Filing Guideline for Plan Year 2021 ACA Forms and Rates

1. The form filing period will be from **4/23/2020 until 6/17/2020**. The Department will allow carriers to submit **rates** no later than **7/15/2020.** Carriers are welcome to file rates earlier than the **7/15/2020** deadline. 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, 2020.

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

Initial FFM QHP Application Submission Window	4/23/2020 – 6/17/2020
Forms are Due	**6/17/2020**
Final Rates are Due	**7/15/2020**
CMS Reviews Initial QHP Application Applications	6/18/2020 – 8/12/2020
Final deadline for issuer changes to QHP Application **Final Deadline for State Approval for both Forms and Rates**	**8/19/2020**
Final CMS Review of QHP Applications	8/20/2020 – 9/10/2020
CMS sends Certification Agreements to Issuers	9/15/2020
Issuers return signed QHP Certifications to CMS	9/15/2020 – 9/23/2020
State sends CMS final plan recommendations	9/15/2020 – 9/23/2020
Limited Correction Window	9/17/2020 – 9/18/2020
CMS sends Certification Notices to issuers	10/5/2020 – 10/6/2020
Open Enrollment	11/1/2020 – 12/15/2020

3. The deadline for approval by the Department is **August 19, 2020**.

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 Plan Year 2021 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. 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.
        9. 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.