OFFICE OF THE
COMMISSIONER OF INSURANCE
GOVERNMENT OF PUERTO RICO

March 7, 2025

**RULING LETTER NO. CN-2025-367-AS**

TO ALL DISABILITY INSURERS AND HEALTH INSURANCE ORGANIZATIONS WRITING HEALTH INSURANCE PLANS IN PUERTO RICO

**FORM AND RATE FILINGS SUBMISSIONS TO BE EFFECTIVE FOR CALENDAR YEAR 2026**

Dear Sirs and Madams:

In accordance with Chapters 8 and 10 of the Health Insurance Code of Puerto Rico ("HICPR"), Disability Insurers and Health Insurance Organizations (including, "HMOs") that write individual and small group health plans, including small groups health plans for bona fide associations, in Puerto Rico must submit to the Office of the Commissioner of Insurance ("OCI") each year, for review and approval, all the forms and rates in relation to metallic plans, all rates for metallic plans even if no change has been made, and rate increases equal to or greater than 10% of current rates. The requirements to file rates with the OCI, as set forth in Section 19.080(2)(a) of the Puerto Rico Insurance Code, 26 L.P.R.A., sec. 1908(2)(a), must be complied only by HMOs writing health coverage in the individual and small group market and all rate changes or modifications, including all rates for metallic plans, must be filed even if no change has been made.

To implement appropriate guidelines to promote an orderly form and rate filing submission for metallic plans to be effective on January 1, 2026, the OCI is hereby implementing the following standards:

IMPORTANT UPDATE NOTICE: NEW REGULATIONS AND HEALTH BENEFITS HAS BEEN IMPLEMENTED BY LAW: Read Carefully. This letter contains twelve (12) attachments and important updates regarding Forms and Rates requirements for 2026 metallic plans. The use of outdated checklists and forms may result in a delay in the review and approval process of your filing. The noncompliance of one or more of the

requirements of this letter will result in the rejection of the filing. Therefore, if the filing was rejected after the intake process and after the deadline date, the submission will be considered as not in compliance with the established submission deadline.

Every health plan insurer and health services organization must strictly comply with the norms, rules and provisions of law established herein and with all the requirements established by the Actuarial Analysis Division that are applicable by law. Legal consultations that may arise from any insurer must be presented to the Commissioner through the legal consultation process established in the Ruling Letter CN-2013-154-PA of June 20, 2013. The review process of medical plans will not be stopped for matters corresponding to pending queries. If you do not comply with what is established in this letter and what is required by the Actuarial Analysis Division, the filing will be disapproved.

## I. Rates Submission

### A. Timeline

Rate filings for non-grandfathered Individual plans that will be effective on January 1, 2026 must be submitted to the OCI on or before May 31, 2025. **The OCI will not guarantee the approval of the submitted rates for individual plans before October 1, 2025, if the carrier does not comply with the established submission deadline.** Regardless of the date on which the preliminary review (Intake Process) of the submission is carried out, if the filing has to be returned to the carrier because the use of outdated checklists or non-compliance with the requirements of this letter, then the submission will be considered as not in compliance with the established submission deadline. As previously informed by the OCI, carriers must obtain approval of the metallic plans rates and forms before October 1st of each year. Carriers whose rates and forms have not been approved before October 1, 2025, will have to market, and make available for everyone, all of their metallic plans in the individual market, without a waiting period, throughout the open enrollment period (October 1 to December 31, 2025) and the entire year 2026, instead of just the open enrollment period.

Rate filings for non-grandfathered Small Group plans, including small group health plans for bona fide associations, must be submitted to the OCI on or before July 1,

2025.carrier[1] wishing to have quarterly rate changes on small group plans, including small group health plans for bona fide associations, in 2026 must file rates for all quarters on or before July 1, 2025. **The OCI will not guarantee the approval of the submitted rates before November 1st for small group plans, if the carrier does not comply with the established submission deadline.**

Grandfathered individual and small group rate increase for HMOs and rate increases over 10% for Disability insurers must be filed at least ninety (90) days before they are to be used.

**B. Rate Filing Submission Requirements**

1. Every filing should be properly submitted through the SERFF system, **including all the information required in this ruling letter and its attachments**. See SERFF Rate Filing Submissions Instructions in Section I(F) of this ruling letter.

2. Rates for additional optional benefits by endorsements (if applicable) must also be submitted in the Rate Schedule tab in SERFF.

3. All Excel files should also be submitted also in PDF print out format.

4. All rate filings should be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (See Attachment 1).

5. The Federal Rate Review Justification Part I - Unified Rate Review Template (URRT) must be submitted in Excel and PDF under the corresponding Tab in SERFF (See Attachment 2). The PDF version must show all the submitted plans as shown in the Excel version. The PDF and Excel document must be identified as: "Unified Rate Review Template (URRT)"

6. The following documents must be included as part of the rate submission under the Supporting Documentation tab in SERFF (Please identify each document in SERFF with a name that match with the content of the document, otherwise the filing will be returned without evaluation and will not be considered received):

[1] Term use in this ruling letter to refer to a Disability insurer and an HMO.

a. Actuarial Memorandum shall comply with the requirements of Puerto Rico, and Part III Actuarial Memorandum and Certification Instructions (See Attachment 3). **The Actuarial Memorandum must be structured in the same format and order established in the mentioned Part III**. The PDF document must be identified as: "Actuarial Memorandum and Certification"

b. Puerto Rico Actuarial Certification (should be identified as "Certification of Data Accuracy";

c. Actuarial Value Calculator Screenshots (for metallic plans only). Each plan must be identified with the name of the plan and its corresponding metallic level (i.e. Bronze, Silver, Gold, and Platinum). The screenshots must be submitted in Excel and PDF. Also, the PDF version of each AV Calculator must be fitted in only one page, as shown in the Excel version. The Actuarial Value Calculator to be used is the HHS 2014. If the filed rates apply to a POS plan, the actuarial value calculator must be properly completed; The PDF and Excel documents must be identified as: "AV Calc (name of the plan – metallic level)

d. SERFF Rate template in Excel and PDF (**one metallic plan per page**). The template must include the effective date of the rates. Also, the Plan Id column of the template must include the name of the plan with its respective metallic level;

e. Rate Manual. The manual must include the following:

   i. Quantitative development of the complete process to determine the final rate. This must include a detail explanation of the process from the base rate to the final rate of each of the submitted plans.
   ii. Each factor used in developing the rates,
   iii. Each adjustment factor used to determine the rates,
   iv. The federal standard age curve, and
   v. An illustrative example of the calculation of the family rate;

f. Puerto Rico Benefits Map in Excel and PDF. The Benefit Map must include for each proposed plan the benefit package to be offered by the carrier for the Small Group and Individual markets. (See Attachment 4); The PDF and Excel documents must be identified as: "Benefit Map"

g. Puerto Rico 2025 updated Rate Filing Checklist. The use of a checklist from previous years will result in a rejection of your filing. For each item that does not apply to the filed plan, the Actuarial Memorandum must explain the reasons for not applying. All separate documents required in this checklist must be identified as follows and the content must match with the name of the document, otherwise the filing will be returned without evaluation: (See updated 2025 Attachment 5) The PDF document must be identified as: "Attachment 5 Rates Checklist"

    i. Comparative Table Rate Increase;
    ii. Calculation demonstration of Rate Increase;
    iii. Current &Proposed Age Dist.;
    iv. Quantitative dev. of Factors for rating;
    v. Comparative Table Cost Sharing Changes;
    vi. Quantitative dev. of New EHB;
    vii. Quantitative dev. of optional additional benefits;
    viii. Quantitative dev. - Prescrip. Drug cost sharing design;
    ix. Quantitative demonst. Paid to Allowed;
    x. Quantitative dev. of plan adj. index rate;
    xi. Quantitative dev. of consumer adj. premium rate.

h. Public form of the rate filing information to be placed on the OCI (OCS) website.

i. Certification of Unique Plan Design. If the plan has a unique plan design that does not work with the Federal Actuarial Value Calculator, a certification of Unique Plan Design shall be attached to the Supporting Documentation tab on SERFF. The insurer must use the template for this certification provided by Centers for Medicare and Medicaid Services (CMS). For details refer to Section VII of Attachment 1. The PDF document must be identified as: "Certification of Unique Plan Design"

j. If applicable, present in Excel and PDF separate evidence of the experience with any additional benefits to the basic coverage that is included in the policy without additional cost to the insured as an added value.

k. A copy of Attachment 8 – Table of Copayment, Coinsurance and Deductibles (see instruction under Section II B(7)(e) in this letter)

7. In compliance with the provisions on rate increases for medical plans required in Sections 10.050(B),(E) and (H) of the Health Insurance Code, if after conducting an analysis of the increase, our Office understands that the richness of the benefits of the plan under our consideration was reduced by the insurer or health service organization in comparison to that of the prior year plan, resulting in the rate increase being unreasonable in relation to the benefits provided and the population that is expected to be covered, will be grounds for denying the rate increase. Reduction in benefit richness means a decrease in covered benefits, an increase in copayments, coinsurance and deductibles applicable to the insured, changes less favorable to the insured in the terms of the plan and additional limitations in the plan.

8. If a rate increase includes coinsurance of 90% or more in the first level of coverage of the Prescription Drug benefit and this Office demonstrates that in the AV Calculator there is a more favorable combination of copayments and coinsurance for the insured without changing the metallic level of the plan, the insurer or health services organization must place the most favorable combination of copayments and coinsurance for the insured, without this resulting in an additional increase in the rate. Failure to do so will be grounds for denying the rate increase.

**C. Use of Approved Rates and Prospective Revisions**

1. The carriers **must only use** the rates filed and approved by the OCI.

2. Lower or higher rates cannot be used, even if the revised rate is on a group level and the rate is not higher than the approved one. Please note that audits will be made to verify that only approved rates are being used.

3. Carriers will not be allowed to implement rate changes to current rates before January 1, 2026, unless a carrier can justify the OCI that their financial solvency will be dangerously low without a rate change.

4. Once rates are approved, they cannot be changed during the year.
5. For the small group market, including small group health plans for bonafide associations, if the rates are increased on a quarterly basis they should be pre-filed all at the same time. No other quarterly rate increases will be accepted.

**D. Rates to be made Public**

The following documents will be published on the OCI website, after the approval of the rate submission:

a. The rates structures (SERFF Rate Template),
Preliminary Justification Part II: Written explanation of any rate increase that is 10% or over; The PDF document must be identified as: "Preliminary Justification Part II" (The information to be submitted in this document must include at least the information required in the five (5) requirements established in Attachment 5.)

**E. Grandfathered Rates Submission**

1. Every filing must be properly submitted through the SERFF system, including all the information required in this ruling letter and its attachments, as applicable. See SERFF Rate Filing Submissions in Section I(F) of this ruling letter.

2. All Excel files must be submitted in both Excel format and PDF print out format.

3. All HMOs rate increases and all Disability insurers rate increases equal to or greater than 10% of rates one year prior must be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (See Attachment 1).

4. The documents previously mentioned in Section I(B)(5) and (B)(6) of this ruling letter must be included as part of the rate submission.

**F. SERFF Rates Filing Submissions**

1. Every SERFF filing **must include the correct Type of Insurance (TOI), Sub-Type of Insurance (Sub-TOI), Market Type and Filing Type**. Incorrect TOI, Sub-TOI, Market Type, or Filing Type **will result in the filing's rejection without evaluation**.

2. SERFF filings must comply with Circular Letter No. CC-2015-1870-AV/AS of December 1, 2015 entitled "General SERFF Instructions for Form and Rate Submissions". Please read carefully the mentioned circular letter before any submission.

3. SERFF filings shall be accompanied with a Transmittal Letter including the name of the carrier making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico.

    i. The transmittal letter must be attached in the "Supporting Documentation Tab". The PDF document must be identified as: "Cover Letter". If the cover letter has to be revised by the insurer, the new version must be identified with the revision date.

    ii. The carrier must identify in the transmittal letter all the metallic levels of the rates being submitted. For example: "we are submitting rates for two (2) Silver plans and one (1) Gold plan for a total of tree (3) metallic plans."

    iii. The transmittal letter must include the filing number of the previously approved rate filing, the filing number where the Forms applicables to the rates are being reviewed, the rate increase percent requested by plan and overall and, if applicable, identify any optional benefit rates.

4. All the fields required in the "Rate/Rule Schedule Tab" must be completed. **A failure to complete them will result in the filing's rejection without evaluation.**

5. All supporting documentation must be included in the "Supporting Documentation Tab", including the Puerto Rico Actuarial Memorandum, Federal Actuarial Memorandum and Certification, Puerto Rico Actuarial Certification, Exhibits (if applicable), Actuarial Value Calculator Screenshots, Rate Manual, Puerto Rico Benefits Map, and the Puerto Rico Rate Filing Checklist.
6. The submitted rates to be approved must be included in the "Rate/Rule Schedule Tab".

7. Documents **must be saved in a non-protected PDF and Excel format**, as applicable, so that the file remains searchable and text can be copied from the document. **The submission of protected documents will prevent the filing's approval. It is the carrier's responsibility to verify before the filing's submission that all documents comply with this item.**

8. Every communication (e.g. any request for additional time to respond to an objection letter, any request of status) must be included in SERFF as a "Note to Reviewer". Every objection letter must be answered by means of a "Response Letter". The OCI will not accept responses to objection letters in a "Note to Reviewer". Other ways of communication will **not** be deemed as received.

## II. Forms Submissions

### A. Timeline

Forms filings for non-grandfathered individual plans that will be effective on January 1, 2026, must be submitted to the OCI on or before May 31, 2025. **The OCI will not guarantee the approval of the submitted forms before October 1, 2025, if the carrier does not comply with the established submission deadline**. As previously informed by the OCI, carriers must obtain approval of the metallic plans rates and forms before October 1st of each year. Carriers whose rates and forms have not been approved before October 1, 2025, will have to market, and make available for everyone, all their metallic plans in the individual market, without waiting period, throughout the open enrollment period (October 1st to December 31st, 2025) and the entire year 2026, instead of just the open enrollment period.

Form filings for non-grandfathered small group plans, including small group health plans for bona fide associations, must be submitted to the OCI on or before July 1, 2025.

**B. Forms Filing Submission Requirements**

1. As a reminder, we inform you that the annual submission of the metallic level plans is considered by our Office as a new product and therefore entails a comprehensive evaluation in its entirety. Therefore, any policy language in the forms that in the opinion of the analyst or the OCI or in accordance with the Insurance Code and the Health Insurance Code represents vague, unclear, or ambiguous language that may lead to error, confusion or misunderstanding will be pointed out to the insurers in a uniform way or in a specific way depending on the case that applies, regardless of whether said language has been approved in previous years. The approval of any policy language in a given year does not bind the OCI's evaluation of said language in subsequent years and does not bar a further review or revision or disapproval of the language in future filings or submissions.

2. Every filing must be properly submitted through the SERFF system and **include all the information required in this ruling letter and its attachments**. See SERFF Form Filing Submissions in Section II(G) of this ruling letter.

3. No endorsement to modify a previously approved metallic plan will be accepted.

4. Optional endorsements with additional benefits are accepted, as long as they are consistent with the coverage of the health plan and comply with the provisions of the Puerto Rico Insurance Code and Health Insurance Code. Rates must be filed concurrently with forms.

5. Attachments must be submitted in Adobe Acrobat (PDF) format unless another format is specifically required by a Reviewer or by this Ruling Letter. If a Reviewer requires that an attachment be submitted in another format (e.g., Excel), an additional copy of the attachment with the same name must also be submitted in PDF format. Scanned documents will not be accepted.

6. In compliance with Act No. 162 of December 30, 2020, which requires that the evidence of coverage and the medical plan identification card is provided in the Braille system for blind subscribers; the insurer shall submit a Certification of translation within the next sixty (60) days from the date of approval of this filing via new SERFF filing under the Supporting Documentation tab. The cover letter of the translation should make reference to the tracking number of the approved filing. You are advised that failure to comply with the aforementioned provisions of law will entail the imposition of sanctions.
7. The following documents must form part of the form submission:

    a. Essential Health Benefit and Preventive Services 2025 updated Checklist (See Attachment 6); The PDF document must be identified as: "Attachment 6 EHB & Prev. Serv. Checklist"

    b. Puerto Rico Form Filing 2025 updated Checklist (See Attachments 7A or 7B); The PDF documents must be identified as: "Attachment 7A Indiv. Checklist" o "Attachment 7B Group Checklist"

    c. Drug Formulary in accordance with the Essential Health Benefit Benchmark for Puerto Rico, if applicable. The formulary must be in final print format as it will be delivered to the insured. The PDF document must be identified as: "Drug Formulary"

        i. The formulary shall include a complete list of all covered drugs, including any tiering structure that it has been adopted and any restrictions on the manner in which the drug can be obtained and in a manner that is easily accessible to insureds, prospective insureds, OCI, and the general public.

        ii. The drugs in the formulary must be grouped into the same categories as the Essential Health Benefit Benchmark for Puerto Rico.

        iii. **The drug formulary filed with the forms must be the final formulary negotiated with the PBM and the one to be used by the carrier during the entire 2026**.

iv. A comparison between the current drug formulary and the proposed drug formulary must be presented in order to identify the differences between the two. Also, must include an explanation of the changes made to the drug formulary.

v. Regarding updates and changes to the formulary between the current coverage and the new coverage, a written statement must be submitted, in accordance with Article 4.050(C) of the HICPR, with the information on which the Pharmacy and Therapeutics Committee based any update. In addition, it must specify which changes, if any, are due to safety reasons, or because the manufacturer of the prescription drug cannot supply it or has withdrawn it from the market.

vi. For our information, you must submit Annex C - Form CSS-AS-04-003 entitled Report on Medical Exception Requests of Circular Letter CC-2013-1832-D. The period requested will be the contract year prior to the contract submitted for approval. In the case of denied medical exception requests, the reasons for the denial and the contract provisions on which such denial was based must be specified in a separate document.

vii. Once the formulary is marked with the Received and Filed stamp, it cannot be changed during the year, except for the changes allowed by Section 4.060(2) of the HICPR.

The carrier's website cannot require the individual to create or access an account or enter a policy number to view the formulary. If the carrier offers more than one plan, then the website must identify which formulary drug list applies to which plan.

d. Providers Directory (The Directory must be in final print format as it will be delivered to the insured.) The PDF document must be identified as: "Providers Directory"

e. Table of Copayment, Coinsurance and Deductibles to be published in the OCI website (See Attachment 8 – 2025 updated). A copy of Attachment 8

must also be submitted in the Rate filing applicable to the Forms filing. Please note that this table does not replace the table of copayment, coinsurance and deductibles that must form part of the contract. The table of the contract must include the cost sharing for each covered service. This table must be submitted in a way that when printed the same it can be legible (size of the letter no less than 10 point). The PDF document must be identified as: "Attachment 8 Copayments Table"

The copayment table "Attachment 8" may not be altered or modified by any insurer. We have revised Attachment 8 for greater uniformity in the review process. Any insurer interested in publishing on their respective digital platforms or media, in an optional manner, a copayment table other than attachment 8 may submit it to the OCS for information purposes, and must also certify that it is a true and exact copy of the copayment table established in the policy. Said table will be subject to compliance with Articles 27.050 of the Insurance Code and Article 13 of the former Rule No. 102 of the Regulations of the Insurance Code of Puerto Rico, as amended and renumbered by Rule No. 110 entitled: "RULES TO REGULATE ELECTRONIC TRANSACTIONS IN THE INSURANCE BUSINESS".

Instructions for completing attachment 8 are as follows:

1. The table will not be modified to add or delete fields.
2. The table will be presented only in Spanish.
3. In the fields or services where the word "if applicable" appears, you must eliminate only the word "if applicable" when the service or field in the table applies to your plan design.
4. The table must be completed only with numerical values, except when a service or field is not applicable, in which case "N/A" must be entered.
5. When copayment applies, the dollar sign ($) and the applicable copayment amount must be entered.
6. When coinsurance applies, the percentage sign (%) and the applicable coinsurance amount must be entered.
7. When deductible applies, the dollar sign ($) and the applicable deductible amount must be entered.
8. No boxes or fields must be left blank.

9. If the insurer charges a lower copayment or coinsurance in a preferred network or facility, it must not include in the table of copayment and coinsurance the commercial name or marketing name of the preferred network or facility.
10. The Prescription Drug coverage will include the applicable copayments or coinsurance according to the coverage design of your plan. Any field that does not apply must fill in the space with an "N/A."
11. If the cost sharing design of the prescription drug coverage of an insurer allows for a combination of a coinsurance with a minimum or maximum copayment, then you must input the applicable coinsurance in the column named "copayment/coinsurance", and in the next column identified as "min/max copago" you must input the minimum or maximum applicable copayment. For example: (30% - min $25).

f. Puerto Rico Contraceptives Methods Checklist (See Attachment 9). The Coverage of FDA-approved Contraceptive Products includes but is not limited to the list in Attachment 9. The PDF document must be identified as: "Attachment 9 Contraceptives Checklist"

g. Prescription Drug EHB-Benchmark Plan Benefits by Category and Class (See Attachment 10) The PDF document must be identified as: "Attachment 10 Prescription Drug Count"

h. Pharmacy and Therapeutics Committee Certification of Compliance – Drug Formulary Classes and Categories (See Attachment 11) The PDF document must be identified as: "Attachment 11 Certification Pharmacy Committee"

i. Prescription Drug Formulary Non-Discrimination Certification of Compliance – (See Attachment 12) The PDF document must be identified as: "Attachment 12 Certification Drug Formulary"

j. Completed and signed certification on compliance with the pharmacy and therapeutics committee (Article 4.050), Form CSS-AS-04-001. This document is found as Attachment A to Circular Letter CC-2013-1832-D of July 10, 2013.

8. All metallic plans and the copayment and coinsurance structure must be filed concurrently and cannot be changed during the year.

9. The metallic plans to be effective for calendar year 2026 must provide that any cost-sharing involved with the prescription drug benefit is included in the overall Maximum Out of Pocket (MOOP) total calculation. This Office has determined that the annual MOOP limit for calendar year 2026 is $6,350 for individual coverage and $12,700 for all other coverage.
10. During the open enrollment period, carriers must market all their metallic plans approved by the OCI; provided that carriers who voluntarily decide to offer their metallic plans outside the open enrollment period must market all said plans during the whole year 2026 and must not limit said marketing to special enrollment (qualifying events) instances. Additionally, the transmittal letter must disclose that the carrier voluntarily decided to offer or not during the whole year 2026 all the metallic plans approved by the OCI.

11. Essential health benefits discrimination is not allowed. One example, without excluding others, of such discrimination has been observed in the maternity benefit. Plans that offer maternity benefits and dependent coverage are required to offer maternity coverage for dependents. The legal and regulatory standards for nondiscrimination in health-related insurance and other health-related coverage are applicable to individual, small group—including small group health plans for bona fide associations—and large group metallic plans, and to grandfathered and transitional health plans. *See* 45 CFR[2] Part 92.

12. A plan or issuer must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF[3] recommendation. As stated in the May 18, 2021 USPSTF recommendation, the follow-up colonoscopy is an integral part of the preventive screening without which the screening would not be complete. The follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing.

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[2] CFR – Code of Federal Regulations

[3] USPSTF – United States Preventive Service Taskforce

13. It is not allowed in the policy any exclusion of treatments and/or prescription drugs by generic or brand name that are to treat a specific disease when there is a state or federal law that requires coverage of treatments and/or prescription drugs for said disease.

14. An explanatory document must be presented with an adequate justification for any exclusion of medications and/or treatments by name in the policy related to a specific disease. In addition, the explanation must include the covered drug options offered by the insurer or health service organization in its drug formulary to treat said disease. Also must identify the class and category of each one and identify under which level the medicine is classified (generic, brand or specialized). The justification must be updated and applicable to the prescription drug benefit design proposed.

15. It is not allowed in the policy to impose more restrictive conditions related to mental health and substance use disorder services than with medical-surgical services in terms of documents and operation, in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

16. Each carrier is responsible for notifying providers about the ICD10 and dental health codes related to all the preventive services covered, in order to guarantee that such services are provided without cost sharing. Said codes must be published via the carrier's website for the attention of providers and consumers. **An updated evidence of compliance with this requirement must be presented as part of the submission in the Supporting Documentation Tab.**

    A print screen of the website showing the link where providers and consumers can access the information requested here is required as evidence.

**C. Clarifications of certain benchmark requirements, state and federal laws**

1. To confirm compliance with Section 48.050(B)(2) of the Health Insurance Code, the insurer must submit a sample communication letter that the insurer must send to a covered person requesting the allowable amounts associated with a specific procedure code and demonstrating how the insurer is going to inform the covered person of the portion of the allowed amount that the plan

will reimburse and the portion of the allowed amount that the covered person will pay, including an explanation that the covered person will be required to pay the difference between the allowed amount as defined by the plan of the insurer and charges billed by an out-of-network provider.

2. To confirm compliance with Section 48.050(B)(4) of the Health Insurance Code, the insurer must submit for our review the tool developed through its website that reasonably allows a covered person or a potential covered person to calculate the anticipated cost for services outside of network, based on the difference between the amount the insurer will reimburse for out-of-network services and the usual and customary cost of out-of-network services. The tool must be working at its full capacity and the relevant tests will be carried out to corroborate its operation.

   In addition to the above, the insurer must present the written communication sample letter that the insurer must send to a covered person or a potential covered person with the information that allows you to calculate the anticipated cost for out-of-network services, based on the difference between the amount the insurer will reimburse for out-of-network services and the usual and customary cost of out-of-network services.

3. Law 79-2020, Law 275-2012 and Law 107-2012 - Medical plans will not be allowed to implement any initiative that has the intention of limiting and dividing the dispensing of Cancer medications recommended by the doctor in accordance with the national clinical guidelines accepted by the oncology medical class, which represents a restriction, delay and unnecessary hindrance to the promptness, quality and efficiency with which medications are prescribed, treatments provided and diagnostic tests carried out on cancer patients.

4. We reiterate the obligation of all insurers and health care organizations to comply with applicable prescription drug essential health benefits (EHB) regulations, including those in 45 CFR[4] 156.122 throughout the year. For example, under 45 CFR 156.125, an issuer does not provide EHB if its benefit design, or implementation of its benefit design, discriminates based on age, expected length of life, present or anticipated disability, degree of

[4] CFR – Code of Federal Regulations

dependency medical, quality of life or other health conditions. Beginning January 1, 2023 (the start of the 2023 plan year) or upon renewal of any plan subject to this rule, whichever occurs first, a nondiscriminatory benefit design provided by EHB is one that is clinically based.

Additionally, health plans should not employ marketing practices or benefit designs that have the effect of discouraging the enrollment of people with significant health needs in them.

5. The OCS may determine whether a prescription drug coverage design is discriminatory and does not comply with essential health benefits based on the analysis of the coverage and the justifications for any exclusions. Therefore, all justification must contain at least the following elements:

    - Argument and support with evidence the design of the drug coverage and validate with specific data, statistics, scientific literature and experience that said design is not discriminatory against insured persons who suffer from serious illnesses, nor does it discourage these insured persons from subscribing to these plans.

    - How does the prescription drug coverage design comply with essential health benefits?

    - How does the drugs on your insurer's formulary are effective and work?

    - How do the drugs on the formulary meet the needs of the insured persons?

    - Why does the insurer believe that the drug coverage design does not discourage insured persons with serious health conditions from subscribing to the plan?

    - Why the insurer believes that the drug coverage design does not discriminate against insured persons with serious health conditions from enrolling in the plan?

- How the drugs offered in the formulary help improve the quality of life of insured persons with serious illnesses?

- What is the difference between the drugs in the formulary and the excluded drugs in terms of effectiveness?

- Why it is in the interest of insured persons with serious illnesses to use the drugs in the formulary presented?
- How the drug coverage design presented helps the insurer to maintain reasonable prices in the plans while maintaining a good quality of services?

6. We remind you that, in Attachment 10 of this letter, the insurer's Drug Formulary must have the same number of drugs or more in each class and category as the drug benchmark for Puerto Rico. We clarify that, to satisfy this requirement, drugs must be chemically distinct in order to be counted as more than one drug. For example, offering two dosage forms or strengths of the same medication would not be offering medications that are chemically different. Similarly, a brand-name drug and its generic equivalent are not chemically different.

7. Pursuant to 45 CFR 156.122, if the reference EHB plan does not include any coverage in a category and/or USP[5] class (count is zero), EHB plans must cover at least one drug in that category and/or USP class.

8. According to the Benchmark plan for Puerto Rico, all medical plans must include generic, brand, preferred brand, non-preferred brand and specialized medications in their prescription drug coverage. Furthermore, according to the benchmark, generic drugs are the first option. Therefore, if the generic version of a covered drug is not available, the health plan must cover the brand name version. In light of the above, exclusions in the health plan for brand name drugs are prohibited when the covered generic is not available.

9. We remind you that Article 4.070 of the Health Insurance Code recognizes the right of policyholders to request medical exceptions under certain circumstances described in the article itself related to non-coverage of

[5] USP – United States Pharmacopeia

prescription drug coverage. Therefore, medical plan exclusions intended to limit or discourage use of the medical exception process are prohibited.

10. According to the Benchmark plan for Puerto Rico, the rate to be paid by the insurer for coverage in the United States for cases in which equipment, treatment or facilities do not exist in Puerto Rico, will be the usual and customary rate of the geographic area where the service was provided. Additionally, the description of this benefit does not include a limitation on the choice of provider in the United States. Therefore, medical plans should not include limitations on coverage in the United States in the policy for the purpose of forcing the insured to obtain services through a provider network contracted in the United States by the insurer.

11. Pursuant to Section 26.050(C)(1) of the Health Insurance Code, in the event that a health insurance organization or insurer does not have a sufficient number or variety of participating providers to provide a covered benefit, such health insurance organization or insurer must ensure that covered persons or insured obtain covered benefits at the same cost that they would have incurred if they had obtained the service from participating providers.

    To ensure compliance with the above, the policy must establish that in the event that an insured is unable to obtain direct and fast access to a participating provider, including pharmacies, any covered benefit that the insured obtains from a non-participating provider and incur the entire cost of the service, including dispensing of medications through a pharmacy, will be covered by reimbursement to the insured at the same cost that they would have incurred if they had obtained the service from participating providers.

12. Pursuant to Section 2.050(A) of the Health Insurance Code, no insurer or health insurance organization providing group or individual health plans shall establish unreasonable annual limits on covered essential benefits or lifetime limits on covered essential benefits. Therefore, we remind you that limitations beyond those established in the Benchmark plan for Puerto Rico are not permitted for essential health benefits and especially pediatric vision and dental health services.

13. Pursuant to Section 2.050(D) of the Health Insurance Code, one of the essential health benefits is any other mandatory service or benefit required by state or federal law or regulation. Therefore, limitations on benefits by state or federal law beyond those established in the law itself are not permitted.

14. We want to clarify that the benchmark coverage identified as "Out of area coverage (US)" will not be interpreted as travel insurance coverage, nor as travel assistance service coverage. The benchmark clearly establishes that this coverage is for every medical plan to provide coverage in emergency situations in the United States and for cases in which the insured requires equipment, treatment and facilities not available in Puerto Rico. Rates to be paid are the usual and customary rate (UCR) of the geographical area in which the services are provided and would have to be paid directly to the provider.

15. Pursuant to subsection (B)(6)(c) of this letter, the version of the actuarial value calculator to be used is that of the year 2014. As everyone knows, the values used in the calculator correspond to copayments, coinsurance and deductibles presented in the Copayment, Coinsurance and Deductible Tables. For these purposes, we want to clarify that the benefit identified as "Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services" in the actuarial value calculator applies the copayment, or coinsurance of the service that appears in the Table of Copayments, Coinsurance and Deductibles identified as "Partial Hospitalization".

16. Attachment 10 of this ruling letter entitled "Prescription Drug EHB-Benchmark Plan Benefits by Category and Class" establishes the minimum quantity of drugs required for each category and class in the drug formulary of every medical plan. However, we remind you of the importance of recognizing the right of every insured person, in accordance with Article 4.070 of the Health Insurance Code, to request coverage for prescription drugs that are not listed on the formulary.

17. Attachment 6 of this ruling letter entitled "ESSENTIAL HEALTH BENEFIT AND PREVENTIVE SERVICES CHECKLIST" establishes, among other things, the types of medications required in the drug formulary of every medical plan. These are: Generics, Preferred Brand, Non-Preferred Brand and Specialty. Therefore, we

remind you of the importance of recognizing the coverage of prescription medications in all their presentations, that is, Generics, Preferred Brand, Non-Preferred Brand and Specialty.

18. All Health Plans must include the following class of medications on your drug formulary to comply with Act 62-2024 Hereditary Angioedema: "Hereditary angioedema agents."

19. Policy conditions or exclusions must be presented in a manner that is easy for anyone to read and understand. We remind you that Section 11.120(3) of the Insurance Code states the following:

> "The Commissioner shall disapprove a policy form, application, rider or endorsement, or withdraw his approval of it, only:
> ...
> (3) If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions that falsely affect the risk intended to be assumed in the general coverage of the contract."

In addition, Section 11.120(9) provides as follows:

> "The Commissioner shall disapprove or withdraw his approval of a policy form, application, rider or endorsement only:
> ...
> (9) If the conditions or exclusions of the policy limit insurance coverage, such that the sale of the policy would result in unjust enrichment on the part of the insurer."

20. The policy must contain all essential health benefits established in the Puerto Rico benchmark and those required by ruling letter or circular or regulation of the OCS or by applicable state or federal law, without limitations beyond those established in the mentioned regulation.

21. Regarding the proposed rate increases, we refer to the following paragraph in Attachment 3 of this ruling letter:

> "The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. All assumptions should be adequately justified with supporting data, where possible, or other rationale for the use of the chosen assumptions."

We remind you that all factors used in developing the rate must be reasonable and duly justified by the actuary. If it is deemed that the information submitted by the insurer is not sufficient, the filing reviewer will request additional information necessary for the approval of the increase.

22. Telemedicine – Any health plan that covers telemedicine services pursuant to Act 168 of 2018, as amended, must include in the policy the applicable copayment or coinsurance, if any. In addition, it must include a description of the benefit with instructions for accessing the service and an explanation of how to obtain the service.

**D. Use of Approved Forms**

1. Carriers **must only use** the forms filed and approved by the OCI, including the drug formulary, which forms part of the contract.

2. Once the forms are approved, they cannot be changed during the year.

**E. Benefits that are legislated during the year.**

If during the year 2025, after the issuance of this letter and before the completion of the health plans' review and approval process, the implementation of any new benefit is required by a state or federal law, ruling letter, circular letter, executive order, decree, or resolution; this Office will require that the language of the new benefit is incorporated in the policies pending approval. An insurer or health services organization is not exempted from complying with the legal or regulatory implementation of the new benefits just because this Office, for any reason, cannot carry out the aforementioned requirement.

**F. Forms Information to be made Public**

Each metallic plan description of benefits and metallic level, together with their corresponding table of copayment, coinsurance and deductibles, will be made public by the OCI. The Table of Copayment, Coinsurance, and Deductibles to be published in the OCI website must be submitted in both Excel and PDF format. (See 2025 updated Attachment 8).

**G. SERFF Forms Filing Submissions**

1. Every SERFF filing **must include the correct Type of Insurance (TOI), Sub-Type of Insurance (Sub-TOI), Market Type, and Filing Type**. An incorrect TOI, Sub-TOI, Market Type, or Filing Type **will result in the filing's rejection without evaluation.** Please refer to the **NAIC Life, Accident & Health, Annuity and Credit Product Coding Matrix.**

2. SERFF filings must comply with Circular Letter No. CC-2015-1870-AV/AS of December 1, 2015 entitled "General SERFF Instructions for Form and Rate Submissions" and Circular Letter CC-2015-1869-AV/AS of December 1, 2015 entitled "General Guidelines and Requirements for Forms Submissions". **Please read carefully these circular letters before making any submission**.

    iv. SERFF filings shall be accompanied with a Transmittal Letter including the name of the carrier making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico. The transmittal letter must be attached in the "Supporting Documentation Tab". The PDF document must be identified as: "Cover Letter". If the cover letter has to be revised by the insurer, the new version must be identified with the revision date.

3. In addition to the transmittal letter, an explanatory memorandum shall be submitted, containing sufficient information to review the filing, including, without limitation, the following:

    a. Identify the metal level(s) of coverage:

_# of Platinum # of Gold #of Silver # of Bronze

b. Explain how each submitted form will be used. Any additional benefit to the basic coverage that is intended to be included in the policy as an added value at no additional cost, must include a detailed explanation of how the process will work from the subscription to the benefit to the payment of claims for said benefit. In addition, the benefit administration process must comply with all applicable provisions of the Puerto Rico Insurance Code and Health Insurance Code.

c. A list of all changes made to the forms (including changes due to new legal requirements, as well as any other changes, such as the deletion of previously approved language or the addition of new language) setting forth the page numbers where the changes are found and the explanation for each changes. If we noted that the insurer does not include all changes, the filing will be returned without evaluation.

d. If the OCI approved an application (and enrollment form, if applicable) for use in a prior year, and the carrier intends to continue using the approved form without change in the upcoming plan year, include the form number and SERFF tracking number of the file containing the application. In this case, no resubmission of the form is needed.

   However, if the previously approved application does not provide for delivery of documents and/or underwriting by electronic means and the insurer intends to use the application for these purposes, then the application must be amended for compliance with Rule 102 of the Regulations of the Insurance Code and submitted for our review and approval.

e. If the OCI approved an endorsement form with optional and/or additional benefits for use in a prior year, and the carrier intends to continue using the approved form without change in the upcoming plan year, include the form number and SERFF tracking number of

the file containing the endorsement. In this case, no resubmission of the form is needed.

f. For small group plans, including small group health plans for bona fide associations, identify the conversion policy that the carrier will use to provide the individual conversion benefit.
We have permitted unaffiliated companies to provide the individual conversion benefit where the group issuer does not offer any individual policies. From now on, however, the contractual arrangement between the two companies and sufficient details to verify its compliance with Section 17.070 of the Insurance Code of Puerto Rico must be submitted under the Supporting Documentation tab.

g. Identify the type of plan (HMO, PPO, POS, EPO, etc.)

h. For individual plans, disclose whether the carrier voluntarily decided to offer or not during the whole year 2026 all the metallic plans approved by the OCI.

4. All forms must be submitted in final format. No draft highlighted or redlined copy form should be included in the "Form Schedule Tab". **Every form included on the Form Schedule tab must be submitted in a clean final print, as intended for use. No insert pages will be accepted.**

5. All the fields required in the "Form Schedule Tab" and "General Information Tab" must be completed. A failure to complete them **will result in the filing's rejection without evaluation.**

6. Only forms that need to be approved by the OCI should be included in the "Form Schedule Tab". The OCI will not approve any forms that have not been included in the Form Schedule Tab (i.e. forms included in a "Note to Reviewer").

7. There must be only one attachment per schedule item on the Form Schedule. Multiple documents must not be included in one attachment.

8. Forms and documents **must be saved in a non-protected PDF format** so that the file remains searchable and text can be copied from the document. **The submission of protected documents will prevent the filing's approval. It is the carrier's responsibility to verify before the filing's submission that all forms and documents comply with this item.**

9. Any supporting documentation must be attached to the "Supporting Documentation Tab", including evidence of previous approval, the table with copayments, coinsurance and deductibles to be published, certifications, memorandum of variable material, highlighted documents, and redlined copies, among others.

10. Under the Supporting Documentation tab, you must present the updated policy document that shows the changes made to the policy text, whether to add, delete or replace text ("track changes" or "redline "tool).

11. A memorandum of variable material is required if any forms contain bracketed variable text. The Statement of Variables (SOV) must contain an index to all brackets in the forms and fully explain the purpose for the variable text. It must also disclose the text that will be inserted into the brackets or explain under what circumstances the bracketed text will either be included or removed in its entirety. **Essential health benefits, uniform clauses of the Code and cost sharing values must not be variable.**

12. A Summary of Benefits and Coverage (SBC) for each plan must be included in the Supporting Documentation tab. The carrier must use the most recent template available from the U.S. Department of Labor.

13. Once submitted, a form filing generally cannot be changed. **DO NOT** file amendments to a filing, except where (a), (b), or (c) below, is true:

    a. Changes to the forms are required to be made in response to a form objection in the filing; or

    b. Changes to the forms are required to be made in response to a rate objection. In this case, send a Note to Reviewer in the form filing requesting an amendment to the filing in response to a rate objection.

The Note to Reviewer must be sent in the filing you are requesting to change, and include specific details of the change requested, including the SERFF Tracking Number for the corresponding rate filing; or

c. The filer has requested and been granted authorization to submit a change through an Amendment on the filing via Note to Filer in SERFF. To request a change to a form filing send a Note to Reviewer requesting to make a change to any SERFF field or to replace, modify, add, amend, or withdraw a form after it has been submitted for review.

    i. The Note to Reviewer must be sent in the filing where the change will be made, and include specific details of the change requested, as well as the reason for the change.

    ii. The reviewer analyst will notify in a Note to Filer whether the request is accepted or denied.

    iii. If the request is accepted, the filing may be updated as directed in the Note to Filer.

    iv. Do not make any modifications other than as specifically authorized in the Note to Filer. Otherwise, the reviewer analyst will require the removal of any unauthorized modifications.

d. Filings modified without proper authorization will be disapproved.

14. Every communication (e.g., a request for additional time to respond to an objection letter, a request of status) must be included in SERFF as a "Note to Reviewer". Every objection letter must be answered by means of a "Response Letter". The OCI will not accept responses to objection letters in a "Note to Reviewer". Other ways of communication will **not** be deemed as received.

15. Provide substantive responses to all objections and include the page numbers where the requested changes appear. If a requested change is not made, an explanation that includes sufficient legal justification for not making the change must be provided.

16. The documents mentioned in item II(B)(5) of this ruling letter must be included as part of the form submission in the "Supporting Documentation Tab" of SERFF.

**H. Plan Renewal**

1. The HICPR and the guaranteed renewability provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Affordable Care Act provide that if a carrier offers health plan in the group or individual market, it must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

2. A carrier that renews a plan in the group or individual market (including a renewal with modifications) must provide written notice of such renewal as follows:

    a. For metallic plans in the individual market, the carrier must provide to each individual market policyholder a written notice of renewal before the first day of the next annual open enrollment period.

    b. For transitional plans in the individual market, grandfathered and non-grandfathered coverage in the group market, the carrier must provide to each plan sponsor or individual, as applicable, a written notice of renewal at least (60) calendar days before the date of the renewal of the coverage.

3. The renewal notices must include the following essential content:

    a. Information about changes, if any, to the enrollee's premiums;

    b. Information about changes, if any, to the enrollee's coverage;

    c. A statement disclosing that upon the termination of the enrollee's current plan, the enrollee is free to choose another health plan offered by the current carrier or by another carrier;

    d. Information about other health plan options from the carrier;

e. Contact information from the carrier for the enrollee to call with questions; and

f. The notice must be written in a clearly understandable manner.

**I. Plan discontinuation**

1. Under the guaranteed renewability provisions of the HICPR, if a carrier decides to discontinue offering a particular health plan in the group or individual market, that plan may be discontinued by the carrier only if, among other things, the carrier provides in writing notice of such discontinuation to each plan sponsor or individual (and to all enrollees included under such coverage) at least (90) calendar days prior to the date of the discontinuation. The purpose of the discontinuance notice prior to the end of coverage is to inform enrollees that their current health plan is being terminated and that they have other health plan options.

2. Written notice must be provided as follows:

   a. Individual metallic plans: the discontinuation notice must be sent on or before the first day of the open enrollment period. Since Puerto Rico's open enrollment period runs from October 1st until December 31st every year, the notices must be sent on or before October 1st.

   b. Transitional plans in the individual and group markets (including large group plans), small group metallic plans, including small group health plans for bona fide associations, and grandfathered plans: the discontinuation notices must be sent at least (60) days before the termination or renewal date of the health plan.

   c. The discontinuation notices must include the following essential content:

      i. A statement that the health plan is being discontinued;

ii. Suggestion of enrollment into a health plan of the carrier that is similar the discontinued plan, with information about the changes in the benefits and premiums arising out of the change from the old plan to the new plan; and a statement disclosing that upon the termination of the plan, the enrollee is free to choose another health plan offered by the current carrier or by another carrier;

iii. Contact information from the carrier for the enrollee to call with questions

iv. Information about other health plan options from the carrier;

v. The notice must clearly explain the options for the employer or individual to obtain or renew health plan coverage; and

vi. The notice must be written in a clearly understandable manner.

**III. Large Group Rates and Form Filings**

Large group rate filings, including large group health plans for bona fide associations, must not be submitted for the OCI's evaluation and approval. This rate filing exemption will apply to all health insurance organization or issuer underwriting health insurance coverage in the large group market, including healthcare service organizations (HMO).[6] However, rate increases of 10% or more over the previous year's rates for large group health insurance coverage, including large group health plans for bona fide associations, must be filed with the OCI for approval at least ninety (90) days before they are to go into effect, as their use requires the OCI's prior approval.

In addition, we must point out that all forms for the large group market, including large group health plans for bona fide associations, are subject to review and approval. Large group forms must comply with all the applicable provisions of the HICPR, which include among others, no Annual or Lifetime Limits, Coverage of

[6] The term "health insurance organization or insurer" includes also health services organizations (HMO), as defined in the Chapter 2 of the Puerto Rico's Health Insurance Code.

Preventive Health Services, Extension of Dependent Coverage, and Preexisting Condition Exclusions.

**IV. Supplemental Health Care Exhibit (SHCE)**

All carriers are hereby required to complete and submit the Supplemental Health Care Exhibit to the NAIC and the OCI before March 30 of each year for Disability insurers, and before March 31 of each year for HMOs. **The carrier must include a copy of this exhibit as part of the rate filing requirements** in the "Supporting Documentation Tab". A failure to submit this exhibit will result in the filing's rejection without evaluation.

Strict compliance with the provisions of this ruling letter is hereby required.

Cordially,

Alexander S. Adams Vega, Esq.
Commissioner of Insurance