FLORIDA OFFICE OF
Insurance Regulation

NOTICE TO INDUSTRY

TO: All insurers authorized to write life & health insurance products in Florida, including those writing supplemental products

The following information is provided as guidance to insurers about the form and rate filing process in Florida for life and health insurance products, mainly federally-authorized Patient Protection and Affordable Care Act (PPACA) compliant products in the small group and individual markets. This overview is intended to assist the industry in understanding the filing process and deadlines, as well as to provide insight into how the Office of Insurance Regulation (OIR) will allocate resources to meet federal timeframes. In the event new federal regulations or guidelines are implemented, this guidance may be subject to change.

While the OIR will continue to process life and health filings unrelated to PPACA (e.g., long-term care, Medicare supplement, annuity products) during the June to August timeframe, companies are requested to delay making any non-essential filings of these types during this period to allow analysts time to focus on the PPACA filings.

PPACA Filing Deadlines

Per the United States Department of Health and Human Services (HHS) and Center for Medicare and Medicaid Services (CMS) Notice of Benefit and Payment Parameters for 2025 guidance within the 2025 Letter to Issuers in the Federally- facilitated Exchanges, the filing submission deadline for PPACA-compliant products (including stand-alone dental plans) in the individual and small group markets is **June 12, 2024**. ***This deadline is applicable for products sold both on and off exchange.***

Additionally, the OIR must complete its review of filings with Qualified Health Plans (QHP) in the risk pool by **August 14, 2024**. Filings will be processed in the order they are received, and there will be no "expedited" status granted to any filings.

Review Timeframe

The OIR is required by section 627.410(2), Florida Statutes (F.S.), to take action on a filing within thirty (30) days of receipt of the form and/or rate filing, with an option to extend this statutory review deadline by another fifteen (15) days. The anticipated filing volume and short review window will likely result in the OIR requiring companies to respond very quickly to requests for information or explanations regarding a filing. Providing complete and clear information in a filing and responding quickly to OIR requests will facilitate the timely review of all filings.

Risk Adjustment Refiling Timelines

Typically, in late June, the final prior year risk adjustment transfer report from CMS is released. Each year OIR gives carriers the opportunity to alter their rates and refile with any needed risk

adjustment edits only. Typical refile timeline is 7-10 days after this report. This year, CMS has pushed back the final risk adjustment transfer report release to July 22, 2024, significantly compressing timelines for the OIR's review. As a result, if any carrier needs to adjust rates for this report release we would ask that rates are refiled by July 25, 2024. If this presents any issues, please contact: Kyle.Collins@floir.com

Information to be Filed

The information requested in this notice should be submitted at the time of filing. Some of the information is not required to be initially submitted to make a complete filing. However, the OIR may require it to be submitted after filing pursuant to section 624.26(2), F.S., and Rule 69O-149.021(6)(c), Florida Administrative Code (FAC). In order to streamline the review process, the issuer is encouraged to submit the information at the time of filing.

Pursuant to Rules 69O-149.002 and 69O-191.051(1), FAC, changes made to a form shall be filed with the OIR and the filing shall include a rate filing or an actuarial certification that the form change does not require a change of rates. In addition, according to the 2025 Letter to Issuers, an issuer must submit the Unified Rate Review Template for all single risk pool plans, including plans with rate increases, rate decreases, no rate changes, and new plans. Therefore, a rate filing will be required for all PPACA-compliant products.

Forms Information

Insurers should file all plan documents for the upcoming plan year. No forms revisions for the 2025 plan year will be accepted after the final federal approval deadline. Insurers should not file non-PPACA (transitional/grandfathered) plans in the same filing as PPACA-compliant plans.

The following is required for a form filing:

- Detailed Cover Letter
- Contract/Policy
- Application/Enrollment Form
- Certificate (if applicable)
- Schedule of Benefits (if separate document and not embedded in the policy/contract)
- Readability Certification
- Riders/Addendums/Endorsements (if applicable)

The OIR has developed worksheets to assist companies making PPACA-compliant form filings. In order to expedite the review process, the OIR encourages companies to download, complete, and upload the applicable worksheet(s) as a part of the form filing submitted to the OIR via IRFS. The worksheets may be downloaded from the OIR website. The worksheets may not contain all of the PPACA requirements. The OIR offers these worksheets as guidance only and the use of them is voluntary.

Rates Information

Taking into consideration the tight timeframe in the rate review process, OIR is thus providing a preliminary rate clarification letter for issuers to answer located in the link below. Upon initial submission of the filing, please submit numbered responses to the following questions in a separate document.

Initial Filing Questions

Templates to be Submitted

An issuer should submit the following templates to the OIR as part of an issuer's Florida filing:

- Plan Data Template*
- ACA Experience Template
- HIV/AIDS Template (See HIV/AIDS Formulary)
- Drug Attestation (See Drug Formulary Attestation)
- Mental Health Parity Attestation
- Federal QHP Plans and Benefits Template
- Federal Prescription Drug Template
- Federal Unified Rate Review Template
- Federal Crosswalk Template
- Federal Summary of Benefits and Coverage
- Federal Business Rules Template
- Federal Network ID Template
- Federal Essential Community Providers/Network Adequacy Template
- Federal Rate Data Template
- Federal Service Area Template

**The Plan Data Template will need to be populated during the IRFS filing process. The template will be validated in IRFS against Federal Templates. A separate component has been created in IRFS specifically for the Federal Rate Data Template. When filing, allow yourself sufficient time to correct any errors or issues which might arise during the validation process.*

Non-Standard Plans

CMS has reduced the number of non-standardized plan options that carriers can offer consumers through Marketplaces on the Federal platform (including SBM-FPs) to two non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area, for Plan Year 2025 and subsequent plan years. As CMS is unable to provide meaningful estimates for the impacts of the limit of two non-standardized plan options for PY 2025 and subsequent plan years, OIR is asking carriers to carefully track these impacts and enrollment data to understand its impact on the market.

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Additionally, under the limit on the number of non-standardized plan options that issuers can offer, CMS will permit additional flexibility specifically for plans focusing on certain health conditions. When submitting plans for Plan Year 2025, carriers should clearly identify which plans they are seeking to qualify for this additional flexibility outside of the reduced non-standard limit.

Drug Formulary Attestation

Per the final Notice of Benefit and Payment Parameters for 2025, OIR continues to be charged with the preliminary enforcement authority to monitor a plan's drug formulary and ensure the plan's benefit design is not unfairly discriminatory. In order to facilitate the OIR's review of a plan's drug formulary, an officer or director of the issuer may submit an attestation with its filing confirming the policy form's compliance with 45 C.F.R. § 156.122, regulating Prescription Drug Benefits, and 45 C.F.R. § 156.125, Prohibiting Discrimination, as well as an explanation of how the insurer has determined that its coverage of HIV/AIDS medications and medications for other chronic conditions (see next Section below) is substantially similar to the safe harbor plan or is otherwise compliant with Florida and federal law. Additionally, insurers are reminded of the requirements of Florida's Prescription Drug Reform Act (SB 1550), as outlined in Florida Statutes and Informational Memorandum OIR-23-01M.

The OIR is prohibited from certifying a plan to be included on the Federally-facilitated Marketplaces if the OIR knows that the plan employs a drug formulary discriminatory in benefit design, benefit implementation, or medical management techniques.

The attestation referenced above is available on the OIR website by clicking here: Drug Formulary Attestation

HIV/AIDS Formulary

For the 2025 plan year, the OIR will continue to monitor the coverage of medications for those living with HIV/AIDS. Sections 627.429 and 641.3007, F.S., specifically prohibits treating those living with HIV/AIDS less favorably than any other condition. Designing benefits or drug formularies that limit access to drug regimens for HIV/AIDS violates these statutes.

A health plan is required to be substantially similar in its scope of benefits to the state's benchmark plan and may not unfairly discriminate in benefit design, in the implementation of its benefit design, or medical management technique.

The OIR will consider a health plan's formulary compliant with these provisions of Florida and federal law if the tiered formulary of HIV/AIDS medications is at least as favorable as the safe harbor plan.

The safe harbor referenced above is available on the OIR website by clicking here:
HIV/AIDS Formulary Template

Compliance with the safe harbor guidelines is not mandatory. However, the OIR is prohibited from certifying a plan to be included on the Federally-facilitated Exchanges if the OIR knows that the plan employs a drug formulary discriminatory in benefit design, benefit implementation, or medical management techniques. Additionally, the OIR will disapprove any plan it finds violates sections 627.429, 641.3007, or 641.31(3)(c)6., F.S.

Emergency Room Coverage

Sections 627.6405, 627.662, and 641.31097, F.S., respectively provide health insurers and health maintenance organizations a mechanism to discourage the inappropriate use of emergency departments for nonemergency care. Carriers and HMOs may require higher copayments for urgent care or primary care provided in an emergency department and may require higher copayments for use of out-of-network emergency departments. Florida Statutes prohibit charging higher copayments for the use of the emergency department for emergency care, as defined in section 395.002, F.S., and services provided to rule out an emergency medical condition.

Mental Health and Substance Use Disorder Benefits and Parity Coverage Requirements

Carriers are reminded that all individual and small group health plans shall at minimum include coverage for the essential health benefit categories identified in Section 1302(b) of PPACA. One category of essential health benefits is mental health and substance use disorder services, including behavioral health treatment.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act, generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that financial requirements and treatment limitations on mental health and substance use disorder benefits be provided in a manner that is no more restrictive than those applied to medical and surgical benefits. (*See* 78 F.R. 68240 (November 13, 2013)).

In order to facilitate the OIR's review, an officer or director of the issuer shall submit an attestation with its filings confirming the insurer's compliance with applicable mental health parity requirements, as well as an explanation and demonstration of how the insurer has determined that is in compliance with the requirements and any supporting documentation. The attestation form is available at Mental Health Parity Attestation.

Telemedicine

All health insurers, health maintenance organizations, and other health entities are encouraged to broaden access telehealth services to help alleviate hurdles for Floridians attempting to utilize telehealth services to receive needed care, as defined in section 456.47(1)(a), Florida Statutes. OIR believes innovative use of technology can provide Floridians more options to receive critical care.

Smoking Surcharge

Please note that federal law prohibits the sale of tobacco products to any person under the age of 21 in accordance with FFDCA § 906(d)(5) and 21 U.S.C. § 387(f)(d)(5). Going forward, carriers are advised to remove any tobacco charge in pricing to enrollees below the age of 21. Issuers must still comply with the methodology in 45 CFR 147.102.

Experience Pooling

In accordance with section 627.410(6)(e)3., F.S., and Rule 69O-149.003(1)(a), FAC, the experience of all non-grandfathered health insurance policy forms in a rate filing that provide similar benefits, whether open or closed, shall be combined unless otherwise permitted. This requirement applies to health insurance policies, including dental policies.

Taxes and Fees

The Health Insurer Tax set forth in PPACA Section 9010 and 26 C.F.R. § 57 has been repealed. Therefore, plans should not reflect the tax in their rate filings.

Experience Reporting

Please provide historical experience since 2021 on a *quarterly* basis. All experience exhibits should be filed in Excel with active formulas for all calculated values and projections. Historical and future Florida experience should be provided in the format outlined in Rule 69O-149.006(3)(b)23., FAC. Please note the Sample Experience Exhibit has been added to the Data Template. Please fill out the fourth tab of the Data Template.

Rate Collection System

The data collection template is generated during the IRFS filing process and must be completed before submitting the filing for review. When filing, allow sufficient time to complete this information before the deadline.

Trade Secret Prompt

For all PPACA-related filings, a pop-up prompt will appear when initially submitting a filing or submitting materials into an existing filing. The prompt reminds users to ensure all items intended to be marked trade secret are marked accordingly and are uploaded with a signed affidavit in accordance with Florida regulations. The prompt specifies the requirements that must be satisfied and lists all materials the user identified as trade secret.

Guaranteed Renewable Insurance and Uniform Modifications of Coverage

Changes to plans and products may be made only in accordance with the HHS Uniform Modification of Coverage regulations or the state and federal guaranteed renewability regulations.

If a change in coverage is not a Uniform Modification of Coverage, the guaranteed renewable provisions in sections 627.6425, 627.6571, and 641.31074, F.S., will apply.

Transitional Policies

The OIR will continue to work with any company that chooses to continue coverage in accordance with the transitional policy to facilitate the continuation of coverage for Floridians in accordance with the March 23 CMS bulletin or any additional extensions by CMS, if applicable.

No Surprises Act/Transparency

The Consolidated Appropriations Act (CAA) was enacted on December 27, 2020. Title I (No Surprises Act) and Title II (Transparency) of Division BB of the CAA amended Title XXVII of the PHS Act by establishing new protections for consumers related to surprise billing and transparency in health care. The OIR encourages issuers to familiarize themselves with the new market-wide reforms, and ensure any contract language does not contradict such reforms.

Anti-Fraud and Cybersecurity

Carriers are reminded, in accordance with section 626.9891, F.S., every insurer in the state must establish and maintain a designated anti-fraud unit or division within the company and electronically file with the Department of Financial Services, Division of Investigative and Forensic Services of the department, and annually thereafter, a detailed description of the designated anti-fraud unit or division or a copy of the contract. The OIR encourages issuers to familiarize themselves with the statute and ensure all filings are up-to-date.

In accordance with section 501.171, F.S., insurers must take reasonable measures to protect and secure data in electronic form containing personal information and report any breach of security affecting 500 or more individuals in this state. Notice to OIR may be provided by emailing DataBreachNotifications@floir.com.

Data Change Request (DCR)

Please ensure filings are correct and complete prior to the final approval and closing of the filings. The OIR will work diligently with all carriers to ensure any/all revisions the company wishes to make during the filing window are processed. The OIR does not intend to approve any Data Change Requests after the filing window has closed on August 14, 2024. This includes changes to the Plans and Benefits Template and Plan name discrepancies, so please confirm the accuracy of the filings prior to closing.

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For questions related to any of the above information, please contact the following staff:

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