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BULLETIN 18-03

Date: January 26, 2018

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

Re: 2019 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, 2019.

Form and Rate Filing Deadlines

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

> *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.*

- Individual health benefit plans sold on and off the Exchange for the 2019 policy year:
    - Forms—Thursday, March 1, 2018;
    - Rates—Tuesday, May 1, 2018;
- Small employer health benefit plans sold on and off the Exchange:
    - Forms—Monday, April 2, 2018;
    - Rates— Tuesday, May 1, 2018;
- Individual stand-alone dental plans forms and rates to be sold on the Exchange—Tuesday, May 1, 2018; and

- Small employer stand-alone dental plans forms and rates to be sold on the Exchange—Tuesday, May 1, 2018.

General Requirements

The essential health benefits will remain the same as for 2017 and 2018. Therefore, the instructions for required benefits and exclusions described in Bulletin 15-33, dated December 10, 2015, will continue to apply to the 2019 plans.

The following requirements apply to the form filings:

1. As in previous years, 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 for health benefit plans, 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. For detailed requirements for each of these documents, please refer to the 2019 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 of benefits 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. If applicable, identification of the plan as a multi-state plan offered in accordance with section 1334 of the Affordable Care Act;

    d. A separate contract or schedule for each plan design that the carrier intends to offer, except that the same schedule should be used for an on-Exchange plan and the "mirrored" off-Exchange version of the same plan (carriers are encouraged to use the same schedule in this situation to expedite the review process);

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 prints 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 that the projected Medical Loss Ratio (MLR) standard of at least 80.0% is expected to be met;

i. For individual health benefit plans, identification of the forms that will be used to provide coverage to those individuals who qualify for the cost-sharing reductions of the ACA or corresponding federal regulations.[2] Additionally, for each cost-sharing reduction plan variation, the corresponding standard plan design must be clearly identified.

j. Certification that the health benefit plan's prescription drug benefit complies with 45 CFR § 156.122 based on the information provided in the 2017 EHB Benchmark Plan Information summary document provided by CMS and the version of the CMS Essential Health Benefits Rx Crosswalk Methodology that is current as of the date of the certification; 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 use disorder 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.

   The documentation should include a clear description of the methodology used by the carrier to determine the dollar amount of all plan payments for the substantially all/predominant analysis. Carriers should review the guidance provided by the Departments of Labor, Health and Human Services, and the Treasury in FAQs about Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation, Q8, published April 20, 2016, and FAQs about Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation, Q3, published October 27, 2016.

6. Please note that the Maryland Health Benefit Exchange ("Exchange") limits the number of plans that may be offered on the Exchange.[3] 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 2019 and a listing of any previously approved forms that will no longer be offered on the Exchange.

[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] *See* Maryland Insurance Administration Bulletin 13-05, dated January 23, 2013.

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 2019 and for substantially 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 2019.[4]

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

Al Redmer, Jr.
Commissioner

By: signature on original

Robert D. Morrow Jr.
Associate Commissioner
Life & Health

[4] Bulletin 13-02 addressed several different options for benefit substitution, including "permitting substitution across the ten statutory EHB categories." The rationale provided in Bulletin 13-02 for rejecting substitution across EHB categories was that a federal rule proposed at the time (77 FR 70670) would prohibit this type of substitution. While there is now a federal proposal to reinstate this substitution option as permissible, the proposed rule retains deference to States, which may enforce a stricter standard on benefit substitution, or prohibit substitution entirely. *See* 82 FR 51106-51107 and 51146 under the *HHS Notice of Benefit and Payment Parameters for 2019* proposed rule published on November 2, 2017. Consequently, while the specific rationale originally provided for rejecting substitution across EHB categories no longer applies, the general rationale provided in Bulletin 13-02 for prohibiting EHB substitution entirely remains applicable.