

Filing Guideline for 2017 ACA Forms and Rates

1. The filing period will be from **4/11/2016 until 5/11/2016**. The Department will allow carriers to submit **rates** no later than **6/11/2016**. Carriers are welcome to file rates earlier than the **6/11/2016** deadline. Carriers filing QHP applications with CMS must submit a completed Rate Data Template in order for the application to be accepted by CMS. This filing period applies to individual, small group and stand-alone dental plans, for use both inside and outside the Marketplace. We are requesting that **Large Group** filings be submitted after August 1, 2016.

2. Tennessee is a FFM and carriers must follow the timeline set out by HHS (see below)

Initial FFM QHP Application Submission Window	4/11/2016 – 5/11/2016
Final Rates are Due	6/11/2016
CMS Reviews Initial QHP Application Applications	5/12/2016 – 6/10/2016
CMS sends 1st Correction Notice	6/15/2016 – 6/16/2016
Deadline for Submission of Revised QHP Data	6/30/2016
CMS Reviews Revised QHP as of 6/30/2016	7/01/2016 – 8/02/2016
CMS sends Second Correction Notice	8/08/2016 – 8/09/2016
Deadline for Final Submission of QHP Application data; Final Deadline for State Approval Deadline for All Risk Pools with QHPs to be in “Final” status In the Unified Rate Review (URR) System	8/23/2016
CMS Reviews Final QHP Data Received as of 8/23/2016	8/26/2016 – 9/16/2016
States Send CMS Final Plan Recommendations	9/08/2016
CMS sends Certification Notices to Issuers	9/15/2016 – 9/16/2016
Issuers send Agreements and Plan List to CMS	9/19/2016 – 9/23/2016
CMS sends Validations Notice to Issuers	10/03/2016 – 10/04/2016
Open Enrollment	11/1/2016 – 1/31/2017

3. The deadline for approval by the Department is **August 23, 2016**.

4. Each plan variation, such as copay versus coinsurance, deductible only, or open or closed networks must have a separate schedule page, rates, actuarial memorandum, and actuarial value calculation.

Each variation does not require a separate filing, but may be combined with the appropriate policy or certificate of coverage. There may be no language variations in the schedules but the deductibles, copays, coinsurance, etc. may be bracketed with the range of number variables.

5. Substitution of EHBs will not be allowed.

6. Filing instructions for 2017 products:

- A. All filings are required to be made via SERFF.
- B. Individual and small group forms and rates may not be combined in the same filing. Do not file large and small group forms and rates together.
- C. Each filing must include the following information:
 1. Identification of where the plan will be sold (i.e. Marketplace, outside the Marketplace or both) Note: Identification includes the rating area(s) where the plan will be sold. A carrier participating in a designated rating area must make coverage available throughout the entire rating area;
 2. If the filing is for use on the Marketplace, the QHP Data Collection and all Federal Templates need to be included in the filing. A Stand-alone dental filing does not have to include the Uniform Rate Review Template;
 3. Identification of the coverage level for each benefit design for a health plan (i.e. bronze, silver, gold, platinum);
 4. Use of the “binder” method of filing products and plans is required for plans in the Marketplace, both medical and dental;
 5. A separate schedule with the language for each plan design that is to be offered, numerical amounts may be bracketed;
 6. Rates must be submitted using the Unified Rate Review Template;
 7. The Actuarial Value of each plan design must be submitted, including a screen shot of the Actuarial Value Calculator;
 8. Certification that the health benefit plan’s prescription drug benefit meets the requirements listed in the 2017 Annual Letter;
 9. Medical Plans that are **only** offered outside the Marketplace do not have to create a binder. Filings must include the following templates: Unified Rate Review Template, Service Area Template, Rate Data Template, Plan and Benefits Template (this is the modified version) and Rating Business Rules Template. Please contact Brian Hoffmeister at brian.hoffmeister@tn.gov for a copy of the Modified Plan and Benefits template.
 10. Stand-alone dental filings that wish to be certified for off-Marketplace use, must create a binder and include all of the templates except the Unified Rate Review Template.

Important Notes

1. There is a new benchmark plan for Plan Year 2017. The new benchmark plan can be found at: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017_Benchmark-Summary_TN.zip
2. The Department expects that carriers will review the new benchmark plan for compliance.
3. With the new benchmark plan containing pediatric dental and vision benefits, there is no longer the need to use the FEDVIP plans to supplement these benefits. Carriers must meet or exceed the pediatric dental and vision benefits contained in the new benchmark plan.