Dental**	H10G.000	Dental Any Size Group
	H10G.001	Pediatric Dental
H10I Individual Health - **Dental**	H10I.000	Individual Dental
	H10I.001	Pediatric Dental

[2]Non-employer group plans are those sold to individuals through associations, trusts or other entities.

[3]Only for use with true individual plans not sold through association, trusts, or other entities.

OHIO TITLE 17 HEALTH INSURING CORPORATIONS (HICS, COMMONLY CALLED HMOS)

BASIC HEALTH CARE/DENTAL

TOI	*SUB-TOI*	*Description and Use*
HOrg02G Group Health Organizations - **Health Maintenance**	HOrg02.002B	Any Size Group - POS (For Non-Employer Group Plans only)
	HOrg02.002C	Any Size Group - HMO Restricted Network (For Non-Employer Group Plans only)
	HOrg02.003B	Large Group Only - POS
	HOrg02.003C	Large Group Only - HMO Restricted Network
	HOrg02.004D	Small Group Only - POS
	HOrg02.004F	Small Group Only - HMO Restricted Network
HOrg02I Individual Health Organizations - **Health Maintenance**	HOrg02I.005B	Individual - POS
	HOrg02I.005D	Individual - HMO Restricted Network
HOrg04G Group Health - Single Service **Dental**	HOrg04G.000	Any Size Group - Dental
	HOrg04G.001	Any Size Group - Pediatric
HOrg04I Individual Health - Single Service **Dental**	HOrg04I.000	Individual - Dental
HOrg-OH Individual Pediatric **Dental** (ACA Compliant)	Individual Pediatric Dental (ACA Compliant)	Individual - Pediatric Dental

MARKET TYPE (ALL FILINGS)

Type	*Size*	*Market Type Options*
Individual	N/A	Individual
		Non-Employer Group
Group	Small	Employer
		Associations
		Blanket
	Large	Discretionary
		Trust
		Other

This coding structure allows applicable Filing Requirements to be displayed in SERFF and helps us to collect data necessary for a variety of tracking and reporting activities.