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BULLETIN 19-23

Date: December 16, 2019

To: Insurers, Nonprofit Health Service Plans, and Health Maintenance Organizations ("Carriers")

Re: Student Health Plan Form and Rate Filing Instructions for the 2020-2021 School Year

The purpose of this Bulletin is to provide guidance to carriers regarding form and rate filing requirements for student health benefit plans that will be issued for the 2020-2021 school year.

When is an annual filing required?

A separate filing to sell or renew a student health benefit plan for the 2020-2021 school year is required if a carrier intends to use new forms, amend previously approved forms, or revise the previously filed rates.

Conversely, a separate filing is *not* required for 2020-2021 school year if a carrier:

a) Is making no changes to the previously approved forms, other than changes that are expressly permitted within the scope of the previously filed statement of variability for the approved forms; and

b) Is proposing no changes to the previously filed rating methodology or the previously approved manual rates.

A carrier that determines a filing is not required for the 2020-2021 school year is expected to monitor changes in federal and state requirements regarding student health benefit plans to ensure that the previously approved forms and rates remain compliant with all applicable requirements.

Filing Procedures and Requirements

If a new student health plan filing is required for the 2020-2021 school year based on the guidelines outlined above, the deadline for submitting the filing is **Monday, February 3, 2020**. The following requirements apply to a student health plan form and/or rate filing:

1. Student health benefit plan filings are required to be submitted under separate SERFF tracking numbers from other filings, using the Type of Insurance ("TOI"): H22 Student Health Insurance. If a carrier intends to file both forms and rates for the 2020-2021 school year, both components must be submitted prior to the **February 3, 2020** deadline in the same filing using the SERFF Filing Type: Form/Rate.

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

    a. Identification of all forms that will comprise the entire contract of insurance, provided in the following manner: a complete listing of previously approved forms that will be used with approval dates and SERFF tracking numbers, and submission for approval of any new or amended forms;

    b. The rating methodology and manual rates for the student health benefit plan product, or, if applicable, the approval date and SERFF tracking number for the previously approved rate filing that remains effective. School-specific rates are not required to be filed; and

    c. 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.

3. Student health benefit plans are required to provide the same essential health benefits that are applicable to the individual market.[1] The essential health benefits for the 2020-2021 school year are based on the 2017 Benchmark Plan selected by the MIA in consultation with the Maryland Health Benefit Exchange. Therefore, the instructions for required benefits and exclusions for individual health benefit plans described in Bulletin 15-33, dated December 10, 2015, will apply to the student health plans designed for the 2020-2021 school year. 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.

4. For the 2020-2021 school year, the MIA will continue to permit variability in cost-sharing, such as copayment amounts, coinsurance percentages, and deductible amounts. Carriers are not required to file a separate schedule of benefits form for each benefit design. However, federal regulations require that student health insurance coverage must provide an actuarial value of at least 60%, and carriers must specify in any plan materials summarizing the terms of coverage the actuarial value and the level of coverage (or next lowest level of coverage)

[1] 45 CFR § 147.145.

that the coverage would otherwise satisfy.[2] Therefore, if a variable schedule of benefits form is submitted, the form must include a variable section where the appropriate actuarial value and level of coverage will be specified, unless the carrier has established an alternative method to provide the required disclosure for each benefit design that is issued. If a carrier chooses to file a separate schedule of benefits form for each benefit design, then each schedule must disclose the appropriate actuarial value and level of coverage, unless an alternative method is used to provide the required disclosure.

5. If new or revised schedule of benefits forms are submitted for approval, the filing must include documentation of compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) regulations as found in 45 CFR § 146.136. If separate schedule of benefits forms are submitted for each benefit design, 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 benefit 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. If variable schedule of benefits forms are submitted, an explanation of variability must be included that clearly demonstrates how the carrier will ensure, for each variable plan design, that each financial requirement applicable to a mental health or substance abuse benefit in the plan design will be no more restrictive than the predominant financial requirement of that type that will apply 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. For additional information, 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. If new or revised rates are submitted for approval, the filing must include:

   a. 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. School-specific rates, however, are not required to be filed;

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

   c. Demonstration that the actuarial value of the coverage is at least 60%, as determined in accordance with 45 CFR § 156.135 using the AV calculator developed and made available by HHS (only required if specific benefit designs are filed);[3] and

[2] 45 CFR § 147.145.

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

d. The screen prints of each plan's AV calculator (only required if specific benefit designs are filed).

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

David Cooney
Associate Commissioner
Life and Health