Title 14 INDEPENDENT AGENCIES

Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE

Chapter 15 Carrier Certification Standards

Authority: Insurance Article §§ 31-108, 31-115 and 31-116, Annotated Code of Maryland

.01 Scope.

This chapter describes the standards a carrier shall meet to be certified as a carrier authorized to participate on the Maryland Health Benefit Exchange under § 31-115(b)(5) of the Insurance Article, Annotated Code of Maryland. This chapter does not apply to certification of individual health benefit, dental or vision plans.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Active carrier business agreement" means the latest iteration of the carrier business agreement provided by the Exchange, signed by the Exchange and the carrier and on file with the Exchange.

(2) "Active non-exchange entity agreement" means the latest iteration of the non-exchange entity agreement provided by the Exchange, signed by the Exchange and the carrier and on file with the Exchange.

(3) "Carrier Business Agreement" means the agreement between the Exchange and the carrier that contains terms and conditions regarding compliance with Exchange policies and State and federal regulations.

(4) “System Companion Guide” means the document developed by the Exchange that provides instructions to carriers to process electronic data transactions between the Exchange and the carrier.

(5) “Carrier Reference Manual” means the document developed by the Exchange that provides business rules and operational instructions to carriers participating on the Exchange.

(6) “Health Maintenance Organization” or “HMO” has the meaning stated in Insurance Article, §19-701(g), Annotated Code of Maryland.

(7) “Non-exchange entity agreement” means the agreement between the Exchange and the carrier that contains privacy and security provisions with which carriers are required to abide by State and federal law.

(8) “Member level report” means a report of the carrier's membership plan enrollment files with the Exchange at a specified time, which includes information about the plan identification code that the member is enrolled in through the Exchange; the coverage effective date; the coverage termination date, if applicable, the termination reason, if applicable; the premium amount; and the amount of advanced premium tax credits, if applicable.

(9) “System for Electronic Rate and Form Filing” or “SERFF” means the online system used by the Exchange, MIA and HHS for the submission, review and approval of product and rate filings between regulators and carriers.

(10) “SERFF Binder” means the portfolio of information that carriers submit to the Exchange, MIA and HHS, as required under state and federal requirements, through SERFF.

(11) “State benchmark plan” has the meaning stated in Insurance Article, §31-101(aa), Annotated Code of Maryland.

.03 Carrier Conditions for Participation and Certification--Generally.

A. In order to participate in the Individual Exchange, the SHOP Exchange, or both Exchanges, carriers must hold a current certificate of authorization issued by the Exchange.

B. To participate in the Exchange and receive a certificate of authorization, carriers shall:

(1) have a Certificate of Authority authorizing the carrier to act as an insurer and engage in the business of health insurance or operate as a nonprofit health service plan or a health maintenance organization in the State of Maryland, under the Insurance Article, Title 4, Subtitle 1 (for insurers) and Title 14, Subtitle 1 (for non-profit health service plans); and the Health General Article, Title 19, Subtitle 7 (for HMOs), Annotated Code of Maryland;

(2) be operating in good standing with the Maryland Insurance Administration;

(3) be licensed as a risk-bearing entity by the State of Maryland;

(4) if offering health plans, demonstrate evidence that the carrier:

(a) is accredited by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC);

(b) has an accreditation status deemed acceptable under the federal accreditation standard described in the Centers for Medicare & Medicaid Services (CMS) 2017 Letter to Issuers in the Federally Facilitated Marketplace; and

(c) submits, in its System for Electronic Rate and Form Filing (SERFF) binder, an accreditation template developed by the Centers for Consumer Information and Oversight (CCIIO) and made available on the Exchange's partner website.

(5) if offering dental plans, demonstrate evidence that the carrier:

(a) holds a valid Maryland Insurance Administration certificate of authority; and

(b) submits a copy of the certificate of authority as a supporting document in its SERFF binder.

(6) have a current, signed carrier business agreement in place, in the form designated by the Exchange;

(7) have a current, signed non-Exchange entity agreement in place, in the form designated by the Exchange; and

(8) retain records related to participation in the Exchange for a period of 10 years and allow reasonable inspection by the Exchange, and, to the extent required by law, other governmental entities including the Department of Health and Human Services.

C. The carrier shall remain an authorized carrier until the certificate of authorization expires or the Exchange suspends or revokes the carrier's certification under Regulation .08 of this chapter.

D. When a carrier that offers one or more qualified plans in the Exchange undergoes a change of ownership as recognized by the State in which the carrier offers the qualified plan:

(1) the carrier shall notify the Exchange of the change in a manner to be specified by the Exchange;

(2) provide the legal name and Taxpayer Identification Number of the new owner and the effective date of the change at least 30 days prior to the effective date of the change of ownership; and

(3) the new owner shall agree to adhere to the requirements of this chapter.

.04 Application for Authorization.

A. Carriers shall submit an application to the Exchange each year, in the form specified by the Exchange, no later than July 1 of the certification year.

B. Carrier applicants shall provide to the Exchange, in the form required by the Exchange:

(1) an application form;

(2) An administrative data template;

(3) Carrier logo;

(4) List of subcontractors; and

(5) Network access plan.

C. An application will not be deemed complete until a carrier submits all of the required application elements.

D. The Exchange, within 45 days of receipt of a completed application, shall notify a carrier of the decision to approve or deny the application.

.05 Conditions for Participation-- Carrier Conduct

A. A carrier shall not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation in the administration of a qualified plan.

B. A carrier shall offer broker compensation for qualified plans offered through the Exchange equal to broker compensation for qualified plans offered outside of the Exchange;

C. A carrier shall comply with any applicable State laws and regulations regarding marketing by health insurance carriers, including:

(1) Insurance Article § 27-202 – 27-205, Annotated Code of Maryland, barring unfair methods of competition or unfair and deceptive acts and practices;

(2) COMAR 31.12.01.09, if the carrier is a health maintenance organization; and

(3) COMAR 31.10.32.04, if the carrier is a nonprofit health service plan.

D. In addition to the standards specified in this regulation, an authorized carrier must follow the standards under Subtitle 35 of Title 14 regarding:

(1) individual and SHOP eligibility, enrollment, and terminations;

(2) Exchange reporting: and

(3) related Exchange operation and business rules provided to carriers through the Carrier Reference Manual and System Companion Guide.

E. A carrier shall allow all qualified individuals to enroll in qualified health plans during open enrollment periods designated by the Exchange in the Individual and SHOP Exchanges.

F. A carrier shall allow qualified individuals determined eligible for special enrollment periods by the Exchange to enroll in qualified health plans outside the open enrollment periods.

G. A carrier shall implement the effective dates of coverage established by the Exchange in accordance with COMAR 14.35.14.04(B) through (D) as specified in enrollment transactions received from the Exchange;

H. A carrier shall process enrollment files received from the Exchange within 24 hours of receipt;

I. A carrier shall terminate an enrollee's coverage only in those circumstances permitted by COMAR 14.35.14.06.

J. A carrier shall accept and process an enrollment for a qualified individual that does not include a Social Security Number, except the health benefit plan may not process the enrollment if: the qualified individual requested enrollment in a Health Savings Account.

K. A carrier shall acknowledge receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.

L. If the primary enrollee, also called the subscriber, is terminated from the qualified health plan by the Exchange due to a redetermination under 45 CFR §155.315(f)(5) for an outstanding inconsistency of information provided in the enrollee's application for the enrollee's citizenship, as specified in §155.305(a)(1), the carrier shall apply all amounts contributed by all enrollees in the subscriber's qualified health plan to the deductible and out-of-pocket costs under the original contract to the new contract for the remaining enrollees.

M. If an applicant initiates enrollment directly with the carrier for enrollment through the Exchange, the carrier shall direct the individual to file an application through the Exchange.

N. A carrier shall reconcile enrollment files with the Exchange no less than once a month and upon request of the Exchange.

O. A carrier shall provide a member level report to the Exchange no less than once per month and upon request of the Exchange.

P. A carrier and its officials, employees, agents and representatives shall:

(1) Comply with any applicable State laws and regulations regarding marketing by health insurance carriers; and

(2) Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in qualified plans.

Q. A carrier shall notify the Exchange in advance of a carrier system or data change that may affect the transmission or receipt of data from the Exchange to the carrier.

R. An authorized carrier shall participate in the Exchange's annual business review process survey.

.06 Conditions for Participation – Premium Payment.

A. Except if an enrollee is annually renewing coverage in the same plan or same product, carrier may require that the enrollee or authorized representative, including a third-party entity under §E of this regulation, pay a binder payment in order to effectuate coverage.

B. A carrier may establish a premium payment threshold policy under which the carrier shall consider an enrollee to have paid all amounts due if the enrollee pays an amount sufficient to maintain a percentage of total premium paid out of the total premium owed equal to or greater than a level prescribed by the carrier, provided that:

(1) the level is reasonable; and

(2) the level and the policy are applied in a uniform manner to all enrollees.

C. If an applicant or enrollee satisfies the premium payment threshold under §B of this regulation, the carrier shall:

(1) Effectuate enrollment based on a payment of the binder payment under §A of this regulation and 45 CFR §155.400;

(2) Avoid triggering the applicable grace period for non-payment of premium under Insurance Article, §31-115(c) through (e), Annotated Code of Maryland; and

(3) Avoid terminating the enrollment for non-payment of premiums under COMAR 14.35.14.06B.

D. A carrier shall not use a payment made to effectuate new coverage against outstanding balances attributed to previously terminated coverage.

E. A carrier shall calculate that the premium for coverage lasting less than one month equals the product of:

(1) the premium for one month of coverage divided by the number of days in the month; and

(2) the number of days for which coverage is being provided in the month.

F. A carrier shall accept premium and cost-sharing payments from the following third-party entities:

(1) Ryan White HIV/AIDS Program under Title XXVI of the Public Health Service Act;

(2) Indian tribes, tribal organizations or urban Indian organizations; and

(3) State and Federal Government programs.

G. A carrier shall establish and publish a standard policy for the termination of enrollment of enrollees through the Exchange due to non-payment of premium as permitted by the Exchange in COMAR 14.35.14.06B and 45 CFR §155.430(b)(2)(ii), which:

(1) Includes the grace period for enrollees receiving advance payments of the premium tax credits as described at Insurance Article, §31-115(c) through (e), Annotated Code of Maryland;

(2) Is applied uniformly to enrollees in similar circumstances; and

(3) Specify in what circumstances a payment shortfall will be considered de minimis under §B of this regulation.

.07 Conditions for Participation - Carrier Notice Requirements.

A. A carrier shall provide new enrollees an enrollment information package that is written in plain language and in a manner that is accessible to individuals living with disabilities and individuals who have limited English proficiency.

B. If an enrollee is delinquent on premium payment, the carrier shall provide the enrollee with notice of such payment delinquency.

C. If a carrier terminates an enrollee's coverage or enrollment in a qualified plan through the Exchange in accordance with COMAR 14.35.14 and 45 CFR §155.430(b)(2)(i), (ii), or (iii), the carrier shall, promptly and without undue delay provide the enrollee with a notice of termination that includes:

(1) The termination effective date, and

(2) The reason for termination.

D. A carrier shall follow all other carrier notice requirements under Title 15 and 31 of the Insurance Article, Annotated Code of Maryland, pertaining to the individual and small group marketplaces, and Parts 147, 154, 155 and 156 of the Code of Federal Regulations.

.08 Requirements for Qualified Plans

A. The carrier shall offer, in the Exchange, only plans that the Exchange certifies as qualified plans under COMAR 14.35.20.

B. The carrier shall ensure that each of its plans comply with the plan certification requirements in COMAR 14.35.20 on an ongoing basis.

C. A carrier shall offer no more than four benefit designs per metal level in the Individual Exchange and four benefit designs per metal level in the SHOP Exchange.

D. A carrier offering stand-alone dental plans shall offer no more than one benefit design per coverage level per tier per product type.

E. A carrier shall meet the plan meaningful different standard in 45 CFR §156.298 for all non-cost-sharing variations of all qualified health plans that the carrier seeks to offer for sale in the Individual Exchange.

F. As set forth the Insurance Article, § 31-115(b)(5), Annotated Code of Maryland, the carrier shall:

(1) offer in each Exchange, the Individual and the SHOP, in which the carrier participates, at least one qualified health plan:

(a) at a bronze level of coverage;

(b) at a silver level of coverage; and

(c) at a gold level of coverage.

(2) if the carrier participates in the Individual Exchange and offers any health benefit plan in the individual market outside the Exchange, offer at least one qualified health plan at the silver level and one at the gold level in the individual market outside the Exchange;

(3) charge the same premium rate for each qualified health plan regardless of whether the qualified health plan is offered through the Exchange, through an insurance producer outside the Exchange, or directly from a carrier;

(4) shall not vary rates for a SHOP qualified employer during the employer's plan year, and

(5) comply with the prohibition on cancellation fees and penalties for termination of coverage, as set forth in the Insurance Article, § 31-108(d), Annotated Code of Maryland.

.09 Off-Exchange Disclosure Related to Pediatric Dental

A. The carrier shall, as set forth in the Insurance Article, § 31-116(f)(3), Annotated Code of Maryland:

(1) disclose to a potential purchaser, for those health benefit plans sold outside the Exchange that do not provide the pediatric dental essential health benefits, that the plan does not include the pediatric dental essential health benefits; and

(2) for those health benefit plans sold outside the Exchange that do not provide the pediatric dental essential health benefits, include on its application completed by a purchaser the attestation set forth in the Insurance Article, § 31-116(f)(3)(ii), Annotated Code of Maryland.

.10 Network Adequacy Reporting and Access Plan

A. For each qualified plan that the carrier seeks to offer for sale through the SHOP Exchange or the Individual Exchange, the carrier shall:

(1) follow the Maryland Insurance Administration network adequacy reporting requirements as set forth under COMAR 31.10.34.05(C)(2);

(2) submit a network access plan using the template provided by the Exchange for each of the carrier's networks;

(3) submit, using the templates the Exchange provides, information the Exchange requires to supplement the network access plans template information, including:

(a) Quantitative information related to network adequacy;

(b) Provider accessibility information; and

(c) Member services information.

.11 Waiver Authority.

A. The Exchange, with the approval of the Exchange Board of Trustees, and for reasons solely within the discretion of the Exchange, may grant a waiver to a specific provision of the application for certification, with or without conditions.

B. A waiver may only be granted to the extent it does not conflict with the provisions of the Insurance Article of the Annotated Code of Maryland or applicable federal and State law.

C. A carrier may submit a request for a waiver on a form developed by the Exchange.

D. Carriers who are newly seeking accreditation from outside entities and have not yet received such accreditation by the Exchange's application deadline should use the waiver process to seek waiver or modification of this condition.

E. The request shall state:

(1) the provision from which a waiver is sought;

(2) the reason the carrier is unable to comply with the provision; and

(3) the reason that compliance with the provision will impose a substantial hardship.

F. The Exchange may grant a waiver if:

(1) it determines that compliance with the provision from which the waiver is sought cannot be accomplished without substantial hardship;

(2) a waiver will not conflict with applicable State and federal law; and

(3) it is in the best interests of the State of Maryland.

G. The Exchange shall issue a final written decision on a waiver request submitted under paragraph A of this regulation within 45 days from receipt of the request and all supporting information.

(1) If the Exchange grants a waiver, the decision shall include the duration of the waiver and any conditions imposed by the Exchange.

(2) If the Exchange determines that the conditions of paragraph D of this regulation are not satisfied, that a waiver is not in the best interests of the State, or that the waiver will conflict with applicable State or federal laws, it shall deny the request.

(3) A denial may not be appealed.

(4) The carrier will be notified of the decision by mail or electronically.

H. The Exchange may revoke a waiver if it appears that the reasons for granting it have ceased to exist.

I. The Exchange's decision and the request for waiver shall be subject to public disclosure.

.12 Authorization Renewals.

A. The Exchange shall review the performance of authorized carriers on an annual basis.

(1) Carriers shall submit information about the following performance areas:

(a) Enrollment data;

(b) Network adequacy;

(c) Quality information; and

(d) Exchange-specific complaints and grievances.

B. A carrier shall provide to the Exchange notice of any premium rate change, as approved by the Commissioner, for a qualified plan sold on the SHOP Exchange or Individual Exchange, at least 45 days before the effective date of the premium rate change.

C. The carrier, for any premium rate increase for a qualified plan sold on the SHOP Exchange or Individual Exchange, shall provide to the Exchange the associated Preliminary Justification Forms I and II filed with the Maryland Insurance Administration.

D. The carrier will notify the Exchange of the final disposition of the premium rate increase request at least 45 days before its effective date.