Frequently Asked Questions for PY2025 Review

New PID's Annual Supplemental Template (PAST) – PY2025

1. The PID appreciates each insurer's approach to designing their ACA complaint plans, recognizing that each plan may cover benefits outside of the PA Benchmark Essential Health Benefit plan. The PAST template was created by the PID to supplement information provided within other templates for ACA compliant plans and Qualified Health Plans and will contribute to the efficiency of the PID's form and rate review.

   Each insurer will have the opportunity to explain the benefits which may be available within each of their plans, as well as explain other important features of the plan functions (e.g., prior authorization program and transparency in coverage URLs). If an insurer/plan does not cover specific items or services, this template also collects that information to aid the PID in the review process.

Benefit Package Tab of the PAST

2. In some instances, CPT code examples have been added to the benefit information field to help explain the benefits which may be considered under a specific category of services. Issuers may cover CPT codes beyond those listed and are not restricted to reporting on only the listed CPT code examples if the issuer covers a broader spectrum of benefits under that service category. If the issuer wants to provide additional information to explain the benefit, the issuer may add that information to column H. Column H is an optional field for issuers to supply more information regarding the benefit.

3. If an issuer does not cover a benefit or benefits within a service category, the issuer should include additional information about the exclusions in column G.

4. In some instances, the Department is specifically requesting information regarding a preventive health benefit; in those instances, column A will specify the category of services as "preventive services" and therefore the information should be provided specifically for preventive services within that category of services (e.g., colorectal screening, OTC birth control, colonoscopy, long-acting injectable preexposure prophylaxis, etc.).

5. The Department does not expect issuers to include any cost sharing information within the benefit explanation field (column H).

Formulary Tab of the PAST

6. Every benefit line is considered independently. For example, substance abuse medications should include all covered substance abuse medications broadly, even if other lines in the Formulary Tab of the PAST list out specific substance abuse medication such as Nasal Naloxone.

7. All general references to drug categories/classes or conditions treated should consider both single entity and combination drug products if applicable and unless otherwise noted (e.g., a specific drug line such as buprenorphine is specific to single entity buprenorphine).

8. Contraception is also addressed in more than one manner in the Formulary Tab of the PAST. One line is broadly referring to all covered "contraception" drugs. There are also specific contraception drugs listed out separately. As noted under item 1, every benefit line is considered independently.

9. Methadone is specifically referring to coverage of Methadone as Medication Assisted Treatment (MAT) for substance use disorders.

10. Gender Affirming Care Medications broadly addresses all drugs covered by an issuer under the gender affirming care benefit (as applicable). The Department provided examples, but issuers may cover drugs beyond what is specifically listed, and those drugs should also be counted/included in the PAST. If the issuer wants to provide additional information to explain the benefit, the issuer may add that information to column L (optional).

11. If there are any restrictions or limitations on ***any*** of the covered drugs for a particular line, the issuer should indicate "yes" in column J. If the issuer wants to provide additional information to explain the benefit, the issuer may add that information to column L. Column L is an optional field for issuers to supply more information regarding the benefit. For example, if an issuer covers most of the drugs in that line without any restrictions or limitations and only one specific drug in that category requires prior authorization, the issuer may include that detail in column L.

12. Additionally, if there are any restrictions or limitations on ***any*** of the covered drugs for a particular line, the issuer should indicate which **types** apply (i.e., specific information is not required). Quantity Limits (QL) if included in the formulary for the drug(s), Step Therapy (ST), and Prior Authorization (PA) are the only restrictions or limitations being addressed in this column. As an example, an issuer might include only "PA" if only prior authorization is applicable to a specific drug category line, or if both prior authorization and step therapy apply, the issuer would include "PA, ST" in the cell.

13. The Department is not requesting information on specific RXCUIs not covered or an explanation of why those RXCUIs are not covered in the PAST.

14. The Department does not expect issuers to include any cost sharing information within the benefit explanation field (column L).

15. The Department is not expecting insurers to submit more than one PAST-formulary template unless there are multiple formularies available; please submit only one per formulary (i.e., issuers may create more than one formulary tab-1, 2, 3, etc. to address multiple formularies).