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BULLETIN 15-33

Date: December 10, 2015

To: Insurers, Nonprofit Health Service Plans, Health Maintenance Organizations and Dental Plan Organizations

Re: 2017 Affordable Care Act (“ACA”) Individual and Small Employer Form and Rate Filing Instructions

The purpose of this Bulletin is to provide guidance to insurers, nonprofit health service plans, health maintenance organizations and dental plan organizations (“carriers”) regarding filing requirements for the individual and small employer form and rate filings for plan or policy years beginning on or after January 1, 2017.

Form and Rate Filing Deadlines

The rate and form filing deadlines for the individual and small employer health benefit plans are as follows:

- Individual health benefit plans sold on and off the Exchange for the 2017 policy year:
 - Forms—March 1, 2016;
 - Rates—May 2, 2016;

Forms and rates must be submitted in the same filing under the SERFF Filing Type: Form/Rate. If the filing is not submitted as a Form/Rate filing, it will be REJECTED. Forms may be filed first and rates added to the same filing at a later date.

- Small employer health benefit plans sold on and off the Exchange:
 - Forms—April 1, 2016;
 - Rates—May 2, 2016;
- Individual stand-alone dental plans forms and rates to be sold on the Exchange—May 2, 2016; and

- Small employer stand-alone dental plans forms and rates to be sold on the Exchange— May 2, 2016.

General Requirements

A new benchmark plan was selected for 2017 that establishes the essential health benefits for the individual and small employer non-grandfathered health benefit plans. The 2017 benchmark plan may be viewed on the Maryland Insurance Administration's website in its entirety at: <http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/2017-BenchMark-Plan.pdf>.

The following requirements apply to the form filings:

1. As in 2014 and 2015, the Maryland Insurance Administration will permit form filings to be filed before the associated rate filings are filed. However, all filings are due within the time periods discussed in this Bulletin. *Forms and rates must be submitted in the same filing under the SERFF Filing Type: Form/Rate. If the filing is not submitted as a Form/Rate filing, it will be REJECTED.*
2. For the rate filing requirements, carriers are required to submit at least the following documents: Part I: Unified Rate Review Template; Part II: Written Description Justifying the Rate Increase; Part III: Actuarial Memorandum and Certification Instructions. For detailed requirements for each of these documents, please refer to the 2017 Unified Rate Review Instructions, which will be published by the Department of Health and Human Services.
3. Variability in cost-sharing, such as copayment amounts, coinsurance percentages or deductible amounts, will not be permitted. Instead, carriers are required to file a separate schedule or benefit form for each benefit design.
4. Individual and small employer form filings may not be combined under the same SERFF tracking number, but are required to be submitted under separate SERFF tracking numbers.
5. Each filing for a health benefit plan is required to include:
 - a. Identification of where the plan will be sold (i.e. in the Exchange, outside the Exchange, or both);
 - b. Identification of the coverage level for each benefit design for a health benefit plan that is not a catastrophic plan (i.e. bronze, silver, gold, platinum);
 - c. Identification of the plan as a multi-state plan, if the health benefit plan is to be a multi-state plan;
 - d. A separate contract or schedule for each plan design that the carrier intends to offer;

- e. The actuarial value of each plan design determined in accordance with the 45 CFR § 156.135 using the AV calculator developed and made available by HHS;¹
 - f. The screen shots of each plan’s AV calculator;
 - g. All rating factors and a demonstration that there are no factors not allowed by the ACA;
 - h. Demonstration of the medical loss ratio calculation to show that the medical loss ratio is at least 80%;
 - i. Identification of whether the plan design is only applicable to those individuals who qualify for the cost-sharing reductions of the ACA or corresponding federal regulations;²
 - j. Certification that the health benefit plan’s prescription drug benefit complies with 45 CFR § 156.122; and
 - k. Documentation of compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) regulations as found in 45 CFR § 146.136. The documentation is required to include an actuarial demonstration of how each financial requirement applicable to a mental health or substance abuse benefit in the plan design is no more restrictive than the *predominant* financial requirement of that type that applies to *substantially all* of the medical/surgical benefits in the same classification.
6. Additional requirements for stand-alone dental plan filings:
- a. Identification of the level of coverage, i.e. low or high, including the actuarial value of the plan determined in accordance with the rule;³ and
 - b. Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles.⁴
7. Please note that the Maryland Health Benefit Exchange (“Exchange”) limits the number of plans that may be offered on the Exchange.⁵ Therefore, each filing that includes forms to be used on the Exchange is required to include a list of the forms that will be sold on the Exchange in 2017 and a listing of any previously approved forms that will no longer be offered on the Exchange.

Small Employer Essential Health Benefits

As indicated above, the essential health benefits for the 2017 small employer health benefit plans will be those found in the 2017 benchmark plan. The 2017 benchmark plan was a non-grandfathered small employer health benefit plan. Therefore, the benefits required in the 2017

¹ If a health benefit plan’s design is not compatible with the AV calculator, the carrier shall submit actuarial certification using the chosen methodology in the rule. 45 CFR § 156.135(b).

² See § 1402 of the Affordable Care Act; 45 CFR § 155.1030; and 45 CFR § 156.420.

³ 45 CFR § 156.150(b)(2).

⁴ 45 CFR § 156.150(b)(3).

⁵ See Maryland Insurance Administration Bulletin 13-05, dated January 23, 2013.

contracts will be very similar to those required in prior years and will be based on the benefits described in Bulletin 13-01, dated January 3, 2013. The same is true with regard to permissible limitations and exclusions. However, some changes are required of the benefits, limitations, and exclusions described in Bulletin 13-01 due to additional benefits included in the 2017 benchmark plan and recent changes in federal rules or guidance. Therefore, the following amendments to the benefits, limitations, and exclusions described in Bulletin 13-01 will be required in each small employer health benefit plan submitted for approval. Many of the amendments described below were required for the 2016 health benefit plan filings.

1. The hearing aid benefit, which is found on pages B34, B49, EOC9 and C10 of the 2017 benchmark plan and originally required by COMAR 31.10.06.03A(34), may not be limited to children, as federal guidance has determined that an age limit is considered to be a discriminatory benefit design under 45 CFR § 156.200(e). Therefore, any age limitation on this benefit or any definition of hearing aid that limits the benefit to children will require amendment.
2. Any definition of habilitative services and the habilitative services benefit is required to comply with the requirements of 45 CFR § 156.115(a)(5)(i). The benefit is also required to include the full list of services originally found in COMAR 31.11.06.03B.
3. The Mental Health and Substance Use Disorder benefit, which is found on pages B30 and B31 of the 2017 benchmark plan, will require the following amendments to comply with MHPAEA:
 - a. Since the 2017 benchmark plan covers professional services from providers who are licensed, *registered or certified* for somatic conditions, any requirement that professional services for the treatment of mental health or substance use disorders be provided by a *licensed* provider is required to be amended to permit the professional to be *registered or certified*.
 - b. Similar to item a. above, any reference that an outpatient diagnostic test be provided and billed by a *licensed* provider is required to be amended to permit the diagnostic test be provided and billed by a *licensed, certified or registered* provider.
 - c. The partial hospitalization benefit may not be limited to benefits provided in an outpatient hospital setting. Since MHPAEA considers partial hospitalization services to be intermediate services,⁶ and since the benchmark plan covers other intermediate services, such as cardiac rehabilitation, in settings outside the hospital the outpatient hospital setting requirement for partial hospitalization would appear to violate MHPAEA.
4. The Prescription Drug benefit, which is found on page B36 of the 2017 benchmark plan and which was originally required by COMAR 31.11.06.03A(26) and E is required to be amended to:

⁶ See Federal Register, page 68246, November 13, 2013.

- a. Include the procedure for standard and expedited exception requests for prescription drugs not otherwise covered, if the benefit is provided through a closed formulary as required by 45 CFR § 156.122(c);
 - b. Comply with § 15-847 of the Insurance Article, regarding specialty drugs; and
 - c. Comply with § 15-846 of the Insurance Article, regarding chemotherapy parity.
5. Allergy serum is required to be covered. See page B8 of the 2017 benchmark plan.
6. Birthing classes are required to be covered, but may be limited to one class per pregnancy. See page B7 of the 2017 benchmark plan.
7. The Pediatric Vision Benefit in the 2017 benchmark plan is richer than the benefit described in Bulletin 13-01. Specifically, the elective contact lens benefit is required to give the covered child the option of benefits for one pair of elective prescription contact lenses per benefit period or multiple pairs of disposable prescription contact lenses per benefit period. See page B20 of the 2017 benchmark plan.
8. While abortion coverage is a part of the 2017 benchmark plan, in accordance with § 1303(b)(1)(A) of the Affordable Care Act, carriers will not be required to cover these services.
9. Note that in accordance with Bulletin 13-01 and COMAR 31.11.06.03-1, benefits are required for all evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Question 6 of Set 29 of Frequently Asked Questions issued jointly by the Departments of Labor, Health and Human Services and the Treasury on October 23, 2015 clarified that these required preventive care benefits include certain weight management behavioral interventions for adult obesity. However, under the 2017 benchmark plan, exclusion 15.14 on page B48 and the Office Visits for Treatment of Childhood Obesity benefit on page C4 appear to provide benefits only for office visits for the treatment of childhood obesity. Any exclusion such as this for office visits for the treatment of adult obesity is not permitted.
10. Note that in accordance with Bulletin 13-01 and COMAR 31.11.06.03A(18), benefits are required for all infertility services, except for those services excluded in COMAR 31.11.06.06B(11). However, any limit on covered infertility services, such as the “6 attempts per live birth” limitation on artificial insemination and intrauterine insemination found on pages B8 and C5 of the 2017 benchmark plan, is required to be deleted, as this type of limitation was not permitted by COMAR 31.11.06.06.
11. Similar to item 10 above, Bulletin 13-01 generally requires coverage of artificial insemination and intrauterine insemination procedures. However, the artificial insemination and intrauterine insemination benefit found on page B7 of the 2017 benchmark plan includes an impermissible requirement related to the use of the spouse’s sperm, which effectively precludes same sex couples from using the benefit. To require the use of the spouse’s sperm would be a discriminatory benefit design that is prohibited by 45 CFR § 156.200(e) and §15-810(b) of the Insurance Article.

12. The formerly permissible exclusion which reads “treatment leading to or in connection with transsexualism, or sex changes or modifications, including, but not limited to surgery,” which is found on pages B49 and B50 of the 2017 benchmark plan and originally permitted by COMAR 31.11.06.06B(32), is required to be deleted as federal guidance has determined that this type of exclusion is a discriminatory benefit design prohibited by 45 CFR § 156.200(e).
13. Please note that the formerly permissible exclusion for travel found in COMAR 31.11.06.06B(24) is required to be revised so as to not apply to travel for organ transplants. The corrected exclusion is found in Exclusion 15.25 of the 2017 benchmark plan on page B49.
14. Pediatric Dental Benefits—While the selected 2017 benchmark plan includes pediatric dental benefits, in accordance with § 31-116(a)(2) and (f)(2) of the Insurance Article, a health benefit plan will not be required to include pediatric dental benefits provided:
 - a. The requirements of § 31-115(c) of the Insurance Article are satisfied for an on Exchange health benefit plan,; and
 - b. The carrier complies with the requirements of § 31-116(f)(2) and (3) of the Insurance Article for an off-Exchange health benefit plan.

Individual Essential Health Benefits

The following is a description of the essential health benefits that will be required of each non-grandfathered health benefit plan in the individual market with policy years that begin on or after January 1, 2017. In accordance with 45 CFR § 155.170, the essential benefits found in the 2017 benchmark plan described above for the small group market will be overlaid with the mandated benefits that applied to health benefit plans in the individual market as of December 31, 2011. Specifically, the essential benefits shall include:

1. All of the benefits required in the small group market identified in this Bulletin;
2. In vitro fertilization in accordance with § 15-810 of the Insurance Article, except that the \$100,000 maximum lifetime benefit is prohibited by 45 C.F.R. § 147.126; and
3. Hair prosthesis in accordance with § 15-836 of the Insurance Article, except that the \$350 limit is prohibited by 45 C.F.R. § 147.126.

With regard to permissible limitations and exclusions, the same permissible limitations and exclusions that are applicable in the small group market also will be applicable in the individual market, with the following exceptions:

1. The exclusion for in vitro fertilization will not be permitted.
2. The exclusion for wigs or cranial prosthesis is required to be revised to indicate that it does not apply to hair prostheses for covered persons whose hair loss results from chemotherapy or radiation treatment for cancer.

Substitution Rules

Maryland Insurance Administration Bulletin 13-02, which was issued January 7, 2013, described in detail the many factors that were considered in making the determination that substitution of essential health benefits (“EHBs”) would not be permitted in the individual and small employer markets for 2014 and that the approach would be reassessed for the future. The approach has been reassessed for 2017 and for the same reasons described in Maryland Insurance Administration Bulletin 13-02, it has been determined that substitution of EHBs will *not* be permitted in the individual and small employer markets for 2017.

Questions about this Bulletin may be directed to the Life/Health Section of the Maryland Insurance Administration at 410-468-2170.

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Life and Health