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BULLETIN 20-01

Date: January 7, 2020

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

Re: 2021 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, 2021.

Form and Rate Filing Deadlines

The Maryland Insurance Administration ("MIA") recognizes that due to the delay by the federal government in releasing the *HHS Notice of Benefit and Payment Parameters for 2021* proposed rule, it would be very challenging for carriers to meet the customary deadline for the submission of forms for individual and small employer health benefit plans. It is imperative, however, that the MIA receives all individual and small employer forms for health benefit plans and stand-alone dental plans as soon as possible to ensure a timely and efficient review process. In consideration of these issues, the MIA is granting additional time for carriers to submit the individual and small employer *health benefit plan* form filings for 2021, but is establishing an earlier than usual filing date for *individual stand-alone dental* form filings.

To the extent possible, carriers are strongly encouraged to submit forms in advance of the deadlines established below. Additionally, although all forms submitted for review must be received by the applicable deadline, the MIA will accept partial form filings prior to the deadlines. Therefore, if a carrier has any forms that are ready to be submitted early, the carrier is encouraged to submit those forms as soon as possible, and then add the remaining forms to the same filing no later than the applicable deadline. Also, as in previous years, forms may be filed first and rates added to the same filing at a later date. *However, 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.*

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:
    - Forms—Wednesday, April 1, 2020;
    - Rates—Friday, May 1, 2020;
- Individual stand-alone dental plans sold on the Exchange:
    - Forms—Wednesday, April 1, 2020;
    - Rates—Friday, May 1, 2020;
- Small employer health benefit plans forms and rates to be sold on and off the Exchange—Friday, May 1, 2020; and
- Small employer stand-alone dental plans forms and rates to be sold on the Exchange—Friday, May 1, 2020.

General Requirements

The essential health benefits will remain the same as for all prior years since 2017. Therefore, the instructions for required benefits and exclusions described in Bulletin 15-33, dated December 10, 2015, will continue to apply to the 2021 plans.

The following requirements apply to the form and rate filings:

1. 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 2021 Unified Rate Review Instructions, which will be published by the Department of Health and Human Services.

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 of benefits form for each benefit design.

3. 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.

4. 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. 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);

d. The screen prints of each plan's AV calculator output, to demonstrate 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;[1]

e. All rating factors and a demonstration that there are no factors not allowed by the ACA;

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

g. 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;

h. Certification that the health benefit plan's prescription drug benefit complies with 45 CFR § 156.122 based on the information provided in the 2017-2021 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

i. 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. 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.

[1] If a health benefit plan's design is not compatible with the AV calculator, the carrier shall submit an 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.

5. 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 2021 and a listing of any previously approved forms that will no longer be offered on the Exchange.

Substitution Rules

MIA 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 2021 and for substantially the same reasons described in MIA Bulletin 13-02, it has been determined that substitution of EHBs will *not* be permitted in the individual and small employer markets for 2021.[4]

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

Al Redmer, Jr.
Commissioner

By: signature on original
David Cooney
Associate Commissioner
Life and Health

[3] *See* MIA Bulletin 13-05, dated January 23, 2013.

[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. Although federal regulations were recently revised to reinstate this substitution option as permissible, the federal rule retains deference to states, which may enforce a stricter standard on benefit substitution, or prohibit substitution entirely. *See* 83 FR 17020-17021 and 17069 under the *HHS Notice of Benefit and Payment Parameters for 2019* final rule published on April 17, 2018. 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.