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BULLETIN 23-2

Date: February 1, 2023

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

Re: 2024 Affordable Care Act ("ACA") Individual and Small Employer Form and Rate Filing Instructions

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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, 2024.

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 2024 policy year:
    - Forms—Wednesday, March 1, 2023;
    - Rates—Monday, May 22, 2023;
- Small employer health benefit plans sold on and off the Exchange:
    - Forms—Monday, April 3, 2023;
    - Rates— Monday, May 22, 2023;
- Individual stand-alone dental plans forms and rates to be sold on the Exchange—Monday, May 1, 2023; and

- Small employer stand-alone dental plans forms and rates to be sold on the Exchange—Monday, May 1, 2023.

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 2024 plans.

The following requirements apply to the form filings:

1. *Beginning this year, for health benefit plans, forms and rates should be submitted in SEPARATE filings by their due dates shown above*. For the form filings, the SERFF Filing Type is Form. For rate filings, the SERFF Filing Type is Rate.

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 form 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. A duplicate copy of 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. The duplicate copy of the screen prints should be submitted as an amendment to the form filing once the rate filing is submitted;[1]

    e. 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

[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).

corresponding federal regulations.[2] Additionally, for each cost-sharing reduction plan variation, the corresponding standard plan design must be clearly identified;

f. Certification that the health benefit plan's prescription drug benefit complies with 45 CFR § 156.122 based on the information provided in the 2017-2024 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

g. 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.

- The documentation is required to include a comparative analysis of all Non-Quantitative Treatment Limitations ("NQTLs") that are shown in the filed forms, along with all the information required by Division BB, Title II, Section 203 of the federal Consolidated Appropriations Act of 2021. The NQTL Analysis Report Template Form developed by the MIA under §15-144 of the Insurance Article, Annotated Code of Maryland, may be submitted to satisfy this requirement, with the applicable NQTLs shown in the forms substituted for the NQTL categories in the template. For additional information, carriers should review the guidance provided by the Department of Labor's Mental Health Parity Self-Compliance Tool. Carriers should also review the guidance provided by the Departments of Labor, Health and Human Services, and the Treasury in FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act Part 45.

The following requirements apply to health benefit plan rate filings.

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

1. Include reference in the Filing Description to the SERFF Tracking Number of the corresponding form filing.

2. 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 2024 Unified Rate Review Instructions, which will be published by the Department of Health and Human Services.

3. Submit 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;[3]

4. Provide all rating factors and a demonstration that there are no factors not allowed by the ACA;

5. Provide a demonstration that the projected Medical Loss Ratio (MLR) standard of at least 80.0% is expected to be met;

6. Claims should be paid through March 31 and the current enrollment in the URRT should be enrollment as of April 30.

Other items required for health benefit plan filings:

1. Please note that the Maryland Health Benefit Exchange ("Exchange") limits the number of plans that may be offered on the Exchange.[4] 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 2024 and a listing of any previously approved forms that will no longer be offered on the Exchange.

2. The No Surprises Act, which is part of the Consolidated Appropriations Act of 2021, took effect January 1, 2022, with final regulations issued under 45 CFR Parts 144, 147, 149 and 156. Review Bulletin 21-24 along with the federal rules to ensure policies comply with the No Surprises Act.

The following requirements apply to Stand Alone Dental Plans filings.

1. Forms and rates must be submitted in the same filing using SERFF Filing Type: Form/Rate. *If the filing is not submitted as a Form/Rate filing, it will be REJECTED.*

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

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

the approach would be reassessed for the future. The approach has been reassessed for 2024 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 2024.

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

KATHLEEN A. BIRRANE
Commissioner

By: **Signature on Original**

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David Cooney
Associate Commissioner
Life and Health