A service of the Maryland Health Benefit Exchange

Carrier Reference Manual

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Maryland Health Connection

State-Based Health Insurance Marketplace

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. A key provision of the law requires all states to participate in health insurance exchanges beginning January 1, 2014. A health insurance exchange is a marketplace to help individuals, families and small businesses shop for coverage through easy comparison of available plan options based on price, benefits and services, and quality.

MARYLAND'S MODEL: A STATE-BASED MARKETPLACE

Each state has the flexibility to determine the design of an operating model that will work best for its residents. An exchange may be operated by the state government, the federal government, or through services coordinated in a state-federal government partnership.

On October 9, 2012, in a letter to the U.S. Secretary of Health, the State of Maryland formally declared intent to establish a state-based health insurance marketplace as a requirement for marketplace certification in January 2013. In December 2012, the State of Maryland received conditional approval to operate Maryland Health Connection.

As a state-based exchange, Maryland is responsible for the development and operation of all core functions including:

- Consumer support for coverage decisions
- Eligibility determinations for individuals in insurance affordability programs
- Enrollment in qualified plans
- Authorization of participating carriers
- Certification of qualified plans
- Operation of the Small Business Health Options Program (SHOP)

In 2011, the MHBE Board of Trustees adopted a set of seven principles to ensure the health care needs of Maryland individuals, families, employers, and employees would be met. These principles continue to guide the policy development and implementation decisions for Maryland Health Connection:

1. ACCESSIBILITY—Maryland Health Connection should reduce the number of Marylanders without health insurance and improve access for all Marylanders.
2. AFFORDABILITY—Affordability of coverage, within the exchange and within the state, is essential to improving Maryland's health care system and economy.
3. SUSTAINABILITY—Maryland Health Connection will need to be sustainable in order to succeed in the long run.
4. STABILITY—Maryland Health Connection should promote solutions that respect existing strengths of our state's health care system and promote stability within the Exchange.
5. HEALTH EQUITY—Maryland Health Connection should work to address longstanding, unjust disparities in health access and health outcomes in Maryland.
6. FLEXIBILITY—Maryland Health Connection should be nimble and flexible in responding to the quickly changing insurance market, health care delivery system, and general economic conditions in Maryland, while being sensitive and responsive to consumer demands.

7. TRANSPARENCY—Maryland Health Connection is accountable to the public, and its activities should be transparent, its services easily available, and its information easily understandable by the populations it assists.

Manual Purpose

The Maryland Health Benefit Exchange Act of 2012 enables the Maryland Health Benefit Exchange (MHBE) to adopt policies and procedures to meet federal requirements and allow carriers[1] offering qualified plans on Maryland Health Connection sufficient time to develop plans and file rates. This manual contains information on the policies and procedures that have been adopted by the MHBE Board of Trustees, as well as regulation promulgated in COMAR Title 14 Subtitle 35. The policies and procedures cover the essential steps necessary for qualified carriers to offer health plans through Maryland Health Connection (MHC), Maryland's state-based health insurance marketplace.[2] This manual will be revisited annually to update carriers on changes to policies and procedures.

This manual reflects carrier, Qualified Health Plan (QHP), and Stand-Alone Dental Plan (SADP) requirements for the 2024 plan year and applies to carriers offering QHPs and SADPS on both the Individual and Small Business Marketplace. Maryland Health Connection for Small Business is the online platform for the Small Business Health Options Program (SHOP). The terms Small Business Marketplace and Maryland Health Connection for Small Business in this manual are references to SHOP.

[1] Carrier – this term is intended to refer broadly to all entities licensed to engage in the business of insurance in Maryland including insurers, health maintenance organizations, non-profit health service plans, dental plan organizations which are subject to State law which regulates insurance.

[2] Maryland Health Benefit Exchange (MHBE) refers to the public corporation and independent unit of state government. Maryland Health Connection is the state-based insurance exchange operated by the Maryland Health Benefit Exchange (MHBE).

CHAPTER 1. Plan Management Overview

The Maryland Health Benefit Exchange (MHBE) will partner with carriers to offer a variety of affordable and high-quality insurance plans to consumers. Policies and procedures for the health insurance plans offered on Maryland Health Connection have been developed to:

GOALS:

- Promote affordability for the consumer and small employer.
- Ensure access to quality care for consumers presenting with a range of health statuses and conditions.
- Facilitate informed choice of health plans and providers by consumers and small employer groups to reduce health disparities and foster health equity.

In order to achieve these goals, MHBE has established Plan Management policies and procedures to ensure that all carriers and the qualified plans they offer meet federal and state requirements.

Plan Management is the department within MHBE that focuses on plan set up, compliance and presentment to consumers. Specific plan management functions include:

- Carrier authorization
- Certification of qualified plans
- Compliance and ongoing monitoring of plans
- Recertification of qualified plans
- Maintenance of operational data
- Management of changes in plan availability
- Management of decertification process
- Presentment of qualified plan data to consumers
- Management and presentment of qualified plan quality data
- Plan shopping and enrollment
- Plan data management and upload
- Reporting and analysis
- Management of Carrier Partnerships
- Collaboration with State and Federal Agencies
- Implementation and management of the SHOP

The MHBE, in partnership with other agencies, will ensure each of these functions can be executed as required by federal and state laws.

CHAPTER 2. Carrier Participation Model

Based on input from stakeholders, MHBE has identified a balanced and incremental approach for its carrier contracting strategy. Section 1311 of the Affordable Care Act outlines a set of minimum standards for carriers contracting with MHBE and doing business on Maryland Health Connection. As a marketplace, MHBE has the statutory authority to add requirements above the ACA minimum standards.

A. Maryland Insurance Market Rules

The Maryland Health Benefit Exchange Acts of 2011 and 2012 established market rules that apply to carriers both inside and outside of Maryland Health Connection as of January 1, 2014. Additionally, the legislation defines the operating requirements for stand-alone dental carriers.

THE FOLLOWING MARKET RULES APPLY TO CARRIERS WHO OFFER PLANS ON MARYLAND HEALTH CONNECTION:

- Carriers must comply with section 1311(c)(1) of the Affordable Care Act.
- Carriers within the same holding company that collectively report $10 million in aggregate annual earned premiums in the *individual* market outside the exchange, have an obligation to offer plans in Maryland Health Connection if the carrier offers plans outside of the exchange.
- Carriers within the same holding company that collectively report $20 million in aggregate annual earned premiums in the *small group* market outside the exchange, have an obligation to offer plans in Maryland Health Connection if the carrier offers plans outside of the exchange.
- Carriers must obtain prior approval of premium rates and forms from the Maryland Insurance Administration (MIA).
- Carriers offering health benefit plans must provide at least one qualified plan in each of the bronze, silver, and gold metal levels on Maryland Health Connection.
- Carriers offering health benefit plans who participate in Maryland Health Connection individual market must offer at least one qualified plan at the silver level and one qualified plan at the gold level in the individual market outside of Maryland Health Connection if the carrier offers any plans in the individual market outside of the exchange.
- Carriers offering health benefit plans who participate in Maryland Health Connection's Small Business marketplace must offer at least one qualified plan at the silver level and one qualified plan at the gold level in the small group market outside the Small Business Marketplace if the carrier offers any plans in the small group market outside of the exchange.
- Carriers must charge the same premium rate for qualified health plans that have benefits that are the same regardless of whether that qualified health plan is offered through Maryland Health Connection, through a producer outside, or directly from the carrier.
- Carriers must offer at least one catastrophic plan inside Maryland Health Connection if catastrophic plans are offered by the carrier outside of Maryland Health Connection.
- Carriers must not charge any cancellation fees or penalties.
- Carriers must ensure that cost-sharing requirements do not exceed limits established under federal or state law.
- Carriers must ensure that deductibles do not exceed limits established under federal or state law.

- Carriers must offer a child-only plan to individuals under age 21 that is rated for child-only coverage in the individual market inside and outside of Maryland Health Connection.
- Carriers may offer dental benefits as stand-alone plans, or benefits sold in conjunction with a medical plan.

B. Annual Review

On an annual basis, MHBE will review the performance of participating carriers and make recommendations on areas of improvement. Performance review areas will include:

- Enrollment data by plan
- Network adequacy (including Essential Community Providers), in conjunction with the MIA
- Quality Assurance
- Annual renewals process with IT/EDI
- Complaints/grievances

As outlined in the carrier business agreement, carriers may be required to complete corrective action plans based on issues identified in the annual review.

CHAPTER 3. Carrier Certification Standards and Annual Process

The Affordable Care Act, Sections 31-106 and 31-108 of the Insurance Article of the Maryland Code, and MHBE published regulations defined in COMAR 14.35.14, 14.35.15, 14.35.16, 14.35.17, and 14.35.18 establishes that carriers must meet several standards to be certified or recertified to operate within the Individual and Small Business Marketplaces. In accordance with these authorities, MHBE has established an Annual Certification Process for health and dental carriers to become certified to offer qualified plans (QHPs and SADPs) on the Individual and Small Business Marketplaces.

Each carrier must complete the annual Carrier Authorization or Reauthorization process, including the submission of a completed Carrier Application Package to MHBE. The certification process takes place during the calendar year prior to when plans become effective. MHBE will review the application against the certification standards detailed in this chapter. Each year MHBE will post the application to its partner website at www.marylandhbe.com.

A. Carrier Certification Process

As part of the annual Carrier Certification Application, carriers must provide required documentation and attestations by the specified due date. Required attestations on network adequacy, provider directories, and discriminatory benefit design are included in the integrated Carrier Application. The location of the required documentation can be found on MHBE's partner website.

Required Carrier Certification Submissions:

- Carrier Application
- Carrier Logo
- List of Subcontracted Vendors Attestation
- Carrier Business Agreement Attestation
- Non-Exchange Entity Agreement Attestation
- Network Adequacy Attestation
- Provider Directory Attestation
- Discriminatory Benefit Design Attestation
- State Reinsurance Program Attestation

Additional information regarding the certification standard addressed by each of these required documents is described in the Carrier Certification Standards section of this manual.

Unless otherwise noted, carriers must submit carrier certification documents through the integrated carrier application process. Exceptions to this general rule are for biennial Amendments and Restatements of the Carrier Business Agreement and other legal documents that may require submission of a physical copy to MHBE.

MHBE must review a Carrier Certification Application submitted to MHBE by a carrier within 45 calendar days of receipt of the completed application. MHBE will notify a carrier if its submitted application is not considered complete and which items are outstanding. All carriers will receive a Carrier Certification Approval or Denial Notice from MHBE within the 45-day period. MHBE will provide denial reasons as well as appeals rights for any carrier that is denied. Plans submitted to MHBE are required to meet the annual Plan

Certification Process and Standards, which are described in Chapter 4. The Certification process/requirements for SADPs are also described in Chapter 4.

B. Carrier Certification Standards

In order to be certified to offer plans through the Marketplace, a carrier must meet certain standards. These standards are detailed in this section and include licensure and accreditation, among other requirements.

i. Maryland Insurance Administration Requirements

To be certified to participate in the Marketplace, carriers must attest that the carrier is licensed by the State of Maryland as a risk bearing entity and is operating in good standing with the MIA. Additionally, the carrier must adhere to the applicable rules and standards in the Insurance Article of the Annotated Code of Maryland. Carriers should use the Carrier Application document to meet this requirement.

ii. Requirement for Accreditation

To be certified to participate in the Marketplace, carriers must hold current accreditation. For carriers that offer health benefits only, the requirement for accreditation will be met if the carrier is accredited by the National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care, or the Utilization Review Accreditation Commission (URAC). MHBE will consider a carrier accredited if it has an accreditation status deemed acceptable under the federal accreditation standard described in The Centers for Medicare and Medicaid Services (CMS) 2020 Letter to Issuers in the Federally facilitated Exchanges. 45 CFR § 155.1045(b) details the timeline QHP carriers must follow for allowable accreditation status. As detailed in the 2020 Letter to Issuers in the Federally Facilitated Exchanges, accredited QHP carriers must attest to meet the standards under 45 CFR § 155.1045(b)(2) and authorize the release of their accreditation information as detailed in 45 CFR § 156.275(a)(2).

For carriers that offer dental benefits only, this standard will be met if the carrier holds a current and valid MIA Certificate of Authority.

Carriers will submit their accreditation information for carrier certification using the integrated carrier application. MHBE will not collect more information than what is submitted to the Federally Facilitated Marketplace (FFM).

Carriers are also required to achieve NCQA's Health Equity Accreditation. This requirement was a unanimous recommendation of the MHBE Health Equity Workgroup. Issuers offering plans through MHC when this requirement began were required to achieve the NCQA Health Equity Accreditation by December 31, 2023. Issuers that had received the NCQA Multicultural Healthcare Distinction prior to PY2024 are considered to provisionally meet the certification requirement, but must transition to the NCQA Health Equity Accreditation according to their certification renewal timeline with NCQA. New issuers will be required to achieve accreditation within 18 months of offering coverage on MHC.

iii. Requirement for an Active Carrier Business Agreement

To be certified to participate in the Marketplace, carriers must have an active Carrier Business Agreement (CBA) on file with MHBE. An active CBA is defined as the latest iteration of the CBA, signed by MHBE and the carrier, and on file with MHBE. The CBA contains terms and conditions regarding

compliance with MHBE policies and state/federal regulations. The CBA is automatically renewed biennially and is subject to restatement and amendment.

As in prior years, carriers may meet this requirement through the CBA Attestation within the integrated Carrier Application.

iv. Requirement for an Active Non-Exchange Entity Agreement

To be certified to participate in the Marketplace, carriers must have an active Non-Exchange Entity Agreement (NEEA). An active NEEA is defined as the latest iteration of the NEEA that is signed by MHBE and the carrier and on file with MHBE. In general, the NEAA is required by MHBE to ensure compliance with the requirements of the ACA, including 45 CFR § 155.260(b)(2) and 45 CFR § 155.270(a), regarding confidentiality, privacy, and security of data accessed by the carrier or exchanged between the carrier and MHBE. Carriers may meet this requirement through the NEEA attestation within the integrated Carrier Application.

v. Network Adequacy Requirement

Federal law (45 CFR 156.230) requires that a qualified health plan must maintain "A network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." The Maryland Insurance Administration (MIA) has established network adequacy standards under COMAR 31.10.44 and carriers must work with the MIA to meet these requirements..

vi. Provider Directory Requirement

Carriers must attest to submitting provider directory data to MHBE every fifteen days in the form and manner established by MHBE. Carriers will affirm that the data provided within submissions are accurate, complete, and up to date under 45 CFR § 156.230(b). Carriers must also attest to complying with 45 CFR § 156.230(b), where carriers must make available, in a manner determined by the carrier, provider directory information on its website without requiring consumer login. This requirement may be completed via the attestation in the integrated Carrier Application.

vii. State Reinsurance Program Attestation

As the requirement to submit claims data to MHBE is delegated to CMS, issuers submitting claims under the SRP must submit an annual attestation to the Maryland Health Benefit Exchange attesting compliance with COMAR 14.35.17.05 and the distributed data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines outlined in 45 C.F.R. 153 Subpart H –Distributed Data Collection for HHS-Operated Programs (153.700 – 153.730).

viii. Patient Data Availability Attestation

Issuers must complete the Patient Data Availability Attestation within the Carrier Application. The attestation requires that individual market QHP issuers comply with the CMS requirements at 45 CFR 156.221.

ix. Additional Requirements

To be certified to participate in the Marketplace, carriers must submit the following items as part of its Carrier Application Process:

a. Carrier Logo

The carrier must provide its logo in .jpg format with 140 x 50 dimensions. The logo will be used for plan shopping on the Maryland Health Connection website. Carriers are advised to reduce white space within its submitted logos. Carriers with previously submitted logos, that will not change, do not need to submit a logo during this process. All new entrants to the Marketplace will need to submit a logo meeting the preceding format and dimension requirements.

b. List of Subcontractors

Carriers will provide a list of any material subcontractor who performs work related to Marketplace functions for the carrier, as addressed in the CBA. For 2021, a renewing carrier should provide any updates to its most recent list on file with MHBE. If there are no updates, the carrier must notify MHBE that the carrier has no updates to its previously submitted list. MHBE will consolidate this submission requirement to the Carrier Application.

c. Non-Discriminatory Benefit Design Attestation

The ACA provides that carriers cannot make any coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life. Carriers must:

1. Comply with any applicable laws and regulations regarding marketing by health insurance carriers.
2. Not employ marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in Qualified Health Plans.

Carriers can attest to meeting the Non-Discriminatory Benefit Design requirements under 45 CFR § 156.225 through an attestation in the Carrier Application.

CHAPTER 4. QUALIFIED PLAN CERTIFICATION PROCESS

The Affordable Care Act, Section 31-115 of the Insurance Article, Maryland Code, and MHBE published regulations defined in COMAR 14.35.14, 14.35.15, 14.35.16, 14.35.17, and 14.35.18, establish that QHPs and SADPs must meet a number of standards in order to be certified or recertified to operate within the Marketplace. Several of these standards are market-wide standards, i.e., they are applicable on and off Marketplace.

MHBE has established an Annual Certification Process for certification of qualified health plans that a certified carrier would like to offer on the Marketplace. This chapter describes the Individual Marketplace's Certification Process specific to both Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs). Carriers are required to submit to MHBE, a Carrier/Administrator Point of Contact for Template Error Resolution. Contact information must include: Name, Title, Phone Number, and Email. This information will be collected as part of the carrier application.

Each year during the plan certification process MHBE will request consumer resources from carriers that inform our consumer assistance team, training department, and designated areas of the Maryland Health Connection website. The following information is requested each year:

- Updated payment guide language
- Educational & wellness program resources
- Copy of mock insurance cards & envelope
- Copy of mock invoices & envelope
- Mock renewal letter
- Updated call center handoff process
- Third party payer policy
- Carrier video webinars

A. Submission Requirements for QHP/SADP Certification

For a QHP/SADP to be certified for sale through the Marketplace, the plan's carrier must submit the Plan Certification Application and all required templates for each plan and for each plan year that the carrier will offer QHPs/SADPs. In addition, carriers must adhere to the Qualified Plan certification standards. The carrier must also successfully participate in the plan data and display process addressed in this section.

Required Plan Certification elements/templates include:

- Plan and Benefits Design Template
- Unified Rate Review Template
- Prescription Drug Template
- Network Template
- Service Area Template
- Rate Data Template
- Plan Crosswalk Template
- Actuarial Memorandum
- Partial County Service Area Justification

- Maryland Essential Community Providers Template (ECP)
- Consumer Narrative*
- URL Template
- Transparency in Coverage Template
- Telehealth Template

*Consumer Narrative is not a requirement for plan certification, however, MHBE encourages carriers to submit this narrative. The consumer narrative is a written justification for a carrier's rate increase. The narrative should be consumer friendly and should include the main factors causing the rate increase.

Templates, with the exception of the Maryland Essential Community Providers and the Telehealth Template, will be located on The Center for Consumer Information and Insurance Oversight (CCIIO) website for carrier resources. The Maryland Essential Community Providers Template may be found on MHBE's partner website. All templates and documents required for Plan Certification must be submitted through the carrier's System for Electronic Rate and Form Filing (SERFF) Binders.

B. Template and Additional Document Submission Timeline

New template requirements are released annually within the first quarter of the calendar year prior to the effective benefit year. Timelines are set according to the estimated MIA rate release schedule. The entire template suite and supporting documentation must be uploaded into SERFF Binders by the first Monday in June. Required templates, supporting documentation, and submission deadlines for each plan year are found in the table below. Each edition of the carrier reference manual will include updated submission requirements for subsequent plan years. Final QHP and SADP submissions will be accepted the following day in the event that the regular submission date falls on a MHBE observed holiday.

Table 1. Plan Certification Template and Supporting Document Submission Timeline.

Template Name	QHP/SADP	Initial Submission	QHP Final Submission	SADP Final Submission
Plan and Benefits Template	QHP and SADP	1st Monday in June	2nd to last Monday in September	1st Monday in September
Unified Rate and Review Template	QHP	1st Monday in June	2nd to last Monday in September	N/A
Prescription Drug Template	QHP	1st Monday in June	2nd to last Monday in September	N/A
Network Template	QHP and SADP	1st Monday in June	2nd to last Monday in September	1st Monday in September
Service Area Template	QHP and SADP	1st Monday in June	2nd to last Monday in September	1st Monday in September

Rate Data Template	QHP and SADP	1st Monday in June	2nd to last Monday in September	1st Monday in September
Plan Crosswalk Template	QHP and SADP	N/A	1st Monday in June	1st Monday in September
Maryland ECP Template	QHP and SADP	1st Monday in June	2nd to last Monday in September	1st Monday in September
Transparency in Coverage Template	QHP and SADP	1st Monday in June	2nd to last Monday in July	1st Monday in September
Telehealth Template	QHP	1st Monday in June	2nd to last Monday in July	N/A

Supporting Document Name	**QHP/SADP**	**Initial Submission**	**QHP Final Submission**	**SADP Final Submission**
Consumer Narrative	QHP	1st Monday in June	2nd to last Monday in September	N/A
Actuarial Memorandum	QHP	1st Monday in June	2nd to last Monday in September	N/A
Partial County Service Area Justification	QHP	1st Monday in June	2nd to last Monday in September	1st Monday in September
Statement of Detailed Attestation Responses for SBM Carriers	QHP	1st Monday in June	N/A	N/A
Network Description PDF	QHP	N/A	1st Monday in June	N/A
Logo	QHP and SADP	N/A	1st Monday in June	N/A

C. Plan Display Reconciliation

MHBE in coordination with carriers will ensure that QHP/SADP data displayed to consumers on the Maryland Health Connection website accurately displays plan benefits and cost sharing. MHBE will engage with carriers (individual QHP and SADP) to begin the data and plan display reconciliation process. This requires an extensive reconciliation process between carrier inputs, including plan templates and PDFs, and the display outputs of these items in plan shopping. The Plan Display Reconciliation process for plans being offered during the subsequent plan year occurs between July and September of the year prior. Between early to mid-August, carriers will receive a designated date and time to participate in plan display testing in the Maryland Health Connection User Acceptance Testing (UAT) environment. Final certification will occur the second to last week in September and MHBE will upload the final templates into production no later than October 1st each year. MHBE will release information on the Plan Display Reconciliation timeline each year through the Annual Issuer Letter.

D. Certification Standards (QHP and SADP)

Qualified plans sold to consumers via Maryland Health Connection must meet all applicable federal and state laws in order to be certified. The MIA reviews contracts/certificate forms and rates as required by state law.

i. Qualified Health Plans (QHPs)

a. ESSENTIAL HEALTH BENEFITS

The ACA requires that all small group and individual health benefit plans sold inside and outside of health benefit exchanges must cover a core set of "essential health benefits" as defined by the U.S. Department of Health and Human Services (HHS).

The benchmark plan determines the specifics of essential health benefits required. All plans offered through Maryland Health Connection and in the individual and small group commercial markets are required to include Maryland's EHBs that are covered in Maryland's benchmark plan. The link to Maryland's Benchmark plan is below.

Embedded pediatric dental benefits in QHPs are optional. QHP carriers intending to offer plans without embedded pediatric dental benefits must inform MHBE of such intent and identify the affected plan by HIOS ID.

Maryland EHB Benchmark Plan: https://www.cms.gov/cciio/resources/data-resources/downloads/updated-maryland-benchmark-display-summary.pdf

Maryland Insurance Administration Bulletin 19-01: Essential Health Benefits Substitution Rules

b. QUALIFIED HEALTH PLAN (QHP) METAL TIERS/ACTUARIAL VALUE

The ACA requires that all small group and individual health benefit plans sold inside and outside of health benefit exchanges must meet the metal tier and actuarial value (AV) requirements, meaning that plans offered by carriers must meet distinct levels of coverage referred to as "metal tiers"—bronze, silver, gold, or platinum:

- Bronze plan - AV of 60 percent;
- Silver plan - AV of 70 percent;
- Gold plan - AV of 80 percent;
- Platinum plan - AV of 90 percent.

Rules for de minimis variation range for AV level of coverage is set according to CMS' final rule. 2024 de minimis variation can be found in the [Final 2024 Actuarial Value Calculator Methodology](#).

c. COST-SHARING LIMITATIONS

The ACA requires that individual health benefit plans sold inside and outside of a health benefit exchange must meet annual cost-sharing limits. 2024 plan limits are as follows:

- The out-of-pocket limit for the 2024 plan year may not exceed $9,450 for self only coverage or $18,900 for family coverage.
- Cost-sharing limits are indexed to per-capita growth in premiums in the United States as determined by HHS.

d. PLAN OFFERINGS

Carriers offering plans on the individual exchange must adhere to the requirements listed below for plan offerings:

- Carriers are required to offer at least one plan in the bronze, silver, and gold metal levels, in each service area in which it participates.
- Carriers must offer at least one catastrophic plan on Maryland Health Connection if it offers one outside of Maryland Health Connection.
- Carriers are required to submit a zero cost-share plan at the bronze level that is available to Native American consumers.
- Carriers must offer a limited cost sharing variation of each plan at the bronze, silver, and gold levels that is available to Native American consumers.
- Carriers will be allowed to offer a minimum of three and a maximum of sixteen plans on Maryland Health Connection. Carriers may offer no more than 4 plans per metal level. This does not include variant plan designs required by legislation (e.g., catastrophic plans, cost-sharing reduction plans).

Each carrier participating in the Maryland marketplace must offer at least one Value Plan at the bronze, silver, and gold metal levels. Value Plans have standardized cost sharing for commonly used services. Plan designs for bronze, silver, and gold metal levels are detailed in the 2024 Annual Letter to Issuers. Each year, all updates and changes to Value Plan standards are provided in the Annual Letter to Issuers. MHBE may provide additional flexibility contingent upon limitations that may arise from the Actuarial Value Calculator for the corresponding plan year.

e. Mental Health Parity and Addiction Equity Act

The ACA requires that all individual and small group plans sold inside and outside of health benefit exchanges comply with the Mental Health Parity and Addiction Equity Act.

f. Service Area Standards

Carriers may serve an area smaller than one county if it demonstrates that boundaries are not designed to discriminate against individuals excluded from the service area. Carriers servicing an area smaller than one county must submit a detailed Partial County Service Area Justification as a part of its application. Carriers that offer non-statewide plans must submit data on the

demographics of the partial areas served by each qualified plan the carrier offers for sale within the SHOP or Individual Exchange in accordance with 45 CFR § 155.1055(b).

MHBE will permit service area changes by the carrier after the initial data submission by petition for limited reasons, such as a carrier's inability to secure enough providers or MHBE's request to serve an unmet need, as determined by the MIA or MHBE. No service area changes will be permitted after the final data submission unless the change constitutes an expansion of the service areas.

g. Prescription Drugs

The certification standards for prescription drug coverage are as follows:

1. Prescription drugs covered under the plan's health benefit must be identified in the plan's MIA filings and the carrier must continue certifying compliance with MIA's filing requirements under 45 CFR § 156.122(a)(1).

2. The drug formulary internet link provided by the carrier must link directly to the list of covered drugs without requiring further navigation. This formulary drug list link, specifically "Prescription Drug Search" in the HBX Plan Shopping Module, should be the same direct formulary drug list for obtaining information on prescription drug coverage that is found in the Summary of Benefits and Coverage (SBC), in accordance with 45 CFR § 147.200(a)(2)(i)(L). The formulary link must directly list covered drugs and include tier and cost sharing information. Plans should indicate the tier and may include a legend to allow the consumer to match the drug category.

3. Carriers have the option of identifying a drug as a "preventative drug" covered at zero cost.

4. Carriers must have in place a drug exception process for standard situations that are not emergency circumstances by which an enrollee can request access to a drug not on the plan's formulary. The carrier must notify the enrollee of its coverage decision no more than 72 hours after receipt of the exception request. Carriers must have an external review process by an independent review organization (IRO) for denied requests. The external review organization must complete its review and provide a decision within 72 hours of receiving the review request. In addition to carrier internal and IRO processes, the existing external review process by MIA under Title 15, Subtitle 10A of the Insurance Article will satisfy this requirement. The carrier must also track drug exceptions and provide information to MHBE upon request.

   The carrier will continue to keep account of the member drug exceptions processed during the plan year and provide summary metrics on processed member drug exceptions to MHBE if requested. MHBE will provide further guidance on how to meet this requirement if necessary.

5. Plans must continue to meet the following standards to improve consumer usability of carrier formulary directories:

- For QHP carrier formulary directories, the tier descriptive category (i.e., generic, preferred brand, etc.) must be made clear for each drug in the formulary. Where the tier descriptive categories may not be added to the formulary directory, i.e., "Tier I" may not be changed to "Generic," a legend that explicitly matches a tier's numeric category (0, I, II, III, etc.) with its descriptive category (Preventive, Generic, Preferred Brand, etc.) may be included with the directory, with MHBE approval, as an alternative option to meet this requirement. Carriers that choose the legend option must have the legend clearly displayed on each viewable section of the formulary. MHBE recognizes that drugs may move from brand to generic tiers during the plan year, and it is expected that each carrier updates its formulary to reflect such changes expeditiously.

h. Marketing and Benefit Design

Carriers must attest to no plan discrimination. MHBE will continue to screen carrier template submissions using available discriminatory benefit design tools provided by the FFM. Carriers are allowed to meet this standard through completion of an attestation, included as part of the Carrier Application (see table). A separate attestation will not be required.

i. About This Plan (PDF)

Carriers may supply MHBE with additional information about their QHP and SADP offerings that may not be detailed or described through the Summary of Benefits and Coverage (SBC). Information carriers can provide can include but may not be limited to:

- Chronic disease management/cost sharing programs
- Wellness/Incentive programs
- Telemedicine Services

Carriers should seek guidance from plan management if they have questions regarding this process. Consumers will utilize the *Important Information About This Plan Link* found on Marylandhealthconnection.gov in order to locate this content.

ii. Stand-Alone Dental Plans (SADPs)

a. ESSENTIAL HEALTH BENEFIT (EHB)

The final rule issued by HHS on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation states that all stand-alone dental plans offered on Maryland Health Connection must contain, at a minimum, the pediatric portion of the EHB package.

b. STAND-ALONE PEDIATRIC DENTAL PLAN TIERS/ACTUARIAL VALUE

Carriers can offer SADPs at varying levels as long as they continue to offer the pediatric dental EHB and meet the annual limitations and cost sharing.

SADPs may not offer more than four dental plans per product per plan type (child-only/family).

c. COST-SHARING LIMITATIONS

For the 2024 plan year the out-of-pocket maximum for stand-alone dental plans is $400 per year for one covered child. For two or more covered children, the out-of-pocket

maximum is $800 in aggregate per year. No lifetime limits are allowed for stand-alone pediatric dental plans.

For family stand-alone dental plans, the adult portion of the dental plan is not considered an EHB therefore the requirements for out-of-pocket maximums or prohibition of lifetime limits will not apply. The out-of-pocket (OOP) maximums will apply only to the pediatric portion of the plan.

iii. Waiver Authority[3]

MHBE, with the approval of the MHBE Board of Trustees, may grant a waiver for specific provisions described in this chapter. MHBE may grant the waiver with or without corresponding conditions. To request a waiver, the carrier should inquire with the MHBE Account Manager.[4]

iv. Denial, Suspension, and Revocation of Certification

MHBE may deny, suspend, revoke, or seek other remedies against the QHP carrier offering a plan under Section 31-115 (k) of the Insurance Article of the Maryland Code for failure to adhere to certification requirements. MHBE may conduct compliance reviews of a plan during the benefit year. The scope of such compliance reviews extends to only include certification standards covered in Section 31115(k) of the Insurance Article of the Maryland Code. If as a result of such compliance reviews, MHBE finds a carrier to be non-compliant, MHBE will require the carrier to correct the findings and meet compliance. Any denial, suspension, or revocation of certification and compliance review findings and corrective action plans are subject to any and all remedies available under state and federal laws and regulations.

v. Biennial Recertification

On a biennial basis, the MHBE may review all the original certification data to confirm the plan still meets requirements and can continue to be offered to consumers. The MHBE has the right to modify the recertification frequency after the first biennial recertification period. The MIA contract/certificate review is not a part of the Annual Review or Biennial Recertification process. Carriers have the right to appeal recertification decisions.

vi. Off Exchange SADP Certification Process and Standards

In compliance with § 31-115(a)(4) of the Insurance Article of the Maryland Code, MHBE will continue to certify Off Exchange SADPs. SADPs that participate in the Exchange-Certified programs are required to submit an Off Exchange Dental Carrier Application and provide MHBE with notice of intent to participate after they have been approved by MIA.

Certified Off-Exchange Stand Alone Dental Plans will not be offered on the Maryland Health Connection Marketplace.

a. PROCESS

Unless otherwise directed by MHBE, carriers must submit plan certification data through the secure System for Electronic Rate and Form Filing (SERFF) Binders. Exceptions to this general rule are limited, and non- allowable before rate release by MIA.

[3] See MHBE Waiver Authority as defined in COMAR 14.35.15

[4] The MHBE Account Manager is the carrier's point of contact for all Plan Management/Operational initiatives. All carriers participating in Maryland Health Connection currently work with the MHBE Account Manager.

MHBE has 45 calendar days from the beginning of the plan certification period to notify the carrier of approval or denial to offer qualified plans on the Marketplace. In such cases where a single plan or a product type is denied certification on the Marketplace, MHBE will provide to the carrier the reasons for denial and instructions to reapply or appeal.

b. STANDARDS

In order to be certified as an Off Exchange SADP, plans are required to:

- Cover the State benchmark pediatric dental essential health benefits
- Comply with annual limits and lifetime applicable to essential health benefits
- Comply with annual limits on cost sharing applicable to stand-alone dental plans under 45 CFR 156.150
- Meet the same actuarial value requirements for the pediatric dental essential health benefits required for a qualified dental plan

E. Additional Resources

Carriers participating in the Maryland marketplace must submit the following resources that provide yearly updates to consumers, consumer assistance workers, and the MHBE Training Department. Each year, during the plan certification period, carriers will coordinate with MHBE Plan Management to submit these resources.

- Updated payment guide language
- Educational and wellness program resources
- Copy of mock insurance card and envelope
- Copy of mock invoice and envelope
- Mock Renewal Letter
- Updated call center handoff process
- Third Party Payer policy
- Carrier Videos

CHAPTER 5. Rating Rules

The ACA restricts the variation of premiums, both inside and outside of health benefit exchanges. Premiums must be calculated using adjusted community rating and may only vary by the following rating factors:

Age (3:1 max)
Geographic Rating Regions
Family Composition

The final rule from HHS regarding Health Insurance Market Rules and Rate Review specifies that rates for families must be determined by aggregating the individual rates for each family member. The final rule allows rates to vary based on age and tobacco use. Any rating variation for age and tobacco use must be applied based on the portion of premium attributed to the individual family member.

At this time, Maryland Health Connection cannot accommodate tobacco rating.

A. Dependent Rating Requirements

All carriers, including SADPs, participating in the Marketplace must cap dependent premium rating at three dependents under 21. The premium amount for no more than the three oldest covered children should be included in determining the total family premium, in accordance with 45 § CFR 147.102(c)(1).

B. Geographic Rating Regions

Maryland is divided into four rating regions for both the individual and small group markets:

- Baltimore Metropolitan: Baltimore City, Baltimore County, Harford County, Howard County, and Anne Arundel County

- Eastern and Southern Maryland: St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County, and Worcester County

- Washington D.C. Metropolitan: Montgomery County and Prince George's County

- Western Maryland: Garrett County, Allegany County, Washington County, Carroll County and Frederick County

BULLETIN 13-08 Geographic Rating Areas

CHAPTER 6. Essential Community Providers

Essential Community Providers (ECPs) are defined in section 340B (a)(4) of the Public Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act. ECPs are provider organizations that by legal obligation, organizational mission, or geographic location, serve a population that has been at risk for inadequate access to care. Federal law requires that a carrier contract with "a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area." (45 CFR §156.235). Carriers will utilize the Maryland Essential Community Providers Template to report compliance with this standard.

A. Expanded ECP Definition

MHBE recognizes ECPs defined under 45 CFR § 156.235(c) and adds local health departments, outpatient mental health centers, and substance use disorder treatment providers as described in COMAR 10.9.80.03.B(1) & B(3), that are licensed, certified, accredited, or approved by Maryland Department of Health as programs or facilities, or a school-based health center. ECPs falling under this definition will be termed "Expansion Providers". A table of ECP categories that includes Expansion Providers can be found on MHBE's carrier resource page.

B. ECP Network Inclusion Standards

MHBE adopts the following ECP network inclusion standards for all QHP plans and carrier networks:

- Providers must be able to meet carrier credentialing standard
- Carriers must contract with at least 35% of available ECPs in each plan's service area as part of each plan's provider network (write in option and alternative allowed)
- Carrier must offer contracts in good faith to the following providers:
  - All available Indian Health Care Providers in the service area
  - Any willing Local Health Department in the plan's service area
  - At least one ECP in each ECP category in each county in the service area

Offering a contract in "good faith" will be met if the carrier offers the same contract terms that a willing, similarly situated, non ECP provider would accept or has accepted from the carrier. MHBE requires that, upon request, carriers provide MHBE verification, including the offered contract, to demonstrate good faith compliance with this standard.

Carriers will use the MHBE developed Essential Community Provider Template to report which ECPs have been contracted for their networks. Additionally, carriers will be allowed to submit ECPs through a write-in option. The following information is required for the write-in option:

- Provider's zip code reflecting provider location within a low-income zip code or Health-Professional Shortage Area included on the "Low-income and Health Professional Shortage Area Zip Code Listing" located at: http://www.cms.gov/ccio/programandinitiatives/health-insurance-marketplaces/qhp.html

- The provider's street address (P.O. Box is not sufficient)
- The National Provider Identifier (NPI) number if the provider has an NPI number.

i. Calculation Methodology for ECP Network Inclusion Standard

Carriers may refer to the instructions on the Essential Community Providers document found under Plan Certification Materials on MHBE carrier resource page.

ii. Alternative ECP Network Inclusion Standards

If a carrier cannot meet the general ECP standard, the carrier may satisfy this standard under an alternative justification. The two groups of carriers, in particular, that may qualify are listed below:

a. QHP carriers that provide a majority of covered professional services through physicians employed by the carrier or through a single contracted medical group qualify to comply with an alternative standard for ECP network inclusion. Carriers that qualify for the alternative standard must demonstrate through a narrative that low-income members receive appropriate access to care and satisfactory service. Such carriers must submit to MHBE provider quality and patient satisfaction metrics. Carriers may work with MHBE to determine an approach for meeting this requirement. Acceptable approaches include provisions of National Quality Forum (NQF) endorsed or submitted for endorsement by NQF metrics, development of a statistically rigorous CAHPS survey of cost-sharing reduction eligible members, or other approaches deemed acceptable by MHBE.

The narrative should describe the extent to which the carrier's provider sites are accessible to, and have services that meet the needs of specific underserved populations, including:

a. Individuals with HIV/AIDS (including those with comorbid behavioral health conditions)
b. American Indians and Alaska Natives (AI/AN)
c. Low income and underserved individuals seeking women's health and reproductive health services
d. Other specific populations served by ECPs in the service area

b. QHP carriers that do not provide a majority of covered services through physicians employed by the carrier or through a single contracted medical group may also qualify for the alternative standard if the carrier is unable to meet the 35% standard because of the volume of providers that are unable to meet the carrier's credentialing requirements. In these cases, the carrier should also provide a written narrative that includes the items addressed above. Carriers with questions on operational guidance for meeting the ECP standard should visit the MHBE Partner website under the Partner/Carrier page.

iii. Dental ECP Inclusion Standard

Dental carriers must offer contracts in good faith to 35% of all ECPs in each plan's service area to participate in the plan's provider network. Dental carriers must also offer a contract in good faith to all available Indian Health care providers in the plan's service area. MHBE encourages SADPs to contract with at least one Federally Qualified Health Center (FQHC) and any willing Local Health Department (LHD).

CHAPTER 7. Post Certification Requirements

To maintain its certification to participate in the Marketplace, a carrier must comply with the post-certification requirements in this chapter.

A. Enrollment Reconciliation Standards

i. QHP/SADP

Carriers shall reconcile enrollment files with MHBE no less than once a month in accordance with 45 CFR §155.400(d). MHBE has leveraged the policy-based payments process, SBMI, to perform reconciliation with carriers. MHBE encourages carriers to work in good faith partnerships to build a process that is mutually beneficial and complies with federal standards.

ii. Broker Payments

Carriers must pay the same broker compensation for plans offered through the Marketplace that the carrier pays for similar plans offered in the State outside the Marketplace. “Similar plan” means a plan with the same HIOS ID.

iii. Quality Reporting

QHP carriers must comply with federal standards, processes, and requirements related to quality reporting through implementation of the Quality Rating System (QRS) and the Enrollee Satisfaction Survey (ESS). Consumers that enter Maryland Health Connection will see decision support tools such as plan quality and performance data to assist in promotion of informed consumer choice.

QHP carriers must continue to implement a Quality Improvement Strategy (QIS) in compliance with federal requirements and direction. Any questions regarding the QIS federal process or QRS technical requirements should be directed to CMS.

a. PRESENTMENT OF QUALITY DATA

Maryland Health Connection presents federal QRS data through the consumer plan shopping interface. The global/composite QRS-score will be displayed to consumers on the plan tile. If the consumer hovers over the score or chooses to explore the plan by clicking on “plan details,” the QRS-scores for Clinical Quality, Plan Affordability and Management, and Enrollee Experience will be viewed.

b. EXCLUDED CARRIERS

There are no existing quality measures for SADPs; SADP carriers will be excluded from the plan quality and performance reporting data displayed on Maryland Health Connection.

Carriers participating in Maryland Health Connection must also maintain compliance with existing state quality reporting rules. Maryland has a 20-year history of monitoring quality and performance of commercial health plans through processes established by Maryland Health Care Commission (MHCC). MHCC’s quality process leverages:

- Consumer Assessment of Health Providers and Systems from the Agency for Healthcare Research and Quality (AHRQ)

- Healthcare Effectiveness Data and Information Set (HEDIS) from National Committee for Quality Assurance (NCQA)
- Maryland Race/Ethnicity, Language, Interpreters, Cultural Competency (RELICC) Assessment
- Maryland Plan Behavioral Health Assessment Maryland Health Plan Profile

RELICCC data will not be made visible to consumers but will help MHBE with understanding disparity issues that may exist.

iv. Member Level Reporting

Participating carriers must provide a Member Level Report (MLR) to MHBE at least once per month. With appropriate reasonable notice (defined as within two weeks), MHBE may request additional MLRs in a month. Annually, and with reasonable advance notice, MHBE will review MLRs to determine if they continue to meet the need, as supplemental information, for MHBE to adjudicate the appropriate corrective actions for consumer enrollment and eligibility errors. With appropriate notice, MHBE may change the reporting frequency for the MLR depending on need. The MLR Reporting Requirement is governed by the rules included in the 834 Companion Guide.

v. Enrollment Administration Standards for Enrollees with Eligible Third-Party Entity Payments

Pursuant to 45 CFR §156.1250, a carrier must accept premium payments from the following third- party entities on behalf of plan enrollees:

- Ryan White HIV/AIDS Program under the title XXVI of the Public Health Service Act
- Indian tribes, tribal organizations, or urban organizations
- State and Federal Government programs

No provision in this subsection should be construed to exceed the FFM definition. MHBE encourages carriers to work with MHBE to prevent adverse enrollment outcomes when carriers terminate Maryland AIDS Drug Assistance Program beneficiaries due to misalignment between carrier and third-party payer payment cycles.

vi. Notices

MHBE and partner carriers will collaborate on consumer communication and notices to ensure coherent, accessible messaging and direction.

vii. Billing Rules

The binder payment must be made in full before coverage will be effectuated. Carriers can establish deadlines for receipt of premium payments in accordance with State and Federal requirements.

viii. Billing Grace Periods

For advanced premium tax credits (APTC) eligible consumers, carriers must abide by the 3-month grace period. For non-APTC eligible consumers, a 31-day grace period applies. Carriers must continue to pay claims during the grace period. These grace periods apply only after coverage effectuation.

In the 2024 Notice of Benefit and Payment Parameters, HHS established that carriers must notify enrollees of payment delinquency within a certain timeframe. MHBE conformed to this federal requirement by adopting COMAR 14.35.14.07C, which states that if an enrollee is delinquent

on premium payment, the carrier must provide the enrollee with notice of such payment delinquency. A carrier must provide such notices promptly and without undue delay, within 10 business days of the date the issuer should have discovered the delinquency.

ix. Requirement to Continue Accumulators

When a primary subscriber is terminated for outstanding citizenship/immigration status verifications, other enrollees should be allowed to continue coverage in a new contract with amounts contributed to deductible and OOP costs under the former contract. Enrollees are also eligible for a 60-day special enrollment period (SEP) to select a new plan if they choose not to continue coverage under the same plan.

x. Increased Access to the QHP Policy Contract

Carriers should supply a URL that provides a direct link to each QHP's Contract on the QHP's Summaries of Benefits and Coverage document. Carriers will meet this requirement as detailed under Department of Labor Guidance.[5]

xi. Medicare Anti-Duplication Reconciliation

In accordance with the guidance issued in the HHS Notice of Benefit and Payment Parameters for 2018, MHBE will engage with carriers during the annual renewal period to identify consumers who have both marketplace and other coverage that would violate the anti-duplication statute. Carriers must comply with Section 15-309(i) of the Insurance Article of the Maryland Code when identifying consumers whose health plan should not be renewed. MHBE will reconcile marketplace enrollees against an enrollee list provided by carriers to ensure marketplace coverage is not renewed for the following plan year.

xii. Carrier Initiated Termination Notices

QHP issuers are required to send to enrollees a termination notice for all termination events described in § 155.430(b), regardless of who initiated the termination.

xii. Carrier Interchange and Enrollment Escalation

MHBE has developed a robust escalations process that allows for collaboration with carriers in order to resolve consumer enrollment discrepancies. Carriers offering plans in the individual market will engage with MHBE in an escalation process that utilizes the carrier interchange (Salesforce platform) and all other necessary forms of communication to achieve timely resolution. MHBE maintains the source of record for enrollments and will manage the escalation process to ensure stewardship over Marketplace enrollments.

[5] https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/foremployersandadvisers/sbd-instructions-for-completing-the-indivdual-health-insurance-coverage-final.pdf

CHAPTER 8. MHBE Small Business Programs

A. Maryland Health Benefit Exchange Small Business

The Maryland Health Benefit Exchange Act of 2012 established a Maryland Small Business Program for employers with 50 or fewer employees and allowed for an Employee Choice benefit model as defined by the ACA. The Maryland Health Progress Act of 2013 and COMAR 14.35.18 further define Maryland SHOP rules.

MHBE provides Maryland's small businesses access to the Small Business Health Care Tax Credit and SHOP certified qualified health plans through the implementation of the Maryland SHOP in April 2014. SHOP was established to provide Maryland's small businesses with options for quality and affordable health insurance for their employees.

MHBE SHOP has been rebranded to operate as Maryland Health Connection for Small Business.

B. MHC for Small Business

The first phase of the platform was made available for the public in July 2020. The goals of Maryland Health Connection for Small Business for employers, employees, and brokers are summarized below.

EMPLOYERS CAN:

- Offer employees choices of insurance companies and qualified medical and dental plans
- Continue to use producers
- Use online tools to predict premiums
- Qualify for tax credits, if eligible
- Access support by phone and online

EMPLOYEES CAN:

- Choose health plans
- Make meaningful comparisons between plans
- Manage their accounts

Small businesses that purchase a plan displayed on MHC for Small Business portal have the option of choosing between three coverage models for their employees:

- Employer Choice – Small employers select a menu of QHPs across metal levels offered by one participating insurance issuer/carrier. This option is also called vertical choice. Employees may choose from among the QHPs selected by the employer. An employer may offer any number of plans: one (1), multiple, or all.

- Employee Choice/Plans Offered Across All Carriers – Small employers select up to two consecutive metal levels of coverage and offer coverage from those metal levels. For example, offering consecutive metal levels means that an employer can offer silver and bronze metal level plans to its employees. However, they are not able to offer non-

consecutive metal levels such as Platinum and Bronze to their employees. Employees may choose any QHP offered by any of the participating insurance carriers within those metal levels.

The Employee Choice enrollment model requires that small employers purchase their certified Small Business Qualified Health Plan (QHP) through a Maryland Health Benefit Exchange Small Business authorized producer, including an insurance carrier's captive producer.

Published rules for MHC for Small Business coverage models (Employee and Employer Choice), Employer Contribution, and Premium Rating are defined in COMAR 14.35.18

C. Eligibility

To participate in the Small Business Marketplace employers must meet eligibility rules as defined in COMAR 14.35.18. New groups will also be required to submit an MHC for Small Business Employer Eligibility Application. This application should be submitted prior to the end of the tax year in which the credit is being sought. Submission of the Employer Eligibility Application and determination of eligibility by MHBE is not required for implementation of the group coverage by the carrier.

Maryland small businesses and tax-exempt organizations qualify for the Small Business Health Care Tax Credit if they:

- offer a small group health insurance coverage through Maryland Health Connection
- Have fewer than 25 full-time equivalent (FTE) employees.
- Pay an average annual salary below an amount established by the IRS
    - This average excludes wages for owner and owner's spouse or family members.
- Contribute at least 50 percent toward employee-only health insurance premiums (35% for tax exempt/nonprofit organizations).

According to COMAR 14.35.18.03(E) and 45 CFR § 155.716, the Maryland Health Benefit Exchange's determination of an employer's eligibility to participate remains valid until the employer makes a change that could end its eligibility under § 155.710(b) or withdraws from participation.

A qualified employer may continue to participate in the MHC for Small Business marketplace if it ceases to be a small employer in accordance with 45 CFR § 155.710 (according to 45 CFR § 157.200(b)). Pursuant to 45 CFR § 155.710(d), MHC for Small Business must treat a qualified employer which ceases to be a small employer solely by reason of an increase in the number of employees of such employer as a qualified employer until the qualified employer otherwise fails to meet the Maryland Health Benefit Exchange Small Business eligibility criteria or elects to no longer purchase coverage for qualified employees through the Maryland Health Benefit Exchange Small Business.

In accordance with COMAR 14.35.18.03(Q) an employer must submit a new application to the Maryland Health Benefit Exchange Small Business if the employer makes a change that would end its eligibility under the requirements of 45 CFR §155.710(b) or withdraws participation with the Maryland Health Benefit Exchange Small Business within 30 days of said change. Beyond the requirements imposed upon employers to submit a new application in circumstances, Maryland Health Benefit Exchange Small Business may require, upon request, in-force SHOP groups to submit a new eligibility application two months prior to their renewal effective date for purposes of redetermination.

The Maryland Health Benefit Exchange Small Business Exchange will notify groups which are no longer determined eligible of their status upon receipt of a new Employer Eligibility Application. Coverage for groups no longer eligible will terminate at the end of the month following the date of ineligibility notification. The notice of ineligibility will be provided within 5 business days from receipt of the updated Employer Eligibility Application.

Maryland Health Benefit Exchange for Small Business will notify carriers of QHPs in which group members are enrolled in coverage within 5 business days of the end of any applicable appeal process under 45 CFR § 155.741.

Eligibility to enroll in a plan offered on Maryland Health Benefit Exchange Small Business does not constitute eligibility for the Federal Small Business Health Care Tax Credit.

D. Ineligibility

In accordance with 45 CFR § 155.716(d), the Maryland Health Benefit Exchange Small Business will offer an eligibility adjustment period for groups that are determined not eligible. The Maryland Health Benefit Exchange Small Business will:

- Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors
- Notify the employer of the inconsistency
- Provide the employer with a period of 30 days from the date on which the eligibility determination notice is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve inconsistency: and
- If after this 30-day period, the Maryland Health Benefit Exchange Small Business has not received satisfactory documentary evidence, the Maryland Health Benefit Exchange Small Business will
    - i. Notify the employer of its denial or termination of eligibility and of the employer's right to appeal such determination; and
    - ii. If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in the Maryland Health Benefit Exchange Small Business at the end of the month following the month in which the ineligibility notice is sent
    - iii. MHBE will notify the group and the affected carriers within 5 days of the determination of ineligibility for the small business

E. Employer Eligibility Appeals

MHBE must provide an eligibility appeals process for the Maryland Health Benefit Exchange Small Business program, in accordance with requirements established in COMAR 14.35.18 and 45 CFR § 155.741 and §§ 155.505(e) through (h) and 155.510(a)(1) and (2) and (c).

An employer has the right to appeal:

1. A notice of denial or termination of eligibility under § 155.716(e)
2. A failure by the Maryland Health Benefit Exchange Small Business to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 155.716(e)

All appeals must be requested within 90 days from the date of the notice of denial or termination of eligibility.

Maryland Health Benefit Exchange Small Business will provide written notice of the right to appeal a denial of eligibility under 45 CFR § 155.716(e). The notice will include:

1. The reason for the denial or termination of eligibility, including a citation to the applicable regulations; and
2. The procedure by which the employer may request an appeal of the denial or termination of eligibility.

In addition, after the appeal decision is issued, the Maryland Health Benefit Exchange for Small Business must provide the employer with written notice of the appeal decision.

If an employer is determined to be eligible following the appeal decision, then at the employer's option, the effective date of coverage or enrollment through the Maryland Health Benefit Exchange Small Business under the decision can either be made retroactive to the effective date of coverage or enrollment through the Maryland Health Benefit Exchange Small Business under the decision can either be made retroactive to the effective date of coverage or enrollment through the Maryland Health Benefit Exchange Small Business that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of appeal decision.

If the employer's ineligible determination is upheld on appeal, then the appeal decision is effective as of the date of the notice of the appeal decision.

F. EMPLOYER CONTRIBUTION

Employers are not required to contribute toward their employee's premiums, but they will not be eligible for tax credits unless they contribute at least 50 percent of the total premium cost. An employer may choose to contribute to the employees' premium amounts by using one of two methods:

Fixed Percent contribution—In this method, the employer pays a set percentage of the employees' health insurance premium. Under the individual rating rules, that means that the dollar amount contributed by the employer for each employee and dependents may vary. The employer may vary the contribution based on the product that the employee chooses (HMO vs. PPO) or by the type of plan (individual vs. family coverage).

Fixed Dollar contribution— In this method, the employer sets a fixed dollar amount for how much the employer and employee will contribute towards an employee's health insurance premium. Each employee pays the same monthly dollar amount based on his or her designated employee tier. Similar to the current marketplace, any small changes in the premium amount due to the number of employees in the plan will be borne by the employer.

Reference Plan Contribution—An employer can select one plan to base their premium contribution off of a "reference plan". The amount the employer decides to contribute towards all of his/her employee contributions will be based on this reference plan regardless of the plan the employee chooses. If dependent coverage is offered, the employer can choose a different contribution amount.

G. COUNTING EMPLOYEES

In the State of Maryland, a small business with 50 employees or fewer is qualified to purchase health insurance for its employees through the SHOP. Pursuant to Insurance Article § 31-101(z)(2)(ii), Annotated Code of Maryland, the number of employees shall be determined by adding:

1. The number of full-time employees, and;
2. The number of full-time equivalent employees (FTEs), which shall be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

For purposes of counting employees, the definition of an employee is an individual who is an employee under the common-law standard for determining employer-employee relationships (20 CFR § 404.1007 and 26 CFR § 31.340 (c)-1(b)).

It is, however, up to the employer to determine whether health insurance benefits are extended to part-time employees as well as full-time employees. Full-time employees that work at least 30 hours per week in any month are counted as one full-time employee. This amount is added to the number of part-time employees. Part-time employees are calculated by taking the hours worked by all part-time employees in a week and dividing that amount by 30. Seasonal workers aren't counted in the calculation for those working up to 120 days in a year.

Table 2 provides a few examples of how to count employees for the purpose of determining SHOP eligibility. Further details can be found at the IRS website.

Table 2. Employer FTE Count Examples.

Employer Profile	# of Employees	Disposition
An accounting company with 120 full time employees (30+ hours per week)	120	Large group/not SHOP eligible
A paving company with 20 full time employees and 20 part time employees that average 15 hours per week	30	Small group/SHOP eligible
A restaurant with 10 full time employees and 60 part time employees that average 15 hours a week	40	Small group/SHOP eligible

* Calculation is based on a four-week month

H. MINIMUM PARTICIPATION RATE

To maintain the existing minimum participation rates in the small group market in Maryland, the Board adopted a policy in December 2012 that requires employers to have a minimum participation rate of 75 percent for Employee Choice Model, in order to purchase insurance through the Maryland Health Benefit Exchange Small Business. Carriers may only utilize exemptions and waivers currently allowable under off/on SHOP rules. The direct enrollment process of MHC for Small Business allows the minimum participation rate for Employer Choice to be determined by the carrier with which the group is enrolling, at a rate not to exceed 75 percent.

Small groups may enroll a single, full-time employee if all other eligible employees have waivers and exemptions from inclusion in a group's minimum participation rate determination. QHPs offered in the Maryland Health Benefit Exchange Small Business may restrict the availability of coverage, with respect to a group health plan that cannot comply with group participation rules, to an annual enrollment period of November 15th through December 15th of each calendar year.

Groups should not be enrolled into group coverage until the participation level is determined and approved. However, if a group is enrolled in error by a carrier or contracted third party, the employer's enrollment into a plan offered through Maryland Health Benefit Exchange Small Business will continue until the end of the month following the month in which the termination notice is sent.

Employees covered under a spouse's or other group health plans, enrolled in public programs, or employees under the age of 26 covered on their parent's plan for whom the coverage does not meet the federal definition of “affordable,” will not be included in the minimum participation calculation. For employers that opt for the employee choice benefit model, the group must have 75 percent of its employees participating when aggregated across all carriers.

MARYLAND BUSINESSES WITH OUT-OF-STATE EMPLOYEES

Maryland small businesses certified to purchase a small group plan on SHOP have two options if they have employees that live or work out-of-state:

1. Choose a carrier with a national network so that employees in any state can select their plans through Maryland Health Connection and still be covered where they live or work.
2. Become qualified to purchase on the SHOP in both the state where they are headquartered as well as the state where their employees work. This is possible if the business meets requirements in both states and both states allow for dual certification. This allows out-of-state employees to select a plan through that state’s SHOP, so that they will have a network of providers where they live and work.

I. DIRECT ENROLLMENT PROCESS

Small employers who are eligible to purchase an MHC for Small Business qualified health plan/s can purchase a certified Qualified Health Plans (QHP) (and when available, Qualified Dental Plans) directly from a participating carrier and/or an MHC-authorized producer (including an insurance carrier’s captive producer) using the approved MHC Employer and Employee Direct Enrollment Applications. Eligible employers who purchase a plan through the direct enrollment process may be eligible to access tax credits afforded to them under the Affordable Care Act (ACA).

For Employee Choice Groups, MHBE or Participating Carrier/Issuer advises an employer that they need to enroll with the assistance of an authorized producer for plan shopping & implementation. Employers will be provided a link to a list of authorized SHOP producers.

Employers (and/or producers) complete an online MHC for Small Business Eligibility Application. The completed online form is used to determine group eligibility (this can happen simultaneously with or after plan implementation).

Employers work with authorized producers or participating carriers to receive premium quotes and plan information. Employers and producers may also use the online MHBE SHOP Quoting Tool. Final plan information and premium rates will be obtained from the participating carriers.

The employer selects a SHOP plan or plans to offer to employees and informs employees about their options. Group implementation information is processed by the participating carriers. For Employee Choice groups, the authorized producer will send a copy of the group implementation materials to MHBE for participation level determination. For Employer Choice groups, participation level determinations are made by the participating carriers.

Employees and dependents enroll in the plan of their choice through the Carrier(s) directly. The employer makes their initial payment to the Carrier and coverage begins. Carriers submit to MHBE a monthly enrollment file of those employees and dependents who enrolled in their Small Business QHPs.

Annual Open Enrollment Period

Employees will have an open enrollment period at their employer's renewal effective date. A carrier must establish an open period that meets the following standards, as required by MD Ins Code § 15-1208.2:

The annual open enrollment period shall be at least 30 days for each small employer. The annual open enrollment period shall occur before the end of the small employer's plan year, based on the small employer's initial date of enrollment.

During the annual open enrollment period, each qualified employee of the small employer shall be permitted to:

- Enroll in a qualified health plan offered by the small employer
- Discontinue enrollment in a qualified health plan offered by the small employer; or
- Change enrollment from one qualified health plan offered by the small employer to a different qualified health plan offered by the small employer

J. PLAN IMPLEMENTATION AND PLAN YEAR

Pursuant to 45 CFR 155.726(b), small businesses can choose to implement group benefits at any time during the year. The effective date will be based upon the carrier deadline rules in effect. These deadline rules apply to both new and renewal businesses. The current SHOP deadline is the 15th of the month prior to the start of coverage.

For a group enrollment received on the first through the fifteenth day of any month, the coverage effective date must be no later than the first day of the following month. For a group enrollment received on the 16th though the last day of any month, the coverage effective date must be no later than the first day of the second following month. In either of the above cases, a small employer may instead opt for a later effective date within a quarter for which small group market rates are available.

A participating carrier may choose to extend deadlines. The group's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage. The effective date of the plan will be based upon when the plan was implemented.

A SHOP-eligible group and/or their authorized producer would need to submit a final premium rate sheet or quote to the carrier along with other new group paperwork to install a group at the participating carrier(s).

In general, all insurance carriers should accept the universal employer and employee Maryland Direct Enrollment Form applications. The Employee Form can also be used to submit waivers, special enrollments, and/or changes to the participating carriers.

I. PEDIATRIC DENTAL EHB

SHOP plans can satisfy the pediatric dental essential health benefits requirement through either embedded dental benefits or stand-alone dental offerings.

CHAPTER 9. Consumer Assistance and Resources

A. Primary Care Provider (PCP) Selection

If a consumer enrolls in a plan requiring the selection of a PCP, the consumer must contact their carrier for selection. A consumer may wish to search for a specific provider and their participating networks before plan selection. Maryland Health Connection provides this access through the “Find A Doctor” tool in plan shopping. The “Find a Doctor” tool is populated by provider directory information submitted by each participating carrier and updated according to the provider directory requirement found in Chapter 3 of this manual.

B. Enrollment Payment URL

Carriers (QHP and SADP) offering plans on Maryland Health Connection must implement an Enrollment Payment URL redirect functionality. The Enrollment Payment URL redirect allows an enrollee to be redirected to a carrier’s website to pay binder premium payments along with tokenization of payment information for their enrollment. The payment URL (PayNow) will be displayed on Maryland Health Connection after completing the plan selection in a QHP offered by carriers and will remain available in the Consumer Account Home page until the consumer’s QHP is effectuated or the coverage start date, whichever is earlier.

A consumer can proceed after plan selection by clicking PayNow or skip this option. Consumers who choose to skip the PayNow option should contact their carrier directly to make their first payment. The carrier will handle all queries related to payments completed using the PayNow URL. Subsequent premium payments can only be paid directly to the carrier.

C. Billing Rules

The binder payment must make a payment that satisfies the carrier’s premium payment threshold policy before coverage will be effectuated, in accordance with COMAR 14.35.07.11(G)(4). An issuer may not apply premium payments made toward the same actively selected plan, or a different plan, when the enrollee’s grace period ends before 12/31 and the enrollee pays the premium for coverage for the next benefit year. If the grace period spans years, the carrier must allow the consumer to remain enrolled in the plan in the new plan year but may terminate coverage if the consumer does not pay all past due premiums by the end of the grace period. However, during OE a consumer who is in a grace period may enroll in a different plan from the same carrier and payment for the new plan may not be applied to debt for the current plan. After termination, the consumer may use any normal enrollment opportunities (SEP, OE if OE is ongoing at the time) to enroll in the same or different plan, and payments must be applied to the new coverage period, not to the past due premium. Carriers can establish deadlines for receipt of premium payments in accordance with State and Federal requirements.

D. Carrier Identification Cards

ID cards will not list the MHBE consumer assistance phone number. Carriers should continue to provide the carrier Member Services telephone number to policyholders and refer them to MHBE regarding questions of eligibility and enrollment.

E. Individuals Eligible for Minimum Essential Coverage

Individuals who are eligible for Medicare or other types of minimum essential coverage (such as employer sponsored health insurance), are not eligible to receive financial assistance through the advanced premium tax credit.

CHAPTER 10. Producer Appointments and Operations

Producers play a critical role in helping MHBE enroll uninsured consumers in plans offered through Maryland Health Connection. MHBE has adopted interim procedures for producer appointments by carriers. These procedures provide necessary guidance for carriers to follow when appointing producers for Maryland Health Connection and include the following requirements. Carriers:

- Must appoint an authorized producer, or provide a basis for denial within 10 business days of receipt of the request
- Cannot deny appointments based on production volume
- Cannot impose production requirements
- Must allow authorized producers to discuss all Maryland Health Connection plans with or without an appointment

A carrier can limit the scope of an appointment to Maryland Health Connection only.

MHBE requires authorized carriers to provide a listing of all appointed producers upon request. MHBE will provide carriers with a master broker file, so they are aware of which producers have been authorized to sell plans on Maryland Health Connection.

In accordance with guidance provided by MHBE on November 20, 2019, MHBE maintains the system of record for active brokers attached to enrollments and should be the only entity processing Broker of Record (BOR) forms. BOR forms received by carriers directly should not be processed and all brokers submitting the forms should be directed to MHBE Producer Operations. This guidance applies to all carriers receiving enrollment data and files directly from MHBE.