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BULLETIN 15-32

Date: December 7, 2015

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

Re: Student Health Plan Form and Rate Filing Instructions for the 2016-2017 School Year

The purpose of this Bulletin is to provide guidance to insurers, nonprofit health service plans, and health maintenance organizations regarding filing requirements for the student health benefit plan form and rate filings for plans that will be issued for the 2016-2017 school year.

The student health plan rate and form filings for the 2016-2017 school year are required to be filed with the Maryland Insurance Administration on or before **February 1, 2016**.

The following requirements apply to the student health plan form and rate filings:

1. The essential health benefits for the 2016-2017 school year are based on the benchmark plan that was chosen in 2012 by the Maryland Health Care Reform Coordinating Council. Therefore, the instructions for required benefits and exclusions for individual health benefit plans described in Bulletin 13-01, dated January 3, 2013 will continue to apply to the plans designed for the 2016-2017 school year, with the following exceptions:

    a. The hearing aid benefit may not be limited to children, as federal guidance has determined that an age limit is considered to be a discriminatory benefit design prohibited by 45 CFR § 156.200(e).

    b. The exclusion which reads "treatment leading to or in connection with transsexualism, or sex changes or modifications, including, but not limited to surgery" 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).

    c. 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.

d. The Mental Health and Substance Use Disorder benefit described in Bulletin 13-01 will require the following amendments to comply with the Mental Health Parity and Equity Addiction Act ("MHPAEA"):

    i. If the health benefit 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.*

    ii. If the health benefit plan covers an outpatient service that is provided and billed by a *licensed, certified or registered* provider, then the outpatient diagnostic text benefit for mental health and substance use disorders described in Bulletin 13-01 is required to be amended to permit the diagnostic test to be provided and billed by a *licensed, certified or registered* provider.

    iii. The partial hospitalization benefit described in Bulletin 13-01 may not be limited to benefits provided in an outpatient hospital setting. Since MHPAEA considers partial hospitalization services to be intermediate services,[1] 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.

e. The Prescription Drug benefit is required to be amended to:

    i. 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);

    ii. Comply with § 15-847 of the Insurance Article, regarding specialty drugs; and

    iii. Comply with § 15-846 of the Insurance Article, regarding chemotherapy parity.

2. 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.

3. Student health benefit plan filings are required to be submitted under separate SERFF tracking numbers from other filings. Student health benefit plans are required to provide the same essential health benefits that are applicable to the individual market.[2]

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[1] *See* Federal Register, page 68246, November 13, 2013.
[2] 45 CFR § 147.145.

4. Each filing for a health benefit plan is required to include:

   a. 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);

   b. A separate contract or schedule for each plan design that the carrier intends to offer;

   c. The actuarial value of each plan design determined in accordance with 45 CFR § 156.135 using the AV calculator developed and made available by HHS;[3]

   d. The screen shots of each plan's AV calculator;

   e. All rating factors and a demonstration that there are no factors not allowed by PPACA and that family tier factors are reasonable and not a surrogate for rating by health status;

   f. Demonstration of medical loss ratio calculation to show that the medical loss ratio is at least 80%;

   g. Certification that the health benefit plan's prescription drug benefit complies with 45 CFR § 156.122; and

   h. Documentation of compliance with MHPAEA regulations as found in 45 CFR 146.136. Such documentation shall include a filing from an actuary demonstrating 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.

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

signature on original

Brenda A. Wilson
Associate Commissioner
Life and Health

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