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BULLETIN 13-05

Date: January 23, 2013

To: Insurers, Nonprofit Health Service Plans, Health Maintenance Organizations, and Dental Plan Organizations (“Carriers”)

Re: Form Filing Requirements for Health Benefit Plans, Dental Plans, and Vision Plans in the Small Employer and Individual Markets with Plan Years or Policy Years Beginning on or after January 1, 2014.

The purpose of this Bulletin is to respond to frequently asked questions from carriers regarding the filing requirements for non-grandfathered health benefit plans, dental plans, and vision plans in the small employer or individual markets with plan or policy years beginning on or after January 1, 2014.

1. When are form filings required to be filed with the Maryland Insurance Administration (MIA)?

The initial open enrollment period for small employers and individuals to enroll in health benefit plans for plan or policy years beginning January 1, 2014 starts on October 1, 2013. Therefore, in order to assure that forms are approved in time for the open enrollment period and that the needs of the Maryland Health Benefit Exchange (“MHBE”) are met, the following filing deadlines apply.

- Health benefit plans
 - Health benefit plans designed to be sold inside the Small Business Options Program (“SHOP”) Exchange or Individual Exchange are required to be filed on or before **April 1, 2013**. The MIA has agreed to provide the MHBE with the approved policy forms and premium rates for qualified health plans that will be sold on the Exchanges by July 1, 2013. Therefore, carriers are required to file the forms with the MIA by April 1, 2013.
 - Health benefit plans designed to be sold *only* outside the SHOP Exchange or outside the Individual Exchange are required to be filed by **July 1, 2013**.

- Amendments to previously approved non-grandfathered health benefit plans are required to be filed on or before **October 1, 2013**. See Question 2 below.
- Stand-alone pediatric dental benefit forms:
 - Stand-alone pediatric dental benefit forms designed to be sold on the SHOP Exchange or Individual Exchange are required to be filed on or before **March 1, 2013**.
 - Stand-alone pediatric dental benefit forms designed to be sold *only* outside the SHOP Exchange or outside the Individual Exchange are required to be filed by **July 1, 2013**.

2. *May a carrier amend a previously approved contract instead of creating a new contract for new sales on or after January 1, 2014?*

Yes. However, any such amendments will be required to meet the other filing requirements of this Bulletin. Please note that existing non-grandfathered individual and small employer health benefit plans will need to be amended for renewals for policy years and plan years that begin on or after January 1, 2014 to include the new essential health benefits and to fit into one of the metal levels.¹

3. *Will the MIA permit form filings to be submitted before the premium rates are submitted for approval?*

Yes. However, both form filings and premium rate filings must be received within the deadlines described in the response to Question 1 above. A form filing will not be approved until the corresponding premium rates are approved by the Office of the Chief Actuary.

4. *Are carriers required to offer health benefit plans in the SHOP Exchange or Individual Exchange in Maryland?*

Effective January 1, 2014, in accordance with §§ 15-1204.1(b) and 15-1303(b) of the Insurance Article, with respect to any health benefit plan that is not a grandfathered health benefit plan, carriers may not offer health benefit plans in the small employer or individual markets in Maryland unless they also offer qualified health plans in the Small Business Health Options Program (SHOP) Exchange of the Maryland Health Benefit Exchange (MHBE) or the Individual Exchange, respectively.² This does not mean that carriers are required to participate in both the

¹ The preamble to the proposed federal regulations states “Section 2707(a) of the Public Health Service (PHS) Act extends the coverage of the EHB package to issuers of non-grandfathered individual and small group policies beginning with plan years starting on or after January 1, 2014, irrespective of whether such issuers offer coverage through an Exchange.” See 77 FR 70646 (Nov. 26, 2012) (to be codified at 45 C.F.R. pts. 147, 155, 156). See also the definition of *essential health benefits package* in § 1302 of the Affordable Care Act.

² Section 15-1204.1(b)(2) of the Insurance Article exempts a carrier from offering qualified health plans in the SHOP Exchange if reported total aggregate annual earned premium from all health benefit plans offered to small employers in the State for the carrier and other carriers in the same insurance company holding system is less than \$20,000,000. Section 15-1303(b)(2) of the Insurance Article exempts a carrier from offering qualified health plans in the Individual Exchange if reported total aggregate annual earned premium from all individual health benefit plans in the State for the carrier and other carriers in the same insurance company holding system is less than \$10,000,000.

small employer and individual markets, but if they participate in at least one of these markets, they are required to participate in the corresponding Exchange.

5. How many health benefit plans is a carrier required to offer in Maryland?

- In accordance with §31-115 of the Insurance Article, carriers participating in the small employer group market are required to file for approval at least one health benefit plan at the bronze level, one at the silver level, and one at the gold level for sale inside the SHOP Exchange and at least one silver and one gold plan for sale outside the SHOP Exchange.³
- Carriers participating in the individual market are required to file for approval at least one health benefit plan at the bronze level, one at the silver level, and one at the gold level for sale inside the Individual Exchange and at least one silver and one gold plan for sale outside the Individual Exchange.⁴

6. Is there a limit to the number of health benefit plans that may be filed for approval?

In 2014, the MHBE is limiting plan designs for each carrier to four per coverage level for sale inside each of the respective Exchanges. Catastrophic plans, child-only plans, and cost-sharing reduction plans required by the Affordable Care Act or corresponding federal regulations⁵ will not be counted toward the four per coverage level maximum.

Outside the Exchanges, carriers are not limited as to the number of health benefit plans that they may file for approval.

7. May a form that is approved for sale inside the Exchange also be sold outside the Exchange?

Yes. However, a health benefit plan that has been approved for sale on the Exchange that does not include the pediatric dental benefits may not be sold outside the Exchange unless a rider providing the pediatric dental benefits is attached to the health benefit plan.

8. May a health benefit plan carve out the pediatric vision benefit?

No. The proposed federal rule prohibits any carve out of the pediatric vision benefit.⁶

9. What variability will be permitted for form filings?

In the past, the MIA has accepted policy form filings that included wide ranges of cost-sharing in the schedules of variability, i.e. deductible [0-\$1,000], coinsurance [70%-100%]. Due to actuarial value and coverage level requirements, this practice will not be permitted for the form filings that are subject to this Bulletin. Instead, carriers are required to file a separate schedule

³ Levels of coverage are defined in §1302(d) of the Affordable Care Act.

⁴ A carrier is not required to offer at least a bronze level of coverage if the carrier offers a qualified catastrophic plan as provided under the Affordable Care Act that is offered only to individuals eligible for catastrophic coverage. *See* Md. Code Ann. Ins. § 31-115(e).

⁵ *See* § 1402 of the Affordable Care Act; 77 FR 73212 (December 7, 2012)(proposed rule 45 CFR § 155.1030; and 77 FR 73214 (December 7, 2012)(proposed rule 45 CFR § 156.420).

⁶ *See* 77 FR 70657 (Nov. 26, 2012) (to be codified at 45 C.F.R. pts. 147, 155, 156).

of benefit form with the specific combination of benefits and cost-sharing for each plan design. Carriers need not file each schedule of benefit form in a separate SERFF filing, but may combine the schedule of benefit forms with the appropriate group policy, certificate of coverage, or individual policy.

10. Are there any special filing instructions for the new or amended non-grandfathered health benefit plans, dental plans, and vision plans in the small employer or individual markets with plan or policy years beginning on or after January 1, 2014?

- All filings are required to be made within the System for Electronic Rate and Form Filing (SERFF).
- 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.
- Carriers filing health benefit plan policy forms and premium rates for prior approval to the MIA are required to include the following information with each filing:⁷
 - Identification of where the plan will be sold (i.e. in the Exchange, outside the Exchange, or both);
 - 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);
 - A separate contract or schedule for each plan design that the carrier intends to offer;
 - The actuarial value of each plan design determined in accordance with the proposed rule on *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* (“proposed rule”)⁸ using the AV calculator developed and made available by HHS;⁹
 - Identification of whether the plan design is only applicable to those individuals who qualify for the cost-sharing reductions of the Affordable Care Act or corresponding federal regulations;¹⁰
 - Certification that the health benefit plan’s prescription drug benefit complies with the proposed rule;¹¹ and

⁷ See also the Filing Rules for Maryland in the System for Electronic Rate and Form Filing (SERFF) for submission requirements and general instructions that apply to all rate and form filings, i.e filing fees, readability certification, filing format and attachments, etc.

⁸ See 77 FR 70644 (Nov. 26, 2012) (to be codified at 45 C.F.R. pts. 147, 155, 156).

⁹ 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 proposed rule. 77 FR 70671 (proposed 45 CFR § 156.135(b)).

¹⁰ See § 1402 of the Affordable Care Act; 77 FR 73212 (December 7, 2012)(proposed rule 45 CFR § 155.1030; and 77 FR 73214 (December 7, 2012)(proposed rule 45 CFR § 156.420).

¹¹ 77 FR 70670 (proposed 45 CFR §156.120).

- If the health benefit plan does not include the pediatric dental benefits, a description of how the health benefit plan will be amended when sold outside the Exchange.
- Additional requirements for stand-alone dental plan filings
 - Identification of the level of coverage, i.e. low or high, including the actuarial value of the plan determined in accordance with the proposed rule;¹²
 - Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles;¹³ and
 - Demonstration that the plan has a reasonable annual limitation on cost-sharing.¹⁴

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

¹² 77 FR 70672 (proposed §156.150(b)(2))

¹³ 77 FR 70672 (proposed §156.150(b)(3))

¹⁴ 77 FR 70672 (proposed §156.150(a))