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BULLETIN 16-35

Date: December 28, 2016

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

Re: Student Health Plan Form and Rate Filing Instructions for the 2017- 2018 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 2017-2018 school year.

The student health plan form filings for the 2017- 2018 school year are required to be filed with the Maryland Insurance Administration (MIA) on or before **February 1, 2017**. For the rate filings, carriers are required to file rating methodology and manual rates with the MIA on or before **February 1, 2017** in the same filing as the forms under the SERFF Filing Type: Form/Rate. Any school specific rates are required to be filed no later than 90 days before the effective date of each plan.

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

1. The essential health benefits for the 2017- 2018 school year are based on the 2017 benchmark plan selected by the Maryland Insurance Administration ("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 plans designed for the 2017- 2018 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.

2. On March 8, 2016, after the MIA-imposed filing deadline had expired for student health plan filings for the 2016-2017 school year, the federal regulations governing student health insurance coverage were revised.[1] The revised regulations provide that for policy years

[1] *See* Federal Register, page 12334, March 8, 2016.

beginning on or after July 1, 2016, the requirement to provide a specific "metal level" of coverage described in section 1302(d) of the Affordable Care Act does not apply to student health insurance coverage. The regulations further provide that student health insurance coverage must provide an actuarial value of at least 60%, and that 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) that the coverage would otherwise satisfy.[2] In consideration of the revised regulations, variability in cost-sharing, such as copayment amounts, coinsurance percentages or deductible amounts, will now be permitted for student health plans. Carriers are no longer required to file a separate schedule of benefits form for each benefit design. However, 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.

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.[3]

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

   a. Disclosure of the actuarial value of the coverage and the metal level (or next lowest metal level) that would otherwise apply. The actuarial value must be at least 60% and must be determined in accordance with 45 C.F.R. § 156.135 using the AV calculator developed and made available by HHS;[4]

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

   c. 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;

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

   e. Certification that the health benefit plan's prescription drug benefit complies with 45 C.F.R. § 156.122 based on the information provided in the CMS Essential Health Benefits Rx Crosswalk Methodology for Plan Year 2017 and the 2017 EHB Benchmark Plan Information summary document provided by CMS; and

   f. Documentation of compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) regulations as found in 45 C.F.R. § 146.136. 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 plan design is no more restrictive than the

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[2] 45 CFR § 147.145

[3] 45 CFR § 147.145.

[4] 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).

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

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Life and Health