Carrier Reference Manual

2026

Release 9.0

Contents

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 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 2026 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).

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 employers.
- 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.

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.

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.

2.1 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 such as stand-alone plans, or benefits sold in conjunction with a medical plan.

2.2 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.

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.

3.1 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 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 it's 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.

3.2 Carrier Certification Standards

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.

3.2.1 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.

3.2.2 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 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.

3.2.3 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.

3.2.4 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.

3.2.5. 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.

3.2.6 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.

3.2.7 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).

3.2.8 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.

3.2.9 Additional Requirements

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

3.2.9.1. 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.

3.2.9.2. 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. A renewing carrier should provide 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.

3.2.9.3. 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.

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 several standards 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

4.1 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
- Actuarial Certification
- Value Plan Attestation

*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.

4.2 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 if 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
Actuarial Certification	QHP and SADP	N/A	2nd to Last Monday in September	2nd to Last Monday in September
Value Plan Attestation	QHP	1st Monday in June	N/A	N/A

4.3 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.

4.4 Certification Standards (QHP and SADP)

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

4.4.1 Qualified Health Plan (QHP) Standards

4.4.1.1 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.

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

4.4.1.2 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. 2026 de minimis variation can be found in the Final 2026 Actuarial Value Calculator Methodology.

4.4.1.3 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. 2026 plan limits are as follows:

- The out-of-pocket limit for the 2026 plan year may not exceed $10,600 for self-only coverage or $21,200 for family coverage.
- Cost-sharing limits are indexed to per-capita growth in premiums in the United States as determined by HHS.

4.4.1.4 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 twelve plans on Maryland Health Connection. Carriers may offer no more than 3 plans per metal level. This does not include variant plan designs required by legislation (e.g., catastrophic plans).

- Carriers are required to include pediatric dental benefits in all QHPs offered on Maryland Health Connection.

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 2026 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 arise from the Actuarial Value Calculator for the corresponding plan year.

4.4.1.5 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.

4.4.1.6 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.

4.4.1.7 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 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.

4.4.1.8 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.

4.4.1.9 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.

4.4.2 Stand-Alone Dental Plans (SADPs)

4.4.2.1 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.

4.4.2.2 STAND-ALONE PEDIATRIC DENTAL PLAN TIERS/ACTUARIAL VALUE

Carriers can offer SADPs at varying levels if 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).

4.4.2.3 COST-SHARING LIMITATIONS

For the 2026 plan year, the out-of-pocket maximum for stand-alone dental plans is $450 per year for one covered child. For two or more covered children, the out-of-pocket maximum is $900 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.

4.5 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]

4.5.1 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, because 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.

4.6 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 re-certification frequency after the first biennial recertification period. The MIA contract/certificate

[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.

review is not a part of the Annual Review or Biennial Recertification process. Carriers have the right to appeal recertification decisions.

4.7 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 Maryland Health Connection Marketplace.

4.7.1 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.

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 the carrier with the reasons for denial and instructions to reapply or appeal.

4.7.2 STANDARDS

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

4.8 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. 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

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.

5.1 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).

5.2 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

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.

6.1. 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.

6.2. 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 standards
- 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.

6.2.1. 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.

6.2.2. 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's 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.

6.3. 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).

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.

7.1 Enrollment Reconciliation Standards

7.1.1 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.

7.1.2 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.

7.1.3 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.

7.1.4. 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.

7.1.5. Orphan Report

Participating in carriers must provide an orphan report to MHBE after receiving its' MHBE generated yearly renewal enrollment files. This report should include the renewal discrepancy population due to:

- Enrollment in carrier membership system but no renewal file received from MHBE
- Renewal file received from MHBE but no enrollment in carrier membership system

MHBE will reconcile enrollments with each carrier and corresponding files will be sent to ensure alignment in both HBX and the carrier's membership system.

7.1.6. 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.

7.1.7. Notices

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

7.1.8. Billing Rules

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

7.1.9. 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.

HHS established that carriers must notify enrollees of payment delinquency within a certain timeframe. MHBE conformed to this federal requirement by adopting COMAR 14.35.14.07, 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.

7.1.10 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.

7.1.11 Increased Access to the QHP Policy Contract

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

[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

7.1.12 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.

7.1.13 Carrier Initiated Termination Notices

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

7.1.14 Carrier Interchange and Enrollment Escalation

MHBE has developed a robust escalation process that allows for collaboration with carriers 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.

7.1.15 Timely Effectuation Files

Carriers will be required to send to MHBE, corresponding 834 effectuation files within 90 calendar days of the coverage start date. For carriers that submit effectuation files after 90 calendar days, MHBE will limit state subsidy payments to a maximum of three months retroactively, including the month the late effectuation is received. Consumers shall be held harmless and must not be billed for missed subsidies due to carrier delays.

8. Consumer Assistance and Resources

8.1 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.

8.2 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 skipping 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.

8.3 Billing Rules

The binder payment must satisfy 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 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.

Payment due dates for QHP selections made during open enrollment should be no earlier than the effective date and no later than 30 days after the effective date. For retroactive enrollments, the latest

payment date is 30 days after the enrollment transaction is received by the carrier. (14.35.07.11F(2) and (3)).

Pursuant to (14.35.07.11F(2) and (3)), due dates should be no earlier than the effective date or no later than 30 days after the effective date for the following special enrollment periods:

- Divorce/legal separation (effective date currently follows 15th of month rule)
- Permanent move (effective date depends on whether plan was selected before or after move)
- Qualified individual or their dependent is an Indian (15th of month rule)
- Changes in citizenship status (15th of month rule)
- Previously incarcerated (effective date depends on whether plan was selected before or after release)
- Hardship exemptions and triggering events under 45 CFR 155.420 (first of month after plan selection)

Pursuant to (14.35.07.11F(4) and (5)), the following special enrollment periods should be no earlier than the effective days after the effective date OR 30 days the carrier receives the enrollment transaction (whichever is later):

- Loss of MEC (first of month after plan selection)
- Marriage/death (first of month)
- Error/misrepresentation/inaction through the Exchange; misconduct through the Exchange; violation of material provision through the Exchange; and exceptional circumstances through the Exchange (effective date determined based on circumstances; shall be no later than the date the coverage would have begun otherwise; **may be retroactive,** depending on the nature of the error)
- SEPs in Regulation .19 - Other for which effective date is first of the month after plan selection

8.4 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.

8.5 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.

9. 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.

9.1 Captive Producer

Effective September 1, 2024, Captive Producers are no longer authorized to sell plans on Maryland's individual exchange. Captive Producers are defined as licensed insurance producers who hold a current and exclusive appointment with a single carrier and receive compensation as a captive producer from only that carrier (Insurance §31-101 (b-1).

Special Enrollment Chart

Qualifying Event	Trigger Date	Shopping Window	Policy Effective Date	Regulatory Authority	834 Code
Birth or Adoption	DOB or date of adoption	60 days from date triggered	Choice	14.35.07.13	02 - Birth 05 – Adoption
Pregnancy	Date of Confirmation	90 days from date triggered	Choice	14.35.07.19D	PREG
Marriage	Date of Marriage	60 days from date triggered	1st of the following month	14.35.07.13	32
Divorce & Legal Separation	Date of Divorce or Separation	60 days from date triggered	1st of the following month	14.35.07.13	EX
Death	Date of Death	60 days from date triggered	1st of the following month	14.35.07.13	EX
Move	Date of Move	60 days from date triggered	1st of the following month	14.35.07.18	43
Loss of MEC	Date of Loss	60 days from date triggered	Before loss date – 1st of the following month. After loss date – 1st of the next following month	14.35.07.12	07
Employer ceases contribution to COBRA subsidies	Date of subsidy cessation	60 days	Before loss date – 1st of the following month. After loss date – 1st of the next following month	14.35.07.19	
Gained New Immigration Status	Date of Status Change	60 days	1st of the following month	14.35.07.19F	NE
Release from Incarceration	Release	60 days before or after	1st of the following month	14.35.07.19G	EX
Easy Enrollment Tax Time	Date of Notice	35 days	1st of the following month	14.35.07.19C	TX
Easy Enrollment Unemployment	Date of Notice	35 days	1st of the following month	14.35.07.19C	UE
Newly Eligible APTC	Date of income drop	60 days	1st of the following month	14.35.07.19B	FC
"Other" SEP	Determined by Consumer Assistance Worker	60 days according to qualifying event	1st of the following month	14.35.07.19L	Determined by Event
Gain or Loss of APTC	Date of Submitted Application	60 days	1st of the following month	14.35.07.19A(1)	FC

Gain or Loss of APTC	Date of Submitted Application	60 days	1st of the following month	14.35.07.19A(1)	FC
Change in CSR	Date of Submitted Application	60 days	1st of the following month	14.35.07.19A(2)	FC
Untimely Notice	Determined by event	60 days	Determined by the original triggering event	14.35.07.19N(2)	EE
Exchange Error	Determined by notification to the qualified enrollee	30 days	Determined by Event	14.35.07.14	EE
Misconduct through Exchange	Date the qualified individual is notified by the Exchange	30 days	Determined by Event	14.35.07.15	EE
Violation of Material Provision by Carrier	Date the qualified individual is notified by the Exchange	30 days	Determined by Event	14.35.07.16	AB
Recognition of Native American/Alaskan Native	Anytime monthly	60 days before or after	1st of the following month	14.35.07.19E	NE
Under 150% FPL		Once monthly	1st of the following month	14.35.07.19M	LI

APPENDIX A: PLAN Certification Standards (2014 – 2026)

2026

1. Actuarial Value De Minimis Ranges – maintain the AV de minimis ranges from PY2025 for PY2026
2. 2026 Value Plan Standards
   a. Same standards as 2025, plus:
   b. Reduce lab copays by specified amounts
   c. Adjust cost sharing to comply with AV calculator
   d. Technical fixes:
      i. Align (make consistent) the cost sharing between Class III and Class IV pediatric dental services
      ii. Align copays for physical/speech/occupational therapy with copays for habilitative service and outpatient rehabilitative services in Silver 94 plan
3. Mental Health and Substance Use Disorder Cost Sharing: Require equivalent cost sharing for mental health/SUD services and primary care services, even if not technically required to meet parity law requirements.

2025

1. 2025 Value Plan Standards (Standard Plans)
   a. Same standards as 2024, plus:
   b. Adjust cost sharing to restrictions on plan generosity per 2025 Actuarial Value Calculator
   c. Clarify specific drug types to be included in $0 diabetes management benefit
2. [Regulatory update, not plan certification standard: reduce plans per metal level a carrier may offer to three instead of four.]

2024

1. Include Link to Actual Plan Contract in Summary of Benefits & Coverage. Require carriers to include direct link to actual plan contract in the plan's Summary of Benefits & Coverage in the section shown below [i.e. "for more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]."]
   a. *See also 2017 #29, 2019 #17. When first introduced, standard was to require a link to the sample contract.*
2. Require issuers to achieve NCQA Health Equity Accreditation
   - Recommendation of MHBE Health Equity Workgroup (unanimous)
   - Existing issuers
     - Require issuers offering through MHC to achieve accreditation by 12/31/2023
     - Recognize issuers that have received NCQA Multicultural Healthcare Distinction prior to PY2024 as provisionally meeting the certification requirement.
   - New issuers: require new issuers to achieve accreditation within 18 months of offering coverage on MHC
3. Plan Certification Standards for Vision Plans in the Individual Market. Visions plans must:
   - Offer one high and one low plan
   - Have vision plans licensed for sale in the MD individual market as of plan year 2023
   - Provide a Maryland-specific account manager to work with plan management team

- Offer the following services:
  - Co-branded website that includes a provider directory
  - Call center
  - Ability for member to pay bill electronically
  - Ability to generate member enrollment materials and notices
  - Ability to provide reporting on plan selection, enrollment, and member demographics
  - Other services determined necessary by MHBE

4. Implement Standard Plans (unanimous recommendation of the 2022 Affordability Workgroup). Require each licensed carrier in the individual market to:
   a. Offer one standard plan at the bronze, silver, and gold metal levels
   b. Identify standard plans by using "Value Plan" in the plan name, and only in standard plan names
   c. Include suite of diabetes care management services for $0 cost sharing
   d. Retire existing value plan requirements. New standard Value Plans will include $0 cost-sharing for a suite of diabetes care management services.
   e. See 2018 #9 when standardized plans were originally introduced; 2019 #12 when the proposal was removed; 2020 #2-5 proposed standard plans but likely were implemented as Value Plans; 2021 #1 & #2 proposed Value Plan modifications; 2022 #1 & #2 proposed additional Value Plan modifications.

2023

Add a Dental PayNow requirement for participating Stand-Alone Dental Plans (SADPs). This would:

- Enable dental enrollees to pay their first months' premium to effectuate coverage immediately upon enrolling, and
- Mirror the PayNow functionality we provide for medical plans.
- *See also 2021 #3 when PayNow functionality was introduced for medical plans*

2022

1. Bronze Plan Modification: Modify before deductible services to include all primary care visits, mental health/substance use disorder outpatient visits, and generic drugs pre-deductible. Limit cost-sharing for primary care, mental/substance use disorder outpatient visits, and generic drugs to co-pays to be determined after release of the 2022 AV calculator
   a. See #2 below for associated standards.
2. Silver Plan Modifications: Modify before deductible services to include mental/substance use disorder outpatient visits (all 2021 silver & gold value plans already meet this standard. Modify before deductible services to include coverage of diabetic supplies (insulin, test strips, and glucometers) with no cost sharing, with permitted limitation of items covered with no cost sharing to preferred brands
   a. See 2018 #9 when standardized plans were originally introduced; 2019 #12 when the proposal was removed; 2020 #2-5 proposed standard plans but likely were implemented as Value Plans; 2021 #1 & #2 proposed Value Plan modifications; 2024 #4 propose full-fledged Standard Plans
3. Telehealth Transparency: Require issuers to describe their coverage of telehealth services in their "Important Information About This Plan" document
4. Require individual market QHP issuers to comply with 45 CFR 156.221(a)-(f)

5. Enhance Dental Plan Information: Require dental carriers to provide information on in-network providers in a format and at a frequency specified by MHBE. Encourage dental carriers to create and provide a link to an "Important Information about This Plan" document to address unique benefits or features of their coverage, which MHC could add to the plan shopping tile. This feature is currently available for medical plans, so this would mirror the current medical plan shopping tile.

2021

1. Value Silver Plans: Modify before deductible services to include Generic Drugs. Modify before deductible services to exclude imaging
   a. See #2 below for associated standards.
2. Value Gold: Increase flexibility including, but not limited to: 1. changes in cost sharing for specialist care visit, lab services, x-rays and diagnostics and imaging. 2. limitations for lab services, x-rays and diagnostics, and imaging. 3. exclusion of imaging before deductible services 4. issuers have the flexibility to modify plan design within the Value plan requirements
   a. See 2018 #9 when standardized plans were originally introduced; 2019 #12 when the proposal was removed; 2020 #2-5 proposed standard plans but likely were implemented as Value Plans; 2022 #1 & #2 proposed additional Value Plan modifications; 2024 #4 propose full-fledged Standard Plans
3. Within calendar year 2021, issuers participating on Maryland Health Connection shall implement a PayNow URL to allow consumers to pay their first month's premium at the point of enrollment. MHBE shall provide additional flexibility to issuers contingent upon technological/timeline limitations should they arise.
   a. *See also 2023—PayNow implemented for dental plans.*
4. Issuers shall disclose in their "Important Information About This Plan" document if they utilize a Co-pay Accumulator Program for prescription drugs covered in their formulary and provide information on how the program may impact their out-of-pocket costs.
5. Stand-Alone Dental Plans shall accept enrollments under special enrollment periods for coverage offered on Maryland Health Connection for the following trigger events: birth or adoption, marriage, move, newly eligible for APTC.
6. SHOP issuers shall offer at least one QHP at the bronze, silver, and gold metal levels that allows for Composite Rating for employers seeking to offer a single plan to their employees.
   a. *See also 2016 #18, 2017 #29, 2018 #14. Composite rating was prohibited in 2016, and then allowed in 2017 under certain circumstances for small group plans. The requirements changed slightly in 2018 and 2021.*
7. Offer optional sample plan designs at the bronze, silver, and gold metal levels.

2020

1. Carriers may not offer more than four dental plans per product per plan (child-only/family).
2. The MHBE Board consider for approval required standard plans on the individual market, according to the recommendations from the 2017 Standardized Benefit Design Work Group Report.*
   a. See 2018 #9 when standardized plans were originally introduced; 2019 #12 removed the proposal; 2021 #1 & #2 proposed Value Plan modifications; 2022 #1 & #2 proposed additional Value Plan modifications; 2024 #4 proposes full-fledged Standard Plans
3. Proposed standard plans will undergo a public comment period of no less than 30 days.

4. Proposed standard plans will consider the work of the Standing Advisory Committee on the inclusion of 3 Primary Care Physician Visits before deductible.
5. Staff will provide stakeholder analysis to the MHBE Board with final recommendations [on standard plans] in advance of the January Board session.
6. MHBE Staff assemble a diverse, representative work group to develop a report with recommendations on policy solutions that will: 1. Reduce out of pocket costs 2. maximize APTC for subsidized consumers 3. Maximize affordability for unsubsidized consumers
7. A policy to require that carriers offer at least one plan in an additional product type on Marketplace if offered off-Marketplace, in the small group market, or state employee health program. And A policy to bar Preferred Provider Organizations from participating on the marketplace without an Exclusive Provider Organization offered as an alternative.
8. Development of a petition process for additions to the Essential Community Providers (ECP) list for providers that meet the federal and state ECP definition. MHBE proposes to develop a timeline for when additions become effective in the determinations of compliance with ECP standard.
   a. *See also 2016 #5, 2017 #14, 2018 #3, and 2019 #3. Many ECP standards were introduced in 2017, including the 30% contracting threshold. In 2018, the proposed standard concerned issuer contracting requirements. Otherwise, ECP standards have remained mostly unchanged since 2017, with a few administrative changes by MHBE.*

2019

1. MHBE recommends the removal of this plan certification standard [*state-EHB primary care benefits*] and proposed that MHBE be directed to assemble a work group to address primary care
2. [*plans submit provider files to CRISP*] MHBE proposes to supplement the 2019 Carrier Application with an attestation. Applying issuers attest to submitting provider directory data to MHBE every two weeks. Applying issuers attest that the submitted data is complete, accurate, and up to date under 45 CFR 156.230 (b).
   a. *See also 2017 #11 and 2018 #1. Certain requirements were introduced in 2017 and then were revoked in 2018.*
3. This standard [*ECP standards*] will remain unchanged from 2018. MHBE proposes to include this standard (including the Alternate ECP Standard) in the next update of the Carrier Reference Manual.
   a. [UPDATE] Addition of "certified" as an acceptable status. Reduction of Administrative Burden: MHBE will work with CMS to add MHBE ECP Expansion providers to the CMS template.
      - *See also 2016 #5, 2017 #14, 2018 #3, and 2020 #8. Many ECP standards were introduced in 2017, including the 30% contracting threshold. In 2018, the proposed standard concerned issuer contracting requirements.*
4. MHBE proposed to include this standard in the next update of the Carrier Reference manual [plan anti-discrimination attestation]
   a. See also 2016 #6, 2017 #15 for original proposal(s).
5. MHBE proposed to refine the language of [the drug formulary internet link standard]. The formulary link provided in "Prescription Drug Search" must link directly to the QHP's list of covered drugs and include tier information. Plans must include a legend to allow the consumer to match the indicated tier with a drug category. MHBE proposes to include this standard in the next update of the Carrier Reference Manual.

a. Originally introduced in 2016 and 2017. See also 2016 #8 and 2017 #8. 2017 added requirement for clearly showing tier category and specified that a legend is acceptable.

6. MHBE proposes to include [the meaningful difference standard] in the next update of the Carrier Reference Manual
   a. See also 2017 #21 (where the standard was introduced)
7. MHBE proposes to add an attestation to the 2019 Carrier Application. Applying issuers must attest to meeting their respective requirements under the final network adequacy regulation promulgated in COMAR 31.10.44 Network Adequacy.
   a. See also 2017 #13 and 2018 #2. A standard requiring carriers to include plan network metrics on the SBC was introduced in 2017 and removed in 2018.
8. MHBE proposes to include this standard [SADPs accept APTC for portion of premium payable to embedded pediatric dental EHB] in the next update of the Carrier Reference Manual
   a. See 2017 #33 when this standard was originally proposed.
9. MHBE proposes to include this standard [SADPs subject to QHP rating rules applicable to dependent caps] in the next update of the Carrier Reference Manual
   a. See 2017 #34 when the standard was originally proposed.
10. MHBE proposes to include this standard [SADPs may not offer more than one plan per product per tier] in the next update of the Carrier Reference Manual
    a. See 2018 #7 when standard was originally proposed.
11. This standard [verification requirement for loss of MEC] will remain unchanged from 2018
    a. See also 2018 #8.
12. This standard [standardized plan options] is removed for 2019. The MHBE will revisit this standard at the discretion of the Board Chair.
    a. See 2018 #9 when standardized plans were originally introduced; 2020 #2-5 proposed standard plans again which were likely were implemented as Value Plans; 2021 #1 & #2 proposed Value Plan modifications; 2022 #1 & #2 proposed additional Value Plan modifications; 2024 #4 propose full-fledged Standard Plans
13. MHBE proposes the removal of this plan certification standard [network breadth indicator on MHC]
    a. See 2018 #11 when this standard was originally proposed.
14. MHBE proposes to develop a working group to determine an automated implementation pathway [for when a primary subscriber is terminated for outstanding citizenship/immigration status verification]. MHBE clarified consumers may access this right manually as established in current processes.
    a. See 2018 #12 when this standard was proposed.
15. MHBE proposes to include this standard [expansion to employer choice model] in the next update of the Carrier Reference Manual
    a. See 2018 #14
16. MHBE proposes to include this standard [*Employer Choice model MIA bulletin 15-34*] in the next update of the Carrier Reference Manual. [UPDATE] MHBE removes “2018” from standard.
    a. See 2018 #14
17. Increased Access to the QHP Policy Contract: MHBE proposes that issuers supply a URL that provides a direct link to each QHP’s Sample Contract on the QHP’s SBC. Issuers will reference the Sample Contract in the box at the top of the first page of the Summary of Benefits and Coverage. [UPDATE] MHBE refines the standard to change it to “Sample Contract” instead of “Schedule of Benefits”
    a. See also 2017 #29, 2024 #1. For 2024, MHBE proposes that carriers include the link to the specific plan contract on the SBC.

18. De minimis payments and termination: MHBE proposes that issuers voluntarily develop a de minimis monthly premium under payments policy. MHBE understands that established mediation pathways may be an effective avenue for the amelioration of such issues. MHBE seeks insight on this plan certification standard to determine whether there is a value add for such a policy. [UPDATE] MHBE has received feedback on this proposed voluntary policy. Given the size of the affected population, the established mediation pathways, and the impact on issuer cost MHBE will remove this plan certification standard from consideration. Instead MHBE will issue guidance on the matter and will include this guidance in the next Carrier Reference Manual.

2018

1. Additional requirements removed due to HB1318. This standard [requiring that plans submit provider files to CRISP] returns to the earlier [2014] standard where issuers must submit a provider directory file to CRISP every two weeks.
   a. *See also 2017 #11 and 2019 #2. The "additional requirements" referenced were introduced in 2017. Additional requirements were added in 2019.*
2. Modified requirement [that carriers include metrics on plan network on the SBC] was removed due to HB 1318 of 2016
   a. *See also 2017 #13 and 2019 #7. This standard was introduced in 2017. In 2019, carriers were required to attest to meeting network adequacy regulations under (COMAR 31.10.44 Network Adequacy) in the 2019 carrier application.*
3. [*ECP standards*] MHBE proposes additional issuer contracting requirements to expansion providers (ex. LHDs). Issuers must utilize the DHMH state-amendment for contracting with government providers when offering contracts. When contracting with any willing LHD issuers must contract for all services - including behavioral health services.
   a. *See also 2016 #5, 2017 #14, 2018 #3, and 2020 #8. Many ECP standards were introduced in 2017, including the 30% contracting threshold.*
4. MHBE recommends removal of this standard [i.e., Maryland Health Progress Act Continuity of Care Evaluation]. MHBE will address Continuity of Care Evaluation through the Standing Advisory Committee.
   a. See also 2016 #10 and 2017 #19. This standard was deferred in 2016 and amended in 2017.
5. MHBE will continue to require [that carriers submit a Network Access Plan]. Carriers will submit the information as requested by MHBE. Plan Management will work to streamline and standardize the submission process. Further, MHBE proposes to include additional information requirements as they pertain to telemedicine services. MHBE will provide an updated template.
   a. See also 2017 #26 (when this standard was introduced).
6. MHBE will create a committee to help design the requirements for determining the coverage example methodology [for the substance use disorder/mental health treatment costs coverage example]
   a. See also 2017 #18
7. Stand-Alone Dental Plans may not offer more than one dental plan per product per tier
   a. See 2019 #10 when this was added to the carrier reference manual.
8. For 2018, MHBE proposes to add verification requirements for SEPs due to loss of MEC. MHBE will assess the results of the added verification to determine if verifications should be added to other SEPs.
   a. See also 2019 #11. Remained unchanged.

9. MHBE proposes to establish "standardized options" for the individual marketplace at the silver and gold levels. Issuers participating on the individual marketplace must include, within their annual QHP product offerings, at least one standardized option. These options will include three silver level cost-share reduction variations and one gold standard variation. MHBE will release guidance on the benefit structure, methodological framework, of these plans with release of the annual issuer letter. These options will apply toward metal level limitation standards.
    a. See also 2019 #12 when the proposal was removed; 2020 #2-5 proposed standard plans but likely were implemented as Value Plans; 2021 #1 & #2 proposed Value Plan modifications; 2022 #1 & #2 proposed additional Value Plan modifications; 2024 #4 proposes true Standard Plans
10. MHBE will create an indicator and filtering mechanism for standardized plans on Maryland Health Connection Plan Shopping User Interface.
11. MHBE proposes, in line with the FFM proposal, to add a network breadth indicator on Maryland Health Connection Plan Shopping to denote a QHPs relative network coverage. MHC is able to deploy the following indicators for network breadth: 1) Broad 2) Narrow 3) IDS (Integrated Delivery System)
    a. See 2019 #13 when this standard was removed.
12. When primary subscriber is terminated for outstanding citizenship/immigration status verification, other enrollees should be allowed to continue on contract with amounts contributed to deductible and OOP costs under contract, if termination results in invalid enrollment group, eligible members have 60 day SEP. MHBE will work with stakeholders to consider future applications such as certain terminations (i.e. new Medicare eligibility, death, divorce, and court-orders) Regardless of who accumulated the costs and the new contract type, such as if the household moves to a self-only plan, and amounts contributed to deductible and OOP costs under original contract should be transferred to new contract
    a. See 2019 #14. Proposed to convene a work group to figure out how to automate this process.
13. MHBE proposes an expansion to the employee choice model. Employers may select up to two consecutive metal tiers (e.g. Bronze and Silver, or Silver and Gold) and employees will be able to select any plan between the chosen metal tiers across any issuer. Issuers electing this option must report election to MHBE.
14. Per MIA Bulletin 15-34, Employer groups in the Employer Choice model may elect to participate in composite rating for either a single QHP offering or multiple QHP from a single carrier. MHBE encourages issuers to offer at least one QHP that will offer composite rating/premium. Issuers must identify the plans to MHBE. Issuers electing this option must report election to MHBE.
    a. *See also 2016 #18, 2017 #29, 2021 #6. Composite rating was prohibited in 2016, and then allowed in 2017 under certain circumstances for small group plans. The requirements changed slightly in 2018 and 2021.*
    b. *Added to carrier reference manual in 2019 (#15/16)*

2017

2. That the carrier, for any premium rate increase for a qualified plan sold on the SHOP Exchange or Individual Exchange, will provide to the Maryland Health Benefit Exchange the associated Preliminary Justification Forms I and II filed with the Maryland Insurance Administration, and will notify the Maryland Health Benefit Exchange of the final disposition of the premium rate increase request at least 45 days before its effective date
    a. See also 2014 #1. Same standard introduced.

3. **Accreditation.** That the carrier holds current and valid accreditation, as follows, for years 2014 and 2015:
   a. That the carrier, unless the carrier offers only dental or vision benefits, is accredited by National Committee for Quality Assurance (NCQA) or URAC as an accredited commercial or Medicaid carrier.
   b. That the carrier, if offering only dental or vision benefits, holds a current and valid Maryland Insurance Administration Certificate of Authority.
   c. *See also 2014 #2. No changes.*
4. The carrier will provide the transparency data required under 45 CFR §156.220(a) for annual qualified plan certification and thereafter as required for maintaining plan certification and recertification.
   a. Originally introduced in 2014 – no changes (see also 2014, #3).
5. A carrier holding certification by the Maryland Health Benefit Exchange shall provide: (1) documentation of the service area of each qualified plan the carrier offers for sale through the SHOP Exchange or Individual Exchange **through the Service Area Template developed by CCIIO**; and (2) data on demographics of areas served by each qualified plan the carrier offers for sale within the SHOP Exchange or Individual Exchange, in accordance with 45 CFR §155.1055(b), except where the carrier provides a statewide service area.
   a. Originally introduced in 2014 (see also 2014, #4).
   b. New text above in bold
6. Issuers may serve an area smaller than one county if they demonstrate that boundaries are not designed to discriminate against individuals excluded from the service area. **Issuers servicing an area smaller than one county must submit a Partial County Service Area Justification**
   a. See also 2016 #1. Bolded text added in 2017.
7. **Provider files to CRISP.** MHBE will continue current requirements that plans submit provider files to CRISP. The provider list must be current (produced at least twice a month), accurate, and complete. Issuers must also provide, in a form and manner to be defined by MHBE, information on "Accepting New Patients" status.
   a. Issuers must also provide the directory information on their website without requiring login. MHBE will further address provider director accuracy through multi-step process:
   b. 2016: Carrier assesses directory accuracy in preparation for 2017 application
   c. With 2017 plan certification application: Carrier provides accuracy information to MHBE, including carrier-selected method of assessment and steps taken to improve accuracy (e.g. provider contracting requirements)
   d. During 2017: MHBE, with EIAC input, proposes to Board standard assessment method, baseline target, and requirements for accuracy improvements; Board adopts standards for 2018 plan certification standard.
   e. 2017-8: Carrier uses standard assessment method and meets baseline target and/or requirements for accuracy improvement; includes information in 2018
   f. *See 2018 #1 and 2019 #2. This standard was revoked in 2018 and returned to the 2014 standard. Additional requirements were added to this standard in 2019.*
8. Carriers must include the following metrics in a plan's SBC to provide consumers with information about the plan's network:
   a. Average wait time for PCPs and MH providers
   b. Average drive distance to PCPs and MH providers
   c. Percent of PCPs and MH providers in network accepting new patients
   d. CAHPS scores

e. OPTIONAL: Additional metrics for any other specialist categories of the carrier's choosing Modified requirement: MHBE will provide template by end of January that includes additional detail about PCP/MH subcategories and standard to determine average drive distance/time. MHBE clarifies that carrier may submit additional information about their metrics. MHBE will determine new location for information (either in separate link in plan shopping or outside of application). MHBE encourages carriers to include SUD information as well

f. *See also 2018 #2 and 2019 #7. This standard was removed in the 2018 plan certification standards in response to HB 1318 of 2016. In 2019, carriers were required to attest to meeting network adequacy regulations under (COMAR 31.10.44 Network Adequacy) in the 2019 carrier application.*

9. Definition of ECP: Federal definition at 45 CFR 156.235(c), with addition of local health departments, outpatient mental health centers and substance use disorder treatment providers, as described at COMAR 10.09.80.03.B(1) & B(3), licensed or approved by DHMH as programs or facilities, and school-based health centers. Providers must be able to meet carrier credentialing standards

   a. Plan network must meet threshold standard: Contract with at least 30% of available ECPs in each plan's service area

      i. Allow write in option and alternative standard
      ii. Offer contracts in good faith to:
      iii. all available Indian Health Care Providers in service area,
      iv. any willing Local Health Dept. in service area, and
      v. At least one ECP in each ECP category in each county in service area, where an ECP in that category is available and provides medical or dental services by issuer plan type (except if not applicable for dental).

   b. *See also 2016 #5, 2018 #3, 2019 #3, and 2020 #8. In 2016, ECP standards were attestation-based. In 2018, the proposed standard concerned issuer contracting requirements. Otherwise, ECP standards have remained mostly unchanged since 2017, with a few administrative changes by MHBE.*

10. MHBE will require plan attestation that it does not discriminate on the basis of any factors set prohibited by federal and state regulation.

    a. See also 2016 #6 (same standard) and 2019 #4 (added to carrier reference manual).

11. Drugs covered under plan's medical benefit must be identified in plan's filings.

    a. *See also 2016 #7. Same standard introduced in 2016.*

12. Drug formulary Internet link provided by plans must link directly to the list of covered drugs without requiring further navigation, and must include tiering and cost-sharing information. **The tier category (i.e. generic, preferred brand, etc.), must be made clear for each drug, a legend is acceptable with MHBE approval.** The formulary drug link must be up-to-date, accurate, and complete. Issuers must make the formulary drug list available on their website in a standard machine readable format as specified by HHS.

    a. Bolded text added in 2017. Originally introduced in 2016. See also 2016 #8.

13. MHBE will work with stakeholders to find appropriate location for outpatient/inpatient substance use disorder and mental health treatment cost examples as well as a template for carriers to provide this information

    a. See also 2017 #28 and 2018 #6.

14. Issuers have the option of identifying a drug as a "preventive drug" covered at zero cost.

    a. See also 2016 #9. No changes.

15. MHBE will develop a time horizon, to evaluate the efficacy of the Maryland Health Progress Act's continuity of care policies and to develop, if determined to be of need, a continuity of care proposal.

    a. See also 2016 #10 and 2018 #4. This was deferred in 2016 and then removed in 2018.

16. Issuers must create a drug exception process for standard situations (in contrast to exigent circumstances) by which an enrollee can request access to a drug not on the plan's formulary. The issuer must notify the enrollee of its coverage decision no more than 72 hours after receipt of the exception request. Issuers must have an external review process by an independent review organization for denied requests. The external review organization must complete its review and provide a decision within 72 hours of receiving the review request. **The Issuer will keep account of, and report on, member drug exceptions processed and provide summary metrics to MHBE determine compliance. MHBE will provide guidance to meet this requirement.**
    a. See also 2016 #11. Bolded text added in 2017.
17. A given carrier's set of plans must meet the FFM meaningful difference standard and continue to meet the four benefit designs maximum per metal level requirement. The FFM meaningful difference standard will be applicable to all non-Zero, non-Limited plan variations.
    a. See also 2019 #6. This standard was added to the Carrier Reference Manual.
18. Certain QHP issuers must comply with standards and requirements related to quality reporting through the implementation of the Quality Rating System (QRS) and the Enrollee Satisfaction Survey (ESS). Issuers are also required to continue to provide quality data and Race, Ethnicity, Language, Interpreter Need, and Cultural Competency (RELICC) data to the Maryland Health Care Commission (MHCC). **MHBE will determine a final approach for the QHP Issuer quality reporting system.**
    a. See also 2016 #13. Bolded text new in 2017.
19. QHP issuers that have offered plans on MHC for at least two (2) years will submit a quality improvement strategy (QIS) for 2017 in functional areas determined by MHBE oversight and compliance staff.
    a. *Was voluntary in 2016 (see 2016 #14).*
20. MHBE will continue conducting compliance reviews in 2017. The scope of this review will be limited to compliance with plan and carrier certification standards and will not extend to requirements enforced by MIA
    a. Began in 2016 (see 2016 #15).
21. To supplement QHP issuer annual submission of the Network Access Plan, MHBE will require plans to explain their strategies to provide meaningful access, MHBE will incorporate into compliance oversight its, to be determined, approach to reviewing meaningful access.
    a. See also 2016 #17 (when MHBE added streamlining processes and a template).
22. QHP issuers must make public, and provide to MHBE, for public release, their Standards for Network Management reported for 2016 NCQA Accreditation, in a form and manner described by MHBE
23. QHP Issuers will submit, as an expansion to their Summary of Benefits and Coverage Form Coverage Examples, Out-patient/Inpatient Substance Abuse Treatment Costs and Out-patient/Inpatient Mental Health Treatment Costs. The criteria and factors for determining these costs will be established by MHBE.
    a. *See also #18 in this year.*
24. QHP Issuers will, on their Summary of Benefits and Coverage forms, will submit a URL that links to each QHP's respective complete benefits or terms, via a policy contract or an in-depth plan document, without further navigation.
    a. See also 2019 #17, 2024 #1. For 2024, MHBE proposes that carriers include the link to the specific plan contract on the SBC.
25. Carriers will be allowed to provide composite rating for small employers if the plan selection is limited to a single plan

a. *See also 2016 #18, 2018 #14, 2021 #6. Composite rating was prohibited in 2016. The requirements changed slightly in 2018 and 2021.*

26. Qualified employers can offer employees a choice of all stand-alone dental plans offered or a single stand-alone dental plan
27. Embedded-Pediatric Dental as an Essential Health Benefit for QHP Issuer plans is optional.
    a. See also 2016 #19. Embedding pediatric dental seems to have been required in 2016.
28. Stand-Alone Dental Plans will accept Advance Premium Tax Credit for the portion of premium payable to the Embedded-Pediatric Dental Essential Health Benefit
    a. See also 2018 #8—this standard was added to the Carrier Reference Manual.
29. Stand-Alone Dental Plans will be subject to QHP rating rules applicable to dependent caps.
    a. See also 2018 #9—this standard was added to the Carrier Reference Manual.

2016

1. Service areas. Issuers may serve an area smaller than one county if they demonstrate that boundaries are not designed to discriminate against individuals excluded from the service area.
   a. *See also 2017*: Added "Issuers servicing an area smaller than one county must submit a Partial County Service Area Justification"
2. Service areas changes.
   a. Will permit service area changes after initial data submission by petition for limited reasons, e.g., issuer's inability to secure enough providers or MHBE request to serve an unmet need.
   b. No service area changes permitted after final data submission unless they constitute an expansion rather than contractions of service area.
3. Provider lists to CRISP. MHBE should continue current requirements that plans submit provider lists to CRISP. The provider list should be current (produced at least twice a month), accurate, and complete. Issuers must also provide the directory information on their websites in a machine-readable file and format.
   a. Updated in 2017, 2018, and 2019
4. Network adequacy. Plans will be required to attest to and describe how their networks will provide access to services for all enrollees without unreasonable delay.
5. Essential Community Providers. Plans will be required to attest to and describe how they ensure adequate ECP participation.
   a. *See also 2017 #14, 2018 #3, 2019 #3, and 2020 #8. Many ECP standards were introduced in 2017, including the 30% contracting threshold. In 2018, the proposed standard concerned issuer contracting requirements. The contracting threshold is now 35% in alignment with the 2023 Notice of Benefit and Payment Parameters.*
6. Anti-discrimination attestation. MHBE should require plan attestation that it does not discriminate on the basis of any factors set forth in the Marketing and Benefit Design of QHPs attestation and prohibited by federal regulation.
   a. See also 2017 #15 (same standard) and 2019 #4 (added to carrier reference manual).
7. Drugs covered under plan's medical benefit must be identified in plan's filings.
   a. Same standard also introduced in 2017. See 2017 #15.
8. Drug formulary Internet link provided by plans must link directly to list of covered drugs without requiring further navigation, and must include tiering and cost-sharing information. The formulary drug link must be up-to-date, accurate, and complete. Issuers must make the formulary drug list available on their website in a standard machine readable format as specified by HHS.

a. Also introduced in 2017. See also 2017 #8. Text added in 2017: "The tier category (i.e. generic, preferred brand, etc.), must be made clear for each drug, a legend is acceptable with MHBE approval."

9. Issuers have the option of identifying a drug as a "preventive drug" covered at zero cost.
   a. *See also 2017 #18. No changes.*
10. Defer proposal regarding continuity of care to afford time to evaluate the efficacy of the Maryland Health Progress Act's continuity of care policies.
    a. See also 2017 #19 and 2018 #4. In 2017, the standard directed MHBE to create a timeline for this evaluation project. This standard was then removed in 2018.
11. Issuers must create a drug exception process for standard situations (in contrast to exigent circumstances) by which an enrollee can request access to a drug not on the plan's formulary. The issuer must notify the enrollee of its coverage decision no more than 72 hours after receipt of the exception request. Issuers must have an external review process by an independent review organization for denied requests. The external review organization must complete its review and provide a decision within 72 hours of receiving the review request.
    a. See also 2017 #20. In 2017, this text was added: "The Issuer will keep account of, and report on, member drug exceptions processed and provide summary metrics to MHBE determine compliance. MHBE will provide guidance to meet this requirement."
12. Board's limitation on the number of permissible plans should remain in effect.
13. Certain QHP issuers must comply with standards and requirements related to quality reporting through the implementation of the Quality Rating System (QRS) and the Enrollee Satisfaction Survey (ESS). Issuers are also required to continue to provide quality data and Race, Ethnicity, Language, Interpreter Need, and Cultural Competency (RELICC) data to the Maryland Health Care Commission (MHCC).
    a. See also 2017 #22. Additional text in 2017: "MHBE will determine a final approach for the QHP Issuer quality reporting system."
14. MHBE encourages QHP issuers that have offered plans on MHC for two (2) years to submit a quality improvement strategy (QIS) for 2016. This is voluntary.
    a. Was made a requirement in 2017 (see 2017 #23).
15. MHBE will move forward with conducting some compliance reviews in 2016. The scope of this review will be limited to compliance with plan certification standards and will not extend to requirements enforced by MIA.
    a. *Continued in 2017 (see #24).*
16. Qualified employers can offer employees a choice of all stand-alone dental plans offered or a single stand-alone dental plan.
17. MHBE should require plans to explain their strategies to provide meaningful access, and MHBE should incorporate into compliance oversight its approach to reviewing meaningful access.
    a. See also 2017 #25.
18. Composite rating not permitted
    a. See also 2017 #29, 2018 #14, 2021 #6. Composite rating was allowed in 2017 under certain circumstances for small group plans, and the requirements changed slightly in 2018 and 2021.
19. Pediatric dental is embedded in QHPs
    a. *See also 2017 #31. Embedding pediatric dental was made optional in 2017.*

2014

1. **Rate increases.** That the carrier, for any premium rate increase for a qualified plan sold on the SHOP Exchange or Individual Exchange, will provide to the Maryland Health Benefit Exchange the associated Preliminary Justification Forms I and II filed with the Maryland Insurance Administration, and will notify the Maryland Health Benefit Exchange of the final disposition of the premium rate increase request at least 45 days before its effective date.
   a. See also 2017 #1. Same standard introduced.
2. **Accreditation.** That the carrier holds current and valid accreditation:
   a. That the carrier, unless the carrier offers only dental or vision benefits, is accredited by National Committee for Quality Assurance (NCQA) or URAC as an accredited commercial or Medicaid carrier.
   b. That the carrier, if offering only dental or vision benefits, holds a current and valid Maryland Insurance Administration Certificate of Authority.
   c. *See also 2017 #2.*
3. **Transparency Data**
   a. That the carrier will provide the transparency data required under 45 CFR §156.220(a) for 2014 qualified plan certification and thereafter as required for maintaining plan certification and recertification.
   b. See also 2017 #3.
4. **Service areas.** A carrier holding carrier certification by the Maryland Health Benefit Exchange shall provide:
   a. Documentation of the service area of each qualified plan the carrier offers for sale through the SHOP Exchange or Individual Exchange; and
   b. Data on demographics of areas served by each qualified plan the carrier offers for sale within the SHOP Exchange or Individual Exchange, in accordance with 45 CFR §155.1055(b), except where the carrier provides a statewide service area.