Date: February 10, 2025

From: The Maryland Health Benefit Exchange

To: Issuers Seeking to Participate in Maryland Health Connection in 2026

Title: DRAFT 2026 Letter to Issuers Seeking to Participate in Maryland Health Connection

The Maryland Health Benefit Exchange (MHBE) is releasing this draft 2026 Letter to Issuers (the Letter). This Letter provides guidance to issuers seeking to offer qualified plans, which include Qualified Health Plans (QHPs), Vision Plans, and Stand-Alone Dental Plans (SADPs), through Maryland Health Connection on the Individual and Small Business Marketplaces. Unless otherwise specified, references to the Marketplace include both the Individual and Small Business Marketplaces. Further, requirements for plan certification and issuer certification, unless otherwise specified, are required for issuers of health plans, vision plans, and stand-alone dental plans.

Published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Marketplace-related topics, are defined in 45 C.F.R. Subtitle A, Subchapter B and in COMAR 14.35.07, COMAR 14.35.14, COMAR 14.35.15. and COMAR 14.35.16. Supplemental guidance, and other market rules applicable to issuers, may be found in the most recent Maryland Health Connection Carrier Reference Manual and the 834 Companion Guide.[1] MHBE expects issuers to consult all applicable regulations, in conjunction with this Letter, to ensure full compliance with the requirements of the Affordable Care Act and other applicable state and federal requirements. Throughout the plan year, qualified plans may be required to correct deficiencies identified in MHBE's post-certification activities, as a result of the investigation of consumer complaints, oversight by the Maryland Insurance Administration (MIA) or by MHBE, or an issuer's own industry standard internal compliance, on-going monitoring, and risk management program. While this Letter explains certain issuer requirements it is not a complete list of the regulatory requirements for issuers.

Public comments on this letter will be accepted through March 12, 2025.

[1] Issuer guidance available here: https://www.marylandhbe.com/carriers/

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CHAPTER 1: ISSUER ANNUAL CERTIFICATION PROCESS AND STANDARDS

The Affordable Care Act, Sections 31-106 and 31-108 of the Insurance Article, Maryland Code, and COMAR 14.35.15 establish that issuers must meet a number of standards in order 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, vision, and dental issuers to become certified to offer qualified plans (QHPs, Vision, and SADPs) on the Individual and Small Business Marketplaces. Unless otherwise specified, the Marketplace refers to the Individual and Small Business Marketplaces.

As in prior years, the certification process will take place during calendar year 2025 for plans effective beginning in 2026. Applications for certification must be submitted annually. MHBE will review and approve or deny each application. This process is described in Chapter 3 of the Carrier Reference Manual. Table 1-A-1 provides an overview of the required submission dates for items included in the certification application. MHBE will review the application against the certification standards described in this chapter and the Carrier Reference Manual.

A. Submission of the Carrier Certification Application

Annually, each issuer must submit a Carrier Certification Application to MHBE to participate in the Marketplace. The application is updated annually and posted to the MHBE partner website at www.marylandhbe.com. For the 2026 plan year, MHBE will continue using a web-based Carrier Certification Application.

As part of the Carrier Certification Application, issuers must also provide the documents listed in Table 1-A-1. Additional information regarding the certification standard addressed by each of these documents is described in section C of this chapter. The table provides due dates for the required documentation and the location of the template for each item, which may be found on MHBE's partner website or with the issuer.

Unless otherwise listed in Table 1-A-1, QHP and SADP issuers must submit carrier certification data through the secure System for Electronic Rate and Form Filing (SERFF) Binders. Exceptions to this general rule are for biennial Amendments and Restatements of the Carrier Business Agreement and other legal documents that require submission of a physical copy to MHBE.

Issuers should be mindful of the appropriate formatting and specifications of the submissions to ensure timely approval of the Carrier Application.

Table 1-A-1. Carrier Certification Submission Dates

Item Name	QHP/SADP/ Vision	Source	Submission Location for Completed Item	Due Date to MHBE
Carrier Application	All	MHBE	MHBE website	June 2, 2025
Carrier Logo	All	Issuer	SERFF	June 2, 2025
List of Subcontractors Attestation	All	Issuer	SERFF	June 2, 2025
Carrier Business Agreement – Attestation	All	MHBE	SERFF	June 2, 2025

Non-Exchange Entity Agreement – Attestation	All	MHBE	SERFF	June 2, 2025
Network Adequacy Attestation	QHP	MHBE	SERFF	June 2, 2025
Provider Directory Attestation	QHP/SADP	MHBE	SERFF	June 2, 2025
Patient Data Availability Attestation	QHP - Individual	MHBE	SERFF	June 2, 2025
State Reinsurance Program Attestation	QHP - Individual	MHBE	SERFF	June 2, 2025
Discriminatory Benefit Design Attestation	All	MHBE	SERFF	June 2, 2025
Value Plan Standards Attestation	QHP	MHBE	SERFF	June 2, 2025
Carrier Certification Review Period	All	MHBE		June 2 - August 1, 2025
Carrier Certification Approval/Denial Notice	All	MHBE	SERFF/Issuer Point-of-Contact	August 1, 2025

B. Review of Carrier Certification Applications & Certificate of Carrier Authorization

MHBE must review a Carrier Certification Application submitted to MHBE by an issuer within 45 calendar days of receipt of the completed application. MHBE will notify an issuer if its submitted application is not considered complete and which items are outstanding. All issuers will receive a Carrier Certification Approval or Denial Notice from MHBE within the 45-day period. A Carrier Certification Approval Notice informs the issuer that they are eligible to submit plans for certification by MHBE for the plan year of 2026. Plans submitted to MHBE are required to meet the annual Plan Certification Process and Standards, which are described in the Carrier Reference Manual and Chapter 4 of this Letter.

In such cases where an issuer is denied from participating in the Marketplace, MHBE will provide reasons for the denial and appeal rights to the issuer.

C. Carrier Certification Standards

Issuers must meet certain certification standards to offer plans on the Marketplace. These standards are covered in this section and include licensure and accreditation, among other requirements. These standards are detailed in Chapter 3 of the Carrier Reference Manual. This section includes summary information for each of the standards. Please refer to Table 1-A-1 for information on whether a standard applies to health, dental, and/or vision issuers.

i. Maryland Insurance Administration (MIA) Requirements for Marketplace Participation

To be certified to participate in the Marketplace, issuers must provide attestation of licensure by the State of Maryland as a risk-bearing entity operating in good standing with MIA, and adherence to applicable rules and standards in the Insurance Article of the Annotated Code of Maryland. This will be collected as part of the Carrier Application.

ii. Requirement for Accreditation

To be certified to participate in the Marketplace, issuers must be accredited by the National Committee for Quality Assurance, Accreditation Association for Ambulatory Health Care, or the Utilization Review Accreditation Commission by 2025. MHBE will consider an issuer accredited if it meets the federal accreditation standard at 45 CFR § 156.275, and follows the accreditation timeline under 45 CFR § 155.1045.

Issuers will submit their accreditation information for carrier certification through the Carrier Application. MHBE will not collect more information than what is collected by the Federally-Facilitated Marketplace (FFM).

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

iii. <u>Requirement for an Active Carrier Business Agreement</u>

To be certified to participate in the Marketplace, issuers must have an active Carrier Business Agreement (CBA) on file with MHBE. The most recent iteration of the Carrier Business Agreement was released in 2022. Additional information may be found in the Carrier Reference Manual.

iv. <u>Requirement for an Active Non-Exchange Entity Agreement</u>

To be certified to participate in the Marketplace, issuers must have an active Non-Exchange Entity Agreement (NEEA). An active NEEA is defined as the latest iteration of the NEEA released by MHBE, and which is signed by MHBE and the issuer and is on file with MHBE. The most recent iteration of the NEEA was released in 2024. Additional information may be found in the Carrier Reference Manual.

v. <u>Network Adequacy, and Provider Directory Attestations</u>

Issuers must complete Network Adequacy and Provider Directory Attestations within the Carrier Application. The attestations require that issuers meet their regulatory and statutory obligations on network adequacy and provider directories in accordance with COMAR 31.10.44 and Insurance Article, §15-112(p)(2)(ii), Annotated Code of Maryland.

Issuers must also adhere to Network Adequacy submission requirements for the Maryland Insurance Administration (MIA). For more information visit the MIA website.

vi. <u>Patient Data Availability Attestation</u>

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.

vii. <u>State Reinsurance Program Attestation</u>

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

viii. Value Plan Standards Attestation

Issuers must complete the Value Plan Standards Attestation within the Carrier Application. This attestation requires issuers to validate that all out of pocket costs for services and benefits not captured on the Plan and Benefits template adhere to the requirements outlined by MHBE as approved by the MHBE Board of Trustees.

A copy of the signed attestation may be submitted through issuer SERFF binders. NOTE: This requirement applies to Individual Market medical carriers only.

viii. Additional Requirements

To be certified to participate in the Marketplace, an issuer must also submit the below items to MHBE. Additional specifications for these items may be found in Chapter 3 of the Carrier Reference Manual.

1. Carrier Logo
2. List of Subcontractors
3. Non-Discriminatory Benefit Design Attestation

D. Waiver Authority

MHBE, with the approval of the MHBE Board of Trustees, may grant a waiver to specific provisions described in this chapter. MHBE may grant the waiver with or without corresponding conditions. To request a waiver, the issuer should inquire with their MHBE Account Manager.[2]

E. Denial, Suspension and Revocation of Certification

MHBE may deny, suspend, revoke, or seek other remedies against the QHP issuer offering a plan under Section 31-115(k) of the Insurance Article, Maryland Code for failure to adhere to certification requirements.

Furthermore, MHBE may conduct compliance reviews of a plan during the plan benefit year. The scope of such compliance reviews extends to only include certification standards covered in Section 31-115(k) of the Insurance Article, Maryland Code. If, as a result of such compliance reviews, MHBE finds an issuer to be non-compliant, MHBE will require the issuer to correct and meet compliance. Any denial, suspension or revocation of certification and compliance review findings and corrective action plans is subject to any and all remedies available under state and federal laws and regulations.

CHAPTER 2: QUALIFIED HEALTH PLAN/STAND-ALONE DENTAL PLAN CERTIFICATION PROCESS

The Affordable Care Act, Section 31-115 of the Insurance Article, Maryland Code, and COMAR 14.35.16 establish that QHPs and SADPs must meet a number of standards in order to be certified or recertified to operate within the Marketplace. Several of these are market-wide standards that apply to plans offered in the individual market inside as well as outside of the Marketplace. The remaining standards are specific to qualified plans (QHPs and SADPs) seeking certification or recertification from the Marketplaces.

[2] The MHBE Account Manager is the issuer's MHBE Point of Contact for all Plan Management/Operational initiatives. All issuers participating in Maryland Health Connection currently work with an MHBE Account Manager.

MHBE has established an Annual Certification Process for certification of qualified plans that a certified issuer would like to offer on the Marketplace. This chapter describes the Individual and Small Business Marketplaces Certification Process for a QHP or SADP to be certified and offered in the Marketplace. Applicable requirements for SADPs have been clearly identified with "SADP." Subject to any changes to federal or state requirements, such as in the MIA Bulletin on the 2026 Rate and Form Filing Deadline or the 2026 Notice of Benefit and Payment Parameters, the following dates are considered finalized.

A. Submission Requirements for QHP/SADP Certification

For a QHP/SADP to be certified for sale through the Marketplace, the plan's issuer must submit the Qualified Plan Certification Application and all required templates for each plan for 2026. Specific details of the documentation within the Plan Certification Application are included in Chapter 4 of the Carrier Reference Manual and within this section.

i. Templates

The templates required as part of the Plan Certification Application are listed in Table 2-A-1. Templates will be located on the CCIIO website for issuer resources at https://www.qhpcertification.cms.gov and the MHBE partner site https://www.marylandhbe.com. All items must be submitted through the plan issuer's SERFF Binders. By April 1, 2025 the 2026 SERFF Binders should be available for use in document submission by issuers. Exceptions to this general rule are limited and may be granted upon request by the issuer and approval by MHBE. Table 2-A-1 includes an initial and final due date. Issuers are encouraged to submit completed templates and supporting documentation, especially if no extensive benefit modifications are expected, earlier than the dates outlined in the table.

For Individual QHPs and SADPs, the entire suite of templates and supporting documentation must be uploaded into the 2025 SERFF Binders by June 2, 2025, for preliminary validation. From the period between June 2 and September 12, 2025, MHBE will engage with Individual QHP and SADP issuers on the data and plan display reconciliation process, which is addressed in further detail in section B of this chapter. Issuers will be unable to view plan data in plan display of the online Maryland Health Connection portal during this period. Issuers are required to participate in plan display testing in the Maryland Health Connection User Acceptance Testing Environment before plans are certified.

Issuers must have their final template suite and supporting documentation into their SERFF Binders by September 12, 2025 (for Individual QHPs and SADPs) and September 19, 2025 (for Small Business QHPs). Final certification in the SERFF portal will occur on September 12, 2025, for Individual QHPs and SADPs. From September 12, 2025 until the start of the 2026 Open Enrollment Period, all plan data for Individual QHP and SADPs will be frozen in production until the change request period begins on November 1, 2025.

Plan Management has scheduled the completion of Small Business Plan Certification for September 19, 2025.

Table 2-A-1. QHP/SADP Plan Certification Templates and Submission Dates

Item Name	QHP/ SADP	Initial Submission Date to MHBE	Individual – Final Submission Date to MHBE	SADP – Final Submission Date to MHBE	SHOP – Final Submission Date to MHBE	Description of Item

Plan and Benefits Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	Template used to collect plan and benefit details.
Unified Rate Review Template	QHP	June 2 2025	Sept. 12, 2025	Not Applicable	Sept. 19, 2025	Provides information and data necessary for ERR Reasonableness Review, rate increase monitoring and Market Rating Rules Compliance Reviews by states and CMS
Prescription Drug Template	QHP	June 2, 2025	Sept. 12, 2025	Not Applicable	Sept. 19, 2025	Template to capture prescription drug tiers and cost-sharing structure
Network Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	Template to capture network ID numbers
Service Area Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	Information identifying a plan's geographic service area.
Rate Data Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	A table for entering plan rates based on rating area, age, and tobacco use
Plan Crosswalk Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	Part of 2025 Plan Certification, used in the auto-renewal process to ensure appropriate transfer of enrollees in case of plan exit.
Part III: Actuarial Memorandu m	QHP	June 2, 2025	Sept. 12, 2025	Not Applicable	Sept. 19, 2025	Part of 2025 Plan Certification, provides actuarial written narrative describing and supporting the information provided in Part I.
Partial County Service Area Justification Attestation	QHP	Not Applicable	Sept. 12, 2025	Not Applicable	Sept. 19, 2025	Part of 2025 Plan Certification, justification from any issuer that submits a partial county service area. Issuers without changes from prior plan years may submit an attestation to meet this requirement.

Maryland ECP Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	Part of 2025 Plan Certification, collects information from issuers on the number of Essential Community Providers they have contracted with. Used to evaluate network inclusion standard.
Transparency in Coverage Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	Part of 2025 Plan Certification, collects numerical claims data from issuers.
URL Template	QHP/ SADP	June 2, 2025	Sept. 12, 2025	Sept. 12, 2025	Sept. 19, 2025	Part of 2025 Plan Certification, collects URLs data that will display in plan shopping on MHC. Submit in SERFF Supporting Documents Section.
Telehealth Cost Share Template	QHP	June 2, 2025	September 12, 2025	Not Applicable	Sept. 19, 2025	State specific QHP template to collect information on cost sharing for virtual care. This template is under development.

ii. Plan Display Reconciliation

A critical part of plan certification is ensuring that the QHP/SADP data displayed to consumers accurately displays premiums, benefits, and cost sharing. This requires an extensive reconciliation process between issuer data, including plan templates and URLs, and the display outputs of these items in plan shopping. **Consistent with the process established for plan year 2025, issuers will be required to submit a final Rate Data Template that has been MIA approved prior to MHBE's plan upload. This requirement will coincide with issuer sign-off in the month of September of each year. In addition, issuers must submit an actuarial certification that the rates in the final Rate Data Template are the same as the rates approved by the MIA.** Plan display reconciliation includes issuers participating in the Small Business Marketplace. Issuers offering plans for small businesses should follow the reconciliation process as detailed in Table 2-A-2 (QHP/SADP Plan Display Reconciliation Timeline).

Table 2-A-2. QHP/SADP Plan Display Reconciliation Timeline

Event/Period	Entity Responsible for Event/Period	Date of Action	Action Description	Source/ Submission Format
Preliminary Template Submission	Issuers	June 2, 2025	Issuers submit a full suite of Plan Management Templates.	SERFF

Validation Analysis	MHBE	June 2- June 26, 2025	MHBE will analyze submitted templates for Plan Management Application Validation. MHBE will provide specific required changes to ensure validation.	SERFF Note to Filer
First Round Template Submission	Issuers	July 8, 2025	Issuers will submit full suite of Plan Management Templates with validation changes. Submissions that require no changes do not need to be resubmitted.	SERFF
Extract Analysis + Feedback	MHBE	July 15, 2025	MHBE will deliver to Issuers Plan Management Module Extracts + Feedback. MHBE will provide specific required changes to ensure an improved data extract.	SERFF Note to Filer
Second Round Template Submission	Issuers	July 22, 2025	Issuers will submit a full suite of Plan Management Templates with extract changes.	SERFF
Extract Analysis/Plan Display Printouts	MHBE	July 29, 2025	MHBE will deliver to issuers Plan Management Module Extracts, Feedback, and Plan Display Printouts. MHBE will provide gap analysis between submitted Plan Shopping Tile and Plan Compare Templates and Plan Display Printouts. MHBE will provide specific required changes to ensure an improved Plan Display.	SERFF Note to Filer
Third Round Template Submission	Issuers	August 5, 2025	Issuers will submit full suite of Plan Management Template with plan display changes.	SERFF
Live Module Data Review	Issuers/ MHBE	August 18 2025 through August 22, 2025	Issuers will perform data review in the Maryland Health Connection Anonymous Browsing UAT environment + Template Fixes and Submissions. MHBE will provide specific required changes to ensure an improved Plan Display.	MHC Anonymous Browsing + SERFF + SERFF Note to Filer

Extract Analysis/ Plan Display Printouts	MHBE	September 2, 2025	MHBE will provide gap analysis between submitted Plan Shopping Tile and Plan Compare Templates and Plan Display Printouts. MHBE will provide specific required changes to ensure an improved Plan Display. If rates are not finalized by Aug. 30, MHBE will provide a printout of Plan Display as soon as possible after rate finalization to include rates as approved by the MIA.	SERFF Note to Filer
Final Binder Submission	Issuers	Individual QHP and SADP: Sept. 12, 2025 SHOP: Sept. 19, 2025	Issuers will submit final Plan Management Template Suite into SERFF.	SERFF
Issuer Signoff	Issuers	Individual QHP and SADP: Before Sept. 16, 2025 SHOP: Sept. 23, 2025	Issuers will sign-off on plans displayed in the UAT environment.	MHC Anonymous Browsing + SERFF Disposition
Plan Upload into Production	MHBE	Individual QHP and SADP: Sept. 18, 2025 SHOP: Sept. 29, 2025	MHBE will target uploading the final individual QHP and SADP templates into production by September 18th and will upload the final templates in production no later than October 2.	MHC Plan Management Module – Production

Plan Data/Template Point-of-Contact
To facilitate the plan data reconciliation process, issuers are required to submit an Issuer/Administrator Point of Contact for Template Error Resolution to MHBE. This information must include: Legal Entity/Issuer, Name, Title, Phone Number and Email. MHBE collects this information via the Carrier Application.

iii. Special Enrollment Period Resulting from Data Errors in Plan Display
MHBE expects robust issuer participation in the plan display reconciliation process to ensure that consumers on Maryland Health Connection enroll with clear expectations of a QHP/SADP's benefits (including cost sharing), service area, and premium. Consumers who enroll in plans with a materially erroneous data display and demonstrate that the erroneous data influenced the consumer's enrollment decision are eligible for a special enrollment period under 45 CFR § 155.420 (d)(12). As in previous years, MHBE staff will work with partner issuers to ensure minimal errors in plan display.

B. Review of Plan Certification Applications & Certificate of Plan Certification
MHBE must review a Plan Certification Application submitted to MHBE by an issuer within 45 calendar days of receipt of the completed application. MHBE will notify an issuer if its submitted application is not considered complete and which items are outstanding. After the 45-day period, all issuers will receive a Plan Certification Approval or Denial Notice from MHBE, with information on issuer options for appeal. A Plan Certification Approval Notice informs the issuer that they are eligible to offer plans through the

Marketplace for the applicable plan year. The plan certification period begins on the date of confirmation of receipt of a complete plan certification application package by the MHBE Account Manager.

C. Waiver Authority

MHBE, with the approval of the MHBE Board, may waive specific provisions described in this chapter, pursuant to COMAR 14.35.16. MHBE may grant the waiver with or without corresponding conditions. To request a waiver, the issuer should inquire with their MHBE Account Manager.

D. Denial, Suspension and Revocation of Certification

MHBE may deny, suspend, revoke, or seek other remedies against the QHP/SADP issuer offering a plan under Section 31-115(k) of the Insurance Article, Maryland Code.

Furthermore, MHBE may conduct compliance reviews of a plan during the plan benefit year. The scope of such compliance reviews extends to only include certification standards established under Section 31-115(k) of the Insurance Article, Maryland Code. Denials, suspensions, revocations of certification, compliance review findings, and corrective action plans are subject to any and all remedies available under state and federal laws and regulations.

If, as result of such compliance reviews, MHBE finds a QHP/SADP to be non-compliant, MHBE will require the QHP/SADP issuer to implement corrective actions and come into compliance. If an issuer chooses to withdraw from the Exchange or the plan is decertified by MHBE, the issuer shall follow plan management guidance as specified by MHBE in ceasing to do business on the Exchange.

CHAPTER 3. OFF-EXCHANGE SADP CERTIFICATION PROCESS AND STANDARDS

MHBE will continue to certify Off-Exchange SADPs. Issuers must complete an application after receiving rate and form approval from MIA.

A. Off-Exchange SADP Submission Requirements & Submission Timeline

SADPs that participate in the Exchange-Certified program must submit an Off-Exchange Dental Carrier Application and provide MHBE with notice of intent to participate after they have been approved by MIA. Exchange certification of the plan can occur any time prospectively or within an eligible plan year.

Unless otherwise directed by MHBE, issuers must submit plan certification data through the secure 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 issuer of approval or denial to offer qualified plans on the Marketplace. In such cases where a single plan or a product-type is denied participation on the Marketplace, MHBE will provide to the issuer the reasons for denial and instructions to reapply or appeal.

B. Certification Standards

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

1. Cover the State benchmark pediatric dental essential health benefits,
2. Comply with annual limits and lifetime limits applicable to essential health benefits, and
3. Comply with rules applicable to stand-alone dental plans under 45 CFR § 156.150.

CHAPTER 4: QHP AND SADP CERTIFICATION STANDARDS

The Affordable Care Act, Sections 31-106 and 31-108 of the Insurance Article, Maryland Code, and COMAR 14.35.16, establish that QHPs and SADPs must meet a number of standards in order to be certified or recertified as QHPs and SADPs for sale in the Individual and Small Business Marketplaces.

MHBE notes that issuers must comply with the rate and form review procedures established by the MIA in its annual bulletin to issuers. MHBE will provide the MIA with issuer Marketplace data, upon request, to support rate and form review. Further, issuers must comply with the rate increase notification requirements under 45 CFR § 155.1020.

MHBE continues to review its Marketplace participation policies to determine if they continue to meet the needs for supporting consumer choice. MHBE must certify QHPs that are in the interest of qualified individuals as determined by MHBE pursuant to the Affordable Care Act § 1311(e)(1)(B), 45 CFR §155.1000(c)(2), and Insurance Article, § 31-115(b)(7), Maryland Code.

A. Existing Qualified Plan Standards

This chapter presents plan certification standards that are new for the 2026 plan year. Issuers that seek to offer coverage on Maryland Health Connection must also comply with existing qualified plan certification standards. These existing standards may be found in Chapter 4 of the Carrier Reference Manual and in previous years' Annual Letter to Issuers.

B. New 2026 Qualified Plan Standards

This section reviews the final 2026 Qualified Plan Standards that are new for 2026. MHBE has also included technical guidance to aid issuers in implementation.

The MHBE Board of Trustees reviewed and approved proposed Qualified Plan Certification Standards that would be new for 2026 at the January 21, 2025 meeting. These standards included updated Value Plan designs and a new requirement pertaining to cost sharing for mental health and substance use disorder office visits. The Board will vote on whether to finalize these standards at the February 18, 2025 meeting.

Value Plans

In 2026, Value Plans will have standardized cost sharing for commonly used services as they have since 2024. Each individual market licensed issuer must offer one Value Plan at each of the Bronze, Silver, and Gold metal levels. Carriers must identify these standardized Value Plans, and only these plans, with "Value" or "Value Plan" in the plan name. Value Plans must also include $0 cost sharing for certain diabetes care management services.

Proposed 2026 Value Plan designs are included in Appendix 1 of this letter. The actuarial value of each of the proposed designs allows for carriers to include $0 cost sharing for certain diabetes care management services. The 2024 Value Plan Workgroup, consisting of eighteen stakeholders from diverse sectors and regions of the state, convened seven times to discuss 2026 Value Plan designs and ultimately recommended a handful of updates in addition to adjustments necessary to bring actuarial value (AV) in compliance with federal restrictions. First, the workgroup recommended that the 2026 plans include reduced cost-sharing for lab services because of the impact to enrollees with chronic, frequently high-

disparity conditions that may require labs to manage. Second, they recommended that 2026 plans have aligned cost-sharing between the two classes (Class III and Class IV) of pediatric dental "major services;" the cost-sharing for Classes III and IV "major services" were not aligned in 2024 and 2025, but "major services" are usually combined into a single class as an industry standard. For 2026, the workgroup recommended that the cost-sharing be aligned across Classes III and IV but vary by metal level.[3] Lastly, the workgroup proposed aligning the copays for physical therapy, speech therapy, and occupational therapy with the copays for habilitative services and outpatient rehabilitative services in the Silver 94% AV Cost-Sharing Reduction plan because all the other plans align these copays and these services often entail the same type of care. The workgroup also recommended updates to bring AVs into federal compliance, including increases to Maximum-out-of-Pocket (MOOP) amounts and minimal-as-possible copay increases from the 2025 amounts. When considering updates, the workgroup prioritized limiting the impact to consumers and following the principle established by the 2022 Affordability Workgroup that cost-sharing across plan designs for the same service should remain the same, or, preferably, decline, as the AV of a plan increases.

MHBE received no comments on the proposed designs.

Mental Health and Substance Use Disorder Cost-Sharing
During this year's open enrollment, MHBE staff received questions from navigators confused that some plans on MHC had higher or different cost sharing for office visits for mental health and substance use disorder (MH/SUD) treatment as compared to the cost sharing for primary care office visits. These navigators were aware that state and federal laws require parity between physical health and MH/SUD benefits. However, due to how parity is calculated under the law, it is possible for plans to comply with the law and still have higher cost sharing for MH/SUD office visits than for primary care office visits.

Different and higher cost sharing for MH/SUD services may reduce the accessibility of those services and lead to confusion in the marketplace from individuals aware of parity laws who expect them to be equivalent. In order to address these concerns, MHBE has proposed that starting in PY26, plans sold through MHC use equivalent cost sharing for primary care and MH/SUD services. Due to parity requirements, it may still be the case that a carrier would use a copay for one service type and coinsurance for the other. For example, a plan might use a copay for primary care and coinsurance for MH/SUD office visits. In that case, the plan would be required to set the coinsurance at a level equivalent to the dollar value of the copay, and would be required to apply the deductible equivalently, e.g. if primary care was not subject to the deductible, MH/SUD office visits also could not be subject to the deductible. MHBE also proposed to encourage, but not require, that plans use copays for these services, consistent with feedback we have received from stakeholders that copays are a more understandable, consumer-friendly cost sharing design.

MHBE received no comments on this proposal.

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[3] Please see the Value Plan Workgroup webpage for more details on the workgroup's process and discussions.

CHAPTER 5: QUALIFIED VISION PLAN CERTIFICATION PROCESS AND STANDARDS

In PY2024, MHBE began partnering with vision plans to offer adult vision benefits to consumers in the individual market. MHC hosts links to external vision plan websites where consumers may enroll in vision plans. Section 31-115 of the Insurance Article, Maryland Code establishes that Qualified Vision Plans (QVPs) must meet a number of standards in order to be certified or recertified to operate within the Marketplace.

This chapter describes the Certification Process and Standards for a QVP to be certified and offered in the individual Marketplace. (Please refer to Chapter 1 for information on the issuer annual certification process and standards applicable to QVP issuers.) Subject to any changes to federal or state requirements, the following dates are considered finalized.

A. Submission Requirements for QVP Certification

Table 5-A-1. QVP Certification Documents and Submission Dates

Item Name	Initial Submission Date to MHBE	Final Submission Date to MHBE	Description of Item
Plan documents and rates	June 2, 2025	Sept. 13, 2025	2026 plan documents and rates filed with MIA for the high and low plan to be offered through MHC.
Information for MHC website	June 2, 2025	August 26, 2025	Vision plan website URL to which MHC will link, brief description of the vision issuer to include on the MHC website, and vision plan call center toll-free phone number and hours
Vision plan website screenshots	June 2, 2025	August 26, 2025	Screenshots illustrating consumer plan shopping and enrollment experience on vision plan website
Enrollment and billing documents	June 2, 2024	August 26, 2025	Mock member card, enrollment packet, invoice, and payment policy

Table 5-A-2. Other QVP Certification Key Dates

Event/Period	Entity Responsible for Event/Period	Date of Action	Action Description
Link testing	MHBE and Issuers	Sep. 22 - Sept 26, 2025	Test MHC link to vision carrier website
Plan shopping	Issuers	Oct. 1 - Oct. 31, 2025	Issuers’ websites live for consumers to review plans
Enrollment starts for PY24	Issuers	Nov. 3 2025	Issuers accept enrollment in PY25 coverage

B. Plan Certification Standards for QVPs in the Individual Market

Participating vision plans must:

- Be available at a high and a low level (two QVPs per carrier)
- Be licensed for sale in the MD individual market as of plan year 2026
- Provide a Maryland-specific account manager to work with the MHBE plan management team
- Offer the following services:
    - A website cob-branded with MHC that serves as a landing page for consumers and includes a provider directory, a simple and easy-to-understand description of plans' covered benefits and out-of-pocket expenses, and allows consumers to compare and enroll in plans;
    - A customer service call center with a toll-free number that is sufficiently staffed to handle questions and assist consumers;
    - Ability for member to pay bill electronically;
    - Ability to generate member enrollment materials and notices;
    - Ability to provide reporting to MHBE on plan selection, enrollment, and member demographics (reporting template to be provided by MHBE); and
    - Other services determined necessary by MHBE.

C. Review of Plan Certification Applications & Certificate of Plan Certification

MHBE must review a Plan Certification Application submitted to MHBE by an issuer within 45 calendar days of receipt of the completed application. MHBE will notify an issuer if its submitted application is not considered complete and which items are outstanding. After the 45-day period, all issuers will receive a Plan Certification Approval or Denial Notice from MHBE, with information on issuer options for appeal. A Plan Certification Approval Notice informs the issuer that they are eligible to offer plans through the Marketplace for the applicable plan year. The plan certification period begins on the date of confirmation of receipt of a complete plan certification application package by the MHBE Account Manager.

D. Denial, Suspension and Revocation of Certification

MHBE may deny, suspend, revoke, or seek other remedies against a QVP issuer offering a plan under Section 31-115(k) of the Insurance Article, Maryland Code.

Furthermore, MHBE may conduct compliance reviews of a plan during the plan benefit year. The scope of such compliance reviews extends to only include certification standards established under Section 31-115(k) of the Insurance Article, Maryland Code. Denials, suspensions, revocations of certification, compliance review findings, and corrective action plans are subject to any and all remedies available under state and federal laws and regulations.

If, as result of such compliance reviews, MHBE finds a QVP to be non-compliant, MHBE will require the issuer to implement corrective actions and come into compliance. If an issuer chooses to withdraw from the Exchange or the plan is decertified by MHBE, the issuer shall follow plan management guidance as specified by MHBE in ceasing to do business on the Exchange.

CHAPTER 6: ISSUER REQUIREMENTS FOR THE STATE REINSURANCE PROGRAM.

This chapter details issuer requirements for participation in the State Reinsurance Program (SRP) under Md. Insurance Code Ann. § 31-117. Issuers should also refer to regulations under COMAR 14.35.17 for information on other requirements under the State Reinsurance Program.

MHBE has extended the agreement with the Centers for Medicare and Medicaid Services (CMS) to administer the SRP by using the External Data Gathering Environment (EDGE) server infrastructure through 2025. Issuers will continue to follow EDGE server data submission timelines and protocols, as under the Risk Adjustment program.

Payment under the SRP is based on reinsurance reports received from CMS. Pursuant to the agreement between MHBE and CMS, CMS applies the approved reinsurance attachment point, coinsurance rate, and cap to carriers' final EDGE server claims and reports the resulting undampened reinsurance payments to CMS. After receipt of CMS's report, in accordance with COMAR § 14.35.17.04, a carrier-specific adjustment factor is calculated by applying the applicable year's dampening factor to the risk adjustment results reported by CMS. The final State Reinsurance Program payment amounts are determined by applying each carrier-specific adjustment factor to the corresponding carrier's reinsurance results.

Please note that carriers participating in the SRP are required to comply with applicable components of the 1332 State Waiver Program Compliance Supplement August 2020, including but not limited to, documented adherence with the Procurement Suspension and Debarment requirements.[4]

A. Parameters for the State Reinsurance Program

The MHBE Board of Trustees set the final parameters for the 2025 SRP at its July 15, 2024 meeting. For the 2025 plan year, the SRP will remit payments for eligible claims according to the below 2025 parameters. Prior years' parameters are included for reference. The Board will set estimated 2026 SRP parameters at its February 18, 2025 meeting.[5]

Table 6-A-1. 2019-2025 State Reinsurance Program Parameters

Parameters	2019 - 2022	2023	2024	2025	Estimated 2026
Attachment Point:	$20,000	$18,500	$20,000	$21,000	TBD
Coinsurance Rate:	80%	80%	80%	80%	TBD
Cap:	$250,000	$250,000	$250,000	$250,000	TBD

[4] https://www.whitehouse.gov/wp-content/uploads/2020/08/2020-Compliance-Supplement_FINAL_08.06.20.pdf; See section 4-93.423.

[5] TBD

Dampening Factor	.760 - .805	.840	.850	.850	TBD

B. Program Payment

MHBE will remit reinsurance payments under the SRP no later than September 30 of the year following the program year.

C. Reporting Requirements

Issuers are expected to continue regular data submission operations to their EDGE servers as under the Risk Adjustment program. In addition, MHBE will contact issuers in spring 2025 to collect claims and enrollment data and 2024 EDGE data, which will be used by MHBE to update SRP projections.

As outlined in COMAR 14.35.17.03(C), for each year that a carrier which offers a reinsurance-eligible plan participates in the State Reinsurance Program, the carrier shall submit to the Board a Carrier Accountability Report by June 30th following the end of the plan year. Carriers participating in the reinsurance program in plan year 2024 must file a report by June 30, 2025. Carriers participating in the reinsurance program in plan year 2025 must file a report by June 30, 2026.

The report must detail carrier actions to manage the costs and utilization of enrollees whose claims are reimbursed under the program. Guidance to carriers on the plan year 2023 report, submitted in 2024, is available on the MHBE website.[6] This guidance will be updated in 2025 for the plan year 2024 report.

[6] https://www.marylandhbe.com/home/carriers/

Appendix 1: Proposed 2026 Value Plan Designs

Proposed 2026 value plan designs are shown below. The changes are intended to reduce lab services copays, bring the designs within federal AV requirements, limit impact to consumers, and follow the principle established by the 2022 Affordability workgroup that cost sharing across plan designs for the same service should remain the same, or, preferably, decline, as the AV of a plan increases.

	Subject to Deductible	Proposed 2026 Gold	Proposed 2026 CSR 94%	Proposed 2026 CSR 87%	Proposed 2026 CSR 73%	Proposed 2026 Base Silver	Proposed 2026 Expanded Bronze
Actuarial Value		81.89%	94.92%	87.92%	73.87%	71.75%	64.71%
Medical Deductible		$1,000	$0	$1,000	$4,500	$4,500	$10,150
Drug Deductible		$150	$0	$150	$750	$750	n/a
Medical MOOP		$8,500	$1,950	$2,850	$6,800	$8,500	$10,150
Rx MOOP		$600	$250	$500	$1,300	$1,300	n/a
Combined MOOP		$9,100	$2,200	$3,350	$8,100	$9,800	$10,150
Emergency Room Services	Yes - No	$350	$75	$150	$500	$500	n/a
All Inpatient Hospital Services (inc. MH/SUD)	Yes - No	$450	$150	$350	$550	$550	n/a
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	Yes - No	$10	$5	$10	$35	$35	$35
Specialist Visit	Yes - No	$35	$20	$35	$110	$110	$110
Mental/Behavioral Health and Substance Use Disorder Office Visits	Yes - No	$10	$5	$10	$35	$35	$35
Mental/Behavioral Health and Substance Use Disorder Outpatient Service	Yes - No	$10	$5	$10	$35	$35	$0
Imaging (CT/PET Scans, MRIs)	Yes - No	$400	$125	$350	$600	$600	n/a
Speech Therapy	Yes - No	$10	$5	$10	$35	$35	$35
Occupational and Physical Therapy	Yes - No	$10	$5	$10	$35	$35	$35
Preventive Care/Screening/Immunization	Yes - No	$0	$0	$0	$0	$0	$0
Laboratory Outpatient and Professional Services	Yes - No	$25	$10	$25	$45	$45	$55
X-rays and Diagnostic Imaging	Yes - No	$50	$20	$50	$150	$150	$150
Skilled Nursing Facility	Yes - No	$75	$30	$75	$150	$150	n/a
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes - No	$250	$50	$75	$150	$150	n/a
Outpatient Surgery Physician/Surgical Services	Yes - No	$125	$60	$125	$150	$150	n/a
Generic Drugs	Yes - No	$10	$0	$6	$25	$25	$25
Preferred Brand Drugs	Yes - No	$30	$5	$25	$75	$75	n/a
Non-Preferred Brand Drugs	Yes - No	$60	$15	$50	$80	$80	n/a
Specialty Drugs (i.e. high-cost)	Yes - No	$75	$25	$60	$100	$100	n/a

Blue text indicates the benefit is covered with cost sharing before the deductible is met. The deductibles and MOOPs shown are for a self-only plan. For a family plan, each member has an individual medical and Rx deductible and MOOP of the amount shown. An individual family member cannot contribute more than the self-only deductible or MOOP toward meeting the family deductible or MOOP. The family has a total medical and Rx deductible and MOOP that is twice the amount shown for a self-only plan. Once the family deductible or MOOP has been met, this satisfies the deductible or MOOP for all family members.

Additional Standardized Service Categories								
Durable Medical Equipment		Yes - No	20%	10%	20%	30%	30%	n/a
Emergency Transportation/Ambulance		Yes - No	$300	$50	$100	$350	$350	n/a
Habilitation Services		Yes - No	$10	$5	$10	$35	$35	$35
Home Health Care Services		Yes - No	$30	$10	$25	$45	$45	n/a
Hospice Services		Yes - No	$0	$0	$0	$0	$0	$0
Inpatient Physician and Surgical Services		Yes - No	$30	$10	$25	$40	$40	n/a
Outpatient Rehabilitation Services		Yes - No	$10	$5	$10	$35	$35	$35
Urgent Care Centers or Facilities		Yes - No	$40	$15	$30	$75	$75	$75
Pediatric Vision								
	Routine Eye Exam for Children (optometrist)	Yes - No	$0	$0	$0	$0	$0	$0
	Eye exam by an Ophthalmologist	Yes - No	$0	$0	$0	$0	$0	$0
	Basic Lenses	Yes - No	$0	$0	$0	$0	$0	$0
	Frames	Yes - No	$0	$0	$0	$0	$0	$0
	Contacts – elective (i.e. in lieu of lenses and frames)	Yes - No	$0	$0	$0	$0	$0	$0
	Contacts – medically necessary	Yes - No	$0	$0	$0	$0	$0	$0
	Low vision testing	Yes - No	$0	$0	$0	$0	$0	$0
	Low vision aid	Yes - No	$0	$0	$0	$0	$0	$0
Pediatric Dental								
	Class I Preventive & Diagnostic Services	Yes - No	$0	$0	$0	$0	$0	$0
	Class II Basic Services	Yes - No	20%	20%	20%	20%	20%	20%
	Class III Major Services	Yes - No	50%	20%	30%	40%	50%	50%
	Class IV Major Services – Restorative	Yes - No	50%	20%	30%	40%	50%	50%
	Class V Orthodontic Services	Yes - No	50%	50%	50%	50%	50%	50%

Enrollees with a primary diagnosis of diabetes pay $0 cost-sharing for:

- PCP visits
- Dilated retinal exam (1x per year)
- Diabetic foot exam (1x per year)
- Nutritional counseling visits
- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)
- A select list of diabetes supplies and medications within the diabetic agents drug class. Other than the below requirements, this list is at the carrier’s discretion. The below requirements are offered in response to a request for more guidance on this coverage requirement; all carriers already met these requirements in 2024. All carriers must include:
    - Test strips and glucometers
    - Preferred brands of insulin

- At least one from each of the following classes of oral hypoglycemics:
  - Biguanides (such as metformin)
  - Thiazolidinediones (such as pioglitazone or rosiglitazone)
  - Sulfonylureas (such as glipizide, glyburide, gliclazide, or glimepiride)

Insurers may charge less than the copays shown for services delivered via telehealth.
Insurers may combine the two outpatient surgery copays into a single copay.