MARYLAND HEALTH PROGRESS ACT OF 2013

ADMINISTRATION'S RECOMMENDATIONS ON STAKEHOLDER AMENDMENTS

March 8, 2013

POLICY/ SECTION		PROPOSED AMENDMENT	EFFECT/RATIONALE	OFFEROR
I. Medicaid Expansion HG §15-101	**UNNECESSARY** because Section 1902(a)(10)(A) of the Social Security Act requires states to provide EPSDT to former foster care youth who are under the age of 21.	A. Retain current definition of "independent foster care adolescent."	Ensures that this category of foster care youth may retain EPSDT as part of their Medicaid benefits, whereas the ACA's new category of former foster care youth will not receive EPSDT.	Coalition of consumer advocates* (See 20 Coalition members listed in Appendix A.)
	MODIFY to give the State discretion to cover children from other states if guidance from the federal government and fiscal considerations make it feasible. The federal government has not	B. Include in the definition of Medicaid-eligible "former foster care youth" those youth who aged out of foster care in another state or D.C.	The federal NPRM suggests states should have this option.	Coalition of consumer advocates

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	yet indicated whether it will provide the data automation capability which would be necessary to verify the foster care status of youth from other states. The State would also need to address the unknown fiscal impact of covering this population, for which 100% federal financing would not be available. *Pages 6, 8*			
	ACCEPT *Page 8*	C. Eliminate income/means testing for former foster care youth.	Necessary to comply with ACA requirements.	Coalition of consumer advocates
	NOT OPPOSED to policy objective, but would require $2.4 million/year of State general funds, and $1.2 M in FY'14 which is not in budget.	D. Require 12 months of continuous eligibility for children in Medicaid and MCHP, with certain exceptions.	Will simplify the process and ensure that children's renewal dates will be in sync with that of their parents, promoting better continuous coverage and better health outcomes for the family.	Coalition of consumer advocates; Maryland's Citizens' Health Initiative & Health Care for All
II. MHBE Financing IN §6-103.2; §31-107; 107.1; §31-107.2	**ACCEPT** with modification that the portion of the tax derived from for-profit HMOs and MCOs which	A. Add IN §6-103.2 to establish a direct distribution of a portion of the tax on health insurance premiums to the MHBE Fund for the sole purpose of funding the operation and	A distribution directly from premium tax revenues to the Exchange Fund, rather than simply a general fund appropriation, is more consistent with the ACA's intent	Administration

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	are currently distributed to the Rate Stabilization Fund will not be part of the distribution to the MHBE Fund. *Pages 12, 24*	administration of the Exchange. The amount shall be sufficient to fully fund Exchange operations.	that the Exchange be sustained through a dedicated revenue stream, and with the framework of the Exchange's special fund.	
	ACCEPT *Pages 24, 25*	B. Direct the MHBE to maintain a separate account for Exchange operations, to expend monies from that account only through an appropriation in the State budget or by budget amendment, and to spend non-state funds before the expenditure of state funds.	Clarifies the methodology for Exchange operating expenditures.	Administration
	ACCEPT *Pages 25, 26*	C. Amend the requirement that the Governor appropriate funds adequate for Exchange operations to establish a minimum $35 million appropriation, with unspent funds reverting at the end of the year to the general fund, and any necessary additional funds provided by deficiency appropriation.	Ensures that the MHBE may spend the funds distributed from the premium tax dollars in accordance with its operating needs.	Administration
	ACCEPT *Page 26*	D. Clarify that all references to "fiscal year" mean the State's fiscal year.	"Fiscal year" is not defined in the Insurance Article.	Administration
	Because Exchange operations are being funded from existing funds which normally go to the GF, rather	E. Require that any monies in the MHBE Fund that remain unspent at the end of the fiscal year be used to reduce premiums for individuals and small businesses rather than revert	Using surplus funds to reduce premiums will protect against the MHBE's fund being diverted for other purposes, as frequently occurs with other special funds. It will also	National Federation of Independent Business

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	than through a new assessment, any excess must revert back to GF.	back to the General Fund.	help mitigate a possible increase in premiums in 2014 and 2015.	
	ACCEPT *Pages 12, 23*	F. Clarify that funds allocated to the Exchange from the premium tax may be used for not only operations but also functions of the Exchange, whether performed by MHBE directly or, through contract or agreement, by another entity or State agency.	Current language limited to "operations" of the Exchange could be read to exclude functions not performed directly by the Exchange but instead delegated by contract or agreement to other entities.	Coalition of consumer advocates; HEAU; Maryland's Citizens' Health Initiative & Health Care for All
III. MHIP Transition IN §14-502(f)	**ACCEPT** *Page 15*	A. Require MHIP to notify members of the opportunity to seek coverage through MHBE or in market outside Exchange, and of the new prohibition on pre-existing condition exclusions.	MHIP members must be made fully aware of their rights and expanded options under the ACA beginning 1/1/14.	Coalition of consumer advocates; Health Education and Advocacy Unit of the Office of the Attorney General (HEAU); Maryland's Citizens' Health Initiative & Health Care for All
	ACCEPT with modification that December, 2013 report required by DLS in budget bill will fulfill requirement for first year, with annual report thereafter until MHIP closes and State reinsurance program	B. Require the MHBE, DHMH, and the Maryland Health Care Commission to submit an annual report on the transition of MHIP enrollees into the Exchange, and the utilization and transfer of MHIP funding to offset the cost of enrollees' care and to help mitigate cost increases for others in the Exchange.	An annual report is an appropriate way to ensure transparency and an understanding of how the transition of MHIP enrollees and funding will be managed, and to retain federal approval for future funding needs.	Maryland Hospital Association; Maryland Chamber of Commerce

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	ends. *Page 17, 18*			
	ACCEPT *Page 17*	C. In the section directing the MHIP and MHBE Boards to determine the amount of funds which will be needed to meet the obligations of the Plan, clarify that this determination must occur every year until the Plan no longer has any "liability for claims submitted by MHIP enrollees" instead of simply until the Plan closes to enrollees.	Claims will continue to come in even after all MHIP enrollees are transitioned to the Exchange.	Administration
	ACCEPT *Page 14*	D. Clarify that in closing MHIP to any new members not enrolled as of December 31, 2013, a current member cannot drop coverage after that date and then reenroll later.	The intent is to close MHIP to any new members and allow continued coverage only for existing members who maintain their coverage without a gap.	Administration
	ACCEPT *Page 15*	E. Allow some MHIP plans to be closed beginning 1/1/14, prior to 1/1/15 which is the earliest date on which all MHIP plans can be closed.	Some MHIP Plus members in subsidized plans will have lower costs if they transition to a subsidized Exchange plan, so it may not make sense to keep the MHIP Plus plans open.	Administration
IV. Plan Certification – Requirements, Enforcement and Appeals IN §31-115 (b), (e), and (k)	**MODIFY** to provide, as in IN §2-212, that upon request for a hearing within 10 days of the agency action, the agency action will be stayed pending the	A. Provide that a carrier may continue to offer its plans in the MHBE pending disposition of the appeal from a denial, revocation, or suspension of plan certification.	Requiring a carrier to withdraw from the MHBE pending an appeal involving a plan certification would cause irrevocable harm to the carrier and potentially to consumers enrolled in the plan as well, if the carrier prevails on appeal.	League of Life and Health Insurers of Maryland, Inc.

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	hearing and final agency decision. Thereafter, the contested case provisions of the APA will govern. *Page 44*			
	ACCEPT with note that federal certification requirements established in State law should track the general categories mandated by the ACA, but should not be as specific as federal regulations, which may change, and should not limit the Exchange's ability to establish standards beyond those required by the ACA. *Page 43*	B. Require the Exchange to establish as certification requirements those standards and data collection requirements that are mandated by federal law or regulation, rather than simply listing these standards as examples of certification requirements the Exchange may elect to impose.	Federal regulations implementing the ACA require health plans to demonstrate compliance with standards involving enrollment, essential community providers, network adequacy, transparency, and accreditation. Maryland law should be consistent with these federal requirements to ensure robust consumer protection and adequate oversight of plan certification.	Coalition of consumer advocates
	Anti-discrimination requirements will be applied more broadly to the entire administration of the Exchange through Amendment XVA.	C. Add to the list of plan certification requirements the mandate to comply with state and federal laws prohibiting discrimination.	Making this an express requirement will help ensure compliance with federal and state anti-discrimination laws.	Coalition of consumer advocates
	See IV(C) above.	D. Make explicit reference in plan certification requirements to the	The history of discrimination against the LGBT community makes it	Maryland's Citizens' Health Initiative &

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		prohibition against discrimination with respect to members of the lesbian, gay, bi-sexual, and transgender (LGBT) community.	necessary to have specific statutory language prohibiting such discrimination.	Health Care for All
	See IV(B) above regarding ACA and regulatory requirements.	E. Specify that the certification requirement relating to network adequacy includes adequate numbers and types of mental health and substance use disorder services providers.	Federal regulations expressly include these specifications, so Maryland law should be consistent with federal requirements.	Coalition of consumer advocates; Maryland Clinical Social Work Coalition
	ACCEPT *Page 42*	F. Clarify that the "policies" adopted by the MHBE Board, which may be the basis of plan certification standards, are the "interim policies" formally adopted by the Board pursuant to its authority under the MHBE Act of 2012.	Plans should not be required to meet standards for certification which are based only on informal policies that have not been vetted, subject to public comment, and approved formally by the Board.	CareFirst; League of Life and Health Insurers of Maryland, Inc.
	MODIFY as follows: Exchange may impose penalty of up to $100 per violation, and in setting the amount of the penalty, shall consider: 1) the type, severity, and duration of the violation; 2) whether the plan knew or should have known of the violation; 3) the extent to which the plan has a history of	G. Amend the Exchange's authority to impose penalties by: 1) specifying that the $100 cap for each violation is per enrollee, and the Exchange may consider the type, severity, and duration of the violation in setting the amount of the penalty; 2) limiting penalties to when the carrier knew or should have known of the violation; 3) prohibiting or waiving part of penalties where the carrier's violation had a reasonable cause and did not involve willful neglect, and the carrier corrected the violation as soon as it	The Exchange should have authority to impose penalties in amounts that will actually deter violations, and $100 per violation is de minimus and would not be an effective deterrent. At the same time, the Exchange should reduce or decline to impose penalties under certain mitigating circumstances. The proposed amendment follows the approach of 26 U.S.C. 4980D(c) of the Internal Revenue Code setting forth the standard for imposing penalties for failure to meet certain	Coalition of consumer advocates

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	violations; and 4) whether the plan corrected the violation as soon as it knew or should have known of the violation. *Page 44*	knew or should have known it had occurred, but maintaining a minimum penalty to ensure deterrence, *e.g*. $15,000.	group health plan requirements.	
	ACCEPT *Pages 40, 42*	H. Clarify that a health benefit plan must offer a bronze level of coverage in the Exchange to be certified as a qualified health plan.	Current language is ambiguous and could be read to mean that the plan must offer a bronze level or higher, instead of requiring all plans to offer a bronze level regardless of any other levels it may offer.	Administration
V. Qualified Vision Plans IN §31-115(d) and (i)	**ACCEPT** and amend §31-116(a)(2)(ii) to remove the reference to §31-115(d), and clarify Exchange's authority to determine whether to allow non-essential vision benefits in the SHOP or Individual Exchange. *Pages 41, 42, 45*	A. Strike subsection (d) which allows qualified health plans to carve out pediatric vision benefits if a qualified vision plan is available to supplement the qualified health plan.	Federal law and regulations will not permit this carve out; all medical plans will be required to include pediatric vision benefits regardless of the availability of supplemental qualified vision plans.	Administration
	ACCEPT *Page 42*	B. Amend the requirement for qualified vision plans to provide that they may include essential pediatric vision benefits *or* any other vision benefits required by federal law or the Exchange.	New federal guidance has clarified that because all qualified health plans must cover essential pediatric vision benefits, qualified vision plans are not necessarily required to include them.	Administration

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VI. Carrier Delegation to MHBE IN §31-103	**ACCEPT** with modification as in VI (B) below. *Pages 21, 22*	A. Clarify that consumer is not liable for any mistakes by MHBE or carrier; require extension of deadlines missed by consumer because of MHBE or carrier error; require that MHBE and carrier resolve any problems and notify consumer of resolution and any necessary action by consumer.	Errors and unintentional mistakes are bound to occur as MHBE becomes operational and takes on collection, billing and other functions, and consumers should not be responsible for consequences of these errors.	Coalition of consumer advocates; HEAU; Maryland's Citizens' Health Initiative & Health Care for All
	ACCEPT with modification as follows: where MHBE is required by law or contract to perform an act for which a carrier would otherwise have responsibility under the Insurance Code, the carrier is not liable or subject to regulatory sanction for MHBE's performance of such act, and the MIA may exercise regulatory oversight over the act. The Exchange and the carrier shall hold the consumer harmless from any adverse consequences relating to the consumer's insurance purchase or	B. Clarify that where MHBE is required by law or has agreed by contract to perform an act, the carrier is not liable for any failure of MHBE to perform that act.	Carriers should be responsible for ensuring consumer protections, but it would be unfair to hold them liable for MHBE's failure to perform functions for which it has assumed responsibility. Carriers cannot exert control over the Exchange, require it to indemnify them, or terminate their contractual relationships with the MHBE.	CareFirst; League of Life and Health Insurers of Maryland, Inc.

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	coverage. In her capacity on the MHBE Board, the Insurance Commissioner shall recuse herself from any enforcement action with respect to such act. *Pages 21, 22*			
VII. Functions and Operations of the Exchange IN §31-108	**ACCEPT** with modification that the Exchange shall comply with Section 508 of the Rehabilitation Act (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 (P.L. 105-220), August 7, 1998, *i.e*. in exercising its responsibilities and performing its functions as required under Title 31. *Pages 27*	A. Provide expressly that in establishing its website, electronic calculator, and consumer assistance services, the Exchange shall ensure that these services are fully and equally accessible to, and independently usable by, blind individuals so that they are able to acquire the same information, engage in the same interactions, and enjoy the same services as sighted users, with substantially equivalent ease of use.	In order to ensure fully accessible use by blind individuals, these functions of the Exchange must be designed to achieve these objectives at the outset.	National Federation of the Blind
VIII. SHOP Rules for Employer Contributions IN §31-111(e)	**ACCEPT** *Page 28*	A. Clarify that the reference plan on which the employer contribution is calculated must be consistent with the type of coverage the employee has selected, *i.e*., individual, family, *etc*.	Language must clearly reflect Exchange Board's policy recommendation on employer contributions	CareFirst; League of Life and Health Insurers of Maryland, Inc.

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	ACCEPT *Page 28, 29*	B. Make the language describing the reference plan consistent with the description of the employer and employee choice models by adding "insurance holding company system" to all references to plans offered by a "carrier."	The law already allows an employer to designate a single carrier or plans offered by related carriers within the same insurance holding company system, so the section describing the reference plan should be consistent. This distinction reflects, for example, the fact that for any family of health insurance products, the HMO product will be offered by a different legal entity from the PPO product, so an employer wishing to offer both would need to be able to select from related carriers rather than a single carrier.	CareFirst; League of Life and Health Insurers of Maryland, Inc.
IX. Consolidated Services Center IN §31-113.1	**ACCEPT**, and include MIA in collaboration to develop SHOP navigator training program to parallel its involvement in developing Individual navigator training program. *Pages 29, 39, 40*	A. Require that the Individual and SHOP Exchanges, the CSC, and the Attorney General's Health Education and Advocacy Unit work collaboratively to assist consumers and to develop training programs for navigators, producers, and CSC permit holders.	The HEAU is the State's federally-designated consumer assistance program, and thus these entities should collaborate in fulfilling their respective consumer assistance functions.	Coalition of consumer advocates; HEAU; Maryland's Citizens' Health Initiative & Health Care for All

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	ACCEPT *Pages 38, 39*	B. Require that, before providing assistance to an individual, a CSC permit holder should inquire whether the individual has insurance, and if so, shall refer the individual back to the producer or carrier providing the policy.	This requirement is consistent with those applicable to navigators.	MAHU; NAIFA-MD
X. SHOP and Individual Exchange Navigator Programs IN §31-112, 113	**ACCEPT** (*not yet reflected in draft of amendments*)	A. Substitute "Connector Entity" where statute currently makes reference to "Navigator Entity."	The federal government created the new category of "assisters" after enactment of the navigator program statute. The MHBE changed its terminology to "Connector Entity" to reflect the addition of "assisters," so the term now encompasses both navigators and assisters. Making the statute consistent would eliminate confusion resulting from different terminology.	Coalition of consumer advocates
	ACCEPT *Page 30*	B. In the section setting forth the purposes of the Navigator Program, add the specific example of assisting individuals who transition between public and private coverage or have lapsed enrollment due to incarceration.	Because of the high risk and acute medical needs of individuals re-entering the community from the criminal justice system, the law should expressly identify this population as a specific category to be targeted for assistance by the Navigator Program.	Coalition of consumer advocates
	ACCEPT *Page 31*	C. Direct that in developing the training program for Individual Navigator certification, the Exchange shall consult with the HEAU in addition to DHMH.	The Exchange's Level II grant includes funding for HEAU to provide Exchange staff training and materials about consumer protections available for appeals	Coalition of consumer advocates; HEAU; Maryland's Citizens'

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			and grievances, so this information should be included in the development of the Navigator training program.	Health Initiative & Health Care for All
	ACCEPT *Page 29*	D. Establish a requirement for the SHOP Exchange, comparable to the one for the Individual Exchange, that in developing its SHOP navigator and CSC employee training program, the SHOP Exchange shall obtain approval from the Insurance Commissioner and shall consult with DHMH and HEAU.	The same reasons for approval and collaboration in developing the Individual Exchange Navigator training are applicable also to the SHOP Exchange.	HEAU; Maryland's Citizens' Health Initiative & Health Care for All
	Stakeholders of the Connector program by definition have experience and expertise with navigator program target populations.	E. Direct that in developing the training program for Individual Navigators, the Exchange's consultation with stakeholders shall include those with experience with target populations.	The law should ensure that training programs are developed initially with expertise of those familiar with target populations most in need of assistance.	Coalition of consumer advocates
	The broker appointment policy is being developed by the Board in consultation with stakeholders.	F. Amend the SHOP and Individual producer authorization programs to provide that a producer may not be required to hold an appointment with a carrier in order to sell qualified plans in the SHOP or Individual Exchanges.	Requiring producer appointments will limit consumer access; jeopardize the robust success of the Exchange; undermine the Exchange's "no wrong door" objective; increase the potential for adverse selection; enable anti-consumer behavior and marketplace mischief; and run counter to existing law governing the Exchange and producer appointments. Producers	Jay Clinton Duke; Independent Insurance Agents and Brokers of America; Independent Insurance Agents of Maryland

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			will not be acting on behalf of carriers in the traditional sense, but rather will have the Exchange as their primary point of contact. The MIA's regulatory oversight of producers is sufficient to ensure qualified service.	
XI. Continuity of Care IN §15-140	**ACCEPT** with modification that continuity of care provisions apply to dental conditions only when there is a coordinated treatment plan in progress. *Pages 47, 52, 53*	A. Amend the definition of "acute condition" to include a dental condition.	The same standards for continuity of care that apply to medical conditions should apply equally to dental conditions.	Coalition of consumer advocates
	ACCEPT with modification that shall apply to adult and pediatric dental conditions, subject to application in XI (A) above. *Pages 52, 53*	B. Add "serious pediatric dental condition" to the list of conditions for which an out-of-network provider should be permitted to continue care during a coverage transition.	Disrupting treatment for children requiring serious dental services like medically necessary orthodontia, restorative services, or oral surgery is potentially harmful, and providers should be able to continue the course of such treatments during a coverage transition.	Coalition of consumer advocates
	ACCEPT removal of the requirement regarding the inability to perform daily activities because these provisions apply depending upon the nature of the condition	C. Amend the definition of "serious chronic condition" to specify that: 1) it includes mental health or substance use disorder and a dental condition; 2) it is certified as a serious condition by a health care provider; and 3) it does not require that an individual	The determination of whether a condition is serious and chronic should rest with the health care provider rather than the carrier, and it should not require a patient to demonstrate the inability to perform daily activities since	Coalition of consumer advocates

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	itself, not its effect on the individual's activities. *Page 53*	demonstrate an inability to perform daily activities.	patients may push themselves to continue activities to daily living despite a serious chronic condition.	
	Unnecessary because the bill provides expressly that the definitions apply only to these continuity of care provisions.	D. Clarify that all definitions of "conditions" in the continuity of care provisions apply to those provisions only, and do not apply elsewhere in Maryland law.	These definitions are tailored narrowly for purposes of continuity of care and may not be appropriate in other contexts.	Maryland Society of Anesthesiologists; First Colonies Anesthesia Associates; Maryland Society of Otolaryngology; Advanced Radiology; Medical Emergency Professionals
	ACCEPT by adopting definition in Health – General § 4-301. *Page 50*	E. Amend the definition of "health care provider" to specify that it constitutes a practitioner licensed, certified, or otherwise authorized "by law" to deliver services, rather than simply "otherwise authorized to deliver services."	Adding "by law" tracks existing law which requires a health care provider to be authorized by law to perform a service.	CareFirst; League of Life and Health Insurers of Maryland, Inc.
	MODIFY as in IX (G) below.	F. In the section requiring a receiving carrier to accept a prior authorization from a relinquishing carrier, add the requirement that the enrollee must provide the new carrier with a copy of the relinquishing carrier's prior authorization.	In order to accept a prior authorization, a receiving carrier will need documentation that provides the details of the treatment and services that were approved by the relinquishing carrier.	CareFirst; League of Life and Health Insurers of Maryland, Inc.

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	ACCEPT with modification that the enrollee must consent and the prior authorization must be provided within 10 days of the request. *Page 53*	G. As a modification of F above, add the requirement that the relinquishing carrier must provide the receiving carrier with a copy of the prior authorization.	Prior authorizations are not typically shared among carriers, but enrollees may not have easy access to this documentation. To the extent receiving carriers need evidence of a prior authorization, the relinquishing carrier is in a better position to provide that documentation than the enrollee.	Administration
	ACCEPT *Page 53*	H. In the section requiring a receiving carrier to accept a prior authorization at the request of an enrollee or enrollee's parent, guardian, or designee, add that the request may also be made by the enrollee's health care provider.	This amendment would allow the health care provider to trigger the requirement that a receiving carrier accept a prior authorization for treatment.	Community Behavioral Health Association of Maryland; Mental Health Association of Maryland
	The MIA already has an appeals and grievance process. In addition, because the EHB has an open drug formulary, all drugs will be covered by health benefit plans. Thus, the appeals process will not address differences in cost-sharing which can lead to the discontinuation of a drug or drug regimen.	I. Require carriers and MCOs to establish an appeals process to review, upon request, a discontinuation of a drug or drug regimen used to treat a mental health condition; require the Insurance Commissioner and DHMH to approve the appeals process; require continuation of the drug or drug regimen pending disposition of the appeal; and require carriers and MCOs to provide data to the Commissioner and DHMH on the number and outcome of appeals.	Access to a robust formulary for mental health drugs is extremely important. Medicaid has a broad formulary and an appeals process regarding access to drugs not on the Medicaid formulary. A similar process is necessary to ensure that individuals with mental health needs continue to have access to a broad array of drugs, to protect individuals from "fail first" and other discriminatory and restrictive medical management processes, and to ensure parity compliance.	Community Behavioral Health Association of Maryland; Mental Health Association of Maryland; MedChi

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	ACCEPT *Page 54*	J. In the provision requiring a receiving carrier to allow a nonparticipating provider to continue treatment at the request of the enrollee or enrollee's parent, guardian or designee, add the "enrollee's treating physician or provider."	Given the provider's role in the enrollee's treatment, and because the enrollee may not be aware of the opportunity to request continuity of care, it is appropriate to allow the enrollee's provider to participate in the decision as to whether treatment should be continued through the transition.	MedChi; Community Behavioral Health Association of Maryland; Mental Health Association of Maryland
	ACCEPT with addition that the notice shall be in a manner prescribed by the MIA. *Page 57*	K. Require a receiving carrier provide notice to a new enrollee of the continuity of care policies governing the enrollee's transition.	Since a request by the enrollee is necessary to trigger continuity of care protections, the enrollee should be made aware of the right and obligation to request transitional care.	Administration
	ACCEPT *Page 55*	L. Amend the provision regarding payment for coverage transition services to: 1) establish that the default payment to the nonparticipating provider shall be that which the carrier would normally pay a participating provider unless existing law providers otherwise or the carrier and provider agree to an alternative; 2) allow the nonparticipating provider to decline the in-network compensation absent an alternative agreement; 3) require the declining provider to give 10 days prior notice to the enrollee and carrier; and 4) require the carrier to	The bill currently does not provide sufficient incentive to carriers and providers to reach agreement, and imposes no deadlines, required notices, or other protections for enrollees. This will result in confusion for enrollees and will not effectively promote continuity of care. Instead, where existing law does not govern, there should be a default payment rate and method that will apply absent an agreement otherwise, and a provider who declines to accept it should provide timely notice.	Coalition of consumer advocates

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		facilitate the member's transition to a participating provider.		
XI. Continuity of Care (cont).	UNNECESSARY because if provider does not accept in-network rates or reach another compensation agreement with carrier/MCO, then AOB law automatically applies, *i.e*. a provider can always be an out-of-network provider.	M. Amend the provision regarding payment for coverage transition services to specify that in addition to the assignment of benefits provision governing payment of hospital-based and on-call physicians, the section of the assignment of benefits law applicable to physician's visits outside the hospital setting shall also apply in the continuity of care context. This portion of law, §14-502.3, requires the physician to provide notice that the physician will "balance bill" the patient.	Extending applicability of the entire assignment of benefits law would obviate the need for the carrier and nonparticipating provider to reach agreement on compensation in the context of a physician's treatment of the patient outside the hospital.	MedChi; Maryland Society of Anesthesiologists; First Colonies Anesthesia Associates; Maryland Society of Otolaryngology; Advanced Radiology; Medical Emergency Professionals
	ACCEPT *Page 56*	N. In the section requiring that the enrollee's obligations shall be the same as they would if receiving services from a participating provider, clarify that this provision is intended to facilitate the continuity of treatment by the nonparticipating provider without balance billing the enrollee.	While the current language intends to institute this projection, it should be clarified to do so explicitly.	Administration
	ACCEPT with modification that carrier and MCO shall facilitate transition to in-network provider. *Page 56*	O. In setting forth what happens when the carrier and provider fail to reach agreement, delete the language stating that the carrier is not required to allow the services to be provided by the nonparticipating provider.	This language is unnecessary, confusing, and potentially in conflict with other parts of the Insurance Article.	Administration

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	UNNECESSARY because it already applies.	P. Apply the entire assignment of benefits law beyond 90 days.	Patients should be able to continue seeing their nonparticipating provider by assigning their benefits for as long as the patients want to continue treatment with that provider.	MedChi; Community Behavioral Health Association of Maryland; Mental Health Association of Maryland
	ACCEPT *Page 57*	Q. Clarify that other laws which may be applicable in the continuity of care context are not limited to the conditions or time frames enumerated in the bill, and these provisions are not intended to make any other law more restrictive.	The list of conditions and specified timeframes to which the continuity of care provisions apply may create confusion for patients, providers, and carriers, particularly in conjunction with other relevant laws without these limitations, so the interplay between these provisions and other laws should be made clear.	Administration
	ACCEPT with modification that upon request, carriers, MCOs, and providers shall provide data determined necessary for effective monitoring and evaluation of continuity of care policy implementation. *Page 58*	R. Strengthen the requirement that carriers, MCOs, and providers submit data on continuity of care to the Exchange, Insurance Commissioner, and DHMH.	These entities need sufficient data in order to be able to evaluate the effectiveness of the continuity of care policies and to determine whether further legislative action is required.	Coalition of consumer advocates

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	See IX (T) below.	S. Require specifically that data be collected that would demonstrate whether there has been any disparate impact on individuals with mental health diagnoses in the implementation of continuity of care policies.	Because of particular problems individuals requiring mental health services have experienced historically with respect to harmful disruptions in care, special attention should be given this issue in evaluating the efficacy of the continuity of care provisions, and adequate data is necessary to examine it effectively.	Community Behavioral Health Association of Maryland; Mental Health Association of Maryland
	ACCEPT with modification that collection of data on the general disparate or discriminatory impact of the continuity of care policies shall be to the extent feasible and permitted by law, and that in their report on the efficacy of the continuity of care policies, the MHBE, MIA, and DHMH shall assess their impact on different populations, including individuals with mental health and substance use diagnoses, and on	T. Require specifically that data be collected with respect to any disparate impact or discrimination against the LGBT community in the implementation of continuity of care policies.	The history of discrimination against the LGBT community makes it necessary to have specific statutory language prohibiting such discrimination.	Maryland's Citizens' Health Initiative & Health Care for All

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	discrimination based on sexual orientation and gender identity. *Page 58*			
	ACCEPT *Page 57*	U. Make explicit that collection of data must be feasible and permitted by law.	State and federal laws governing privacy and discriminatory practices may preclude asking certain questions or collecting certain kinds of data.	Administration
	The timing of the legislative session precludes readiness for implementation in 2014; carriers will be filing their rates within weeks, and the MIA would not be able to complete a timely review and approval if the deadline were moved. The Exchange Board recommended that because of these logistical obstacles, the continuity of care provisions should not be made mandatory until 2015, but it encouraged all carriers to implement them voluntarily as soon as	V. Change the effective date of the continuity of care policies from January 1, 2015 to January 1, 2014.	The continuity of care protections should go into effect at the same time as do the Medicaid expansion and Exchange enrollment because the adverse effects of coverage transitions (or "churn") between Medicaid and the Exchange will be felt most acutely in the first year. The State should also begin collecting data immediately to evaluate the effectiveness of these protections, and an earlier implementation date will not impose an onerous burden on carriers, particularly since many have some continuity of care policies in place already.	Coalition of consumer advocates; Community Behavioral Health Association of Maryland; Mental Health Association of Maryland; Maryland's Citizens' Health Initiative & Health Care for All; MedChi; Maryland Association of Community Health Centers; American Academy of Pediatrics – Maryland Chapter

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	possible.			
	ACCEPT *Page 53*	W. Whichever year is the effective date of the continuity of care provisions, specify the contracts to which they apply, i.e. contracts issued or renewed on or after 1/1/2014 or 15.	The current language is imprecise and ambiguous as to which contracts are affected.	Administration
	ACCEPT *Page 53*	X. Make explicit that this section does not apply to benefits or services provided through the Maryland Medical Assistance fee-for-service program.	Medicaid and MCHP fee-for-service carve-outs are not designed or funded in such a way as to render the application of these policies feasible.	Administration
	ACCEPT *Page 55*	Y. Provide that in addition to the list of conditions for which a nonparticipating provider may continue treatment, the provisions may apply to a condition on which the provider and carrier or MCO mutually agre.	Providers and carriers/MCOs today often agree upon other conditions for which continuity of care is particularly important, and these provisions should allow for those agreements.	Johns Hopkins
XII. MHBE Standing Committee IN §31-106(g)	**ACCEPT** with modification that on or before July 1, 2014, in addition to its ad hoc, issue-specific, advisory committees, the Board shall create a standing committee which shall be charged with the responsibility of	A. Provide that one of the Exchange's two standing advisory committees shall be the "Health Access Connector Committee."	With open enrollment in October, 2013 and launch in January, 2014, the Exchange is moving from development to a fully operational phase. As such, the MHBE Board and staff could benefit from a standing committee with broad-based representation and expertise, and with a focus more comprehensive in scope than prior	Coalition of consumer advocates

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	addressing a broad range of issues on which the Board may seek its input. *Pages 22, 23*		advisory committees, in order to help maintain and continue to improve upon the quality of Exchange operations. The Committee would provide a two-way channel of communication between the Exchange and the consumers, providers, carriers, producers, and others who work with or are served by its operations. It would provide assistance particularly in assessing data and the implementation of policies which the Board has expressly stated its intent to reevaluate over the next few years.	
XIII. MHBE's Procurement Authority IN §31-106(f)	Unnecessary because, as required in §31-106(f), the MHBE has adopted and followed written policies which promote the goals and objectives of the State's procurement laws.	A. Establish further restrictions on the MHBE's procurement authority.	The Exchange should be subject to more oversight.	National Federal of Independent Business
XIV. Tobacco Rating	**ACCEPT** with the report to be submitted by December 1, 2014. *Page 59*	A. Require the MIA and Exchange to conduct a study of the impact of the tobacco use rating rule and whether the State should enact more stringent standards than the 1.5 variation permitted by the Affordable Care Act.	The Affordable Care Act sets a floor, not a ceiling, for rating rules, so states may impose more stringent requirements. The 1.5 rating for tobacco use may make premiums unaffordable for smokers for whom	Coalition of consumer advocates

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			health care is critical. Delays in diagnosing smoking-related conditions will also escalate health care costs. Changing the rule for 2014 would be too difficult because of time constraints, but the State should study the issue to determine whether the rule should be studied for subsequent years.	
	Premature because we lack data regarding uptake, actuarial basis for rating, *etc*., and making a change this session for 2014 plans would run afoul of imminent rate filing deadlines.	B. Eliminate tobacco use as a permissible rating factor in Maryland.	Charging tobacco users higher premiums has not been shown to reduce smoking and may result in reduced access to care for those who need it most. We should rely instead on evidence-based methods of improving public health. Studies have shown that the 50% rating factor permitted by the ACA will result in many tobacco users remaining uninsured, thereby losing access to smoking cessation programs and treatment for serious health conditions. The tobacco surcharge is also likely to hit hardest certain vulnerable populations, *e.g*. minorities and low-income individuals.	American Cancer Society Cancer Action Network
XV. Administration of MHBE IN §31-119	**ACCEPT** with modification that all bases for non-discrimination be	A. In the mandate that the MHBE be administered in a manner designed to prevent discrimination, make explicit reference to discrimination against	The history of discrimination against the LGBT community makes it necessary to have specific statutory language prohibiting such	Maryland's Citizens' Health Initiative & Health Care for All

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	enumerated (*e.g*. race, ethnicity, gender, religion, disability, *etc*.), and reference to LGBT community be changed to "sexual orientation and gender identity." *Page 46*	the LGBT community.	discrimination.	
	ACCEPT with modification that reference to LGBT community be changed to "sexual orientation and gender identity," and that data collection be to the extent feasible and permitted by law. *Pages 46, 47*	B. In the directive that the MHBE's annual report include data to identify disparities related to gender, race, ethnicity, geographic location, language, disability, or other attributes of special populations, add "membership in the LGBT community."	The history of discrimination against the LGBT community makes it necessary to have specific statutory language prohibiting such discrimination.	Maryland's Citizens' Health Initiative & Health Care for All
XVI. Interim Policies	**ACCEPT** with modification as follows: 1) any interim policies shall be in response only to federal policy requiring action within a time frame which precludes adoption of regulations; 2) all interim policies shall be	A. Broaden the scope of the Exchange's authority to adopt interim policies, as directed in the MHBE Act of 2012, in order to ensure that it may comply with all federal deadlines and be prepared to begin open enrollment in October, 2013 and full scale operations in January, 2014. Such authority is necessary also because some federal guidance is still forthcoming and may be different	The timeline of the full-scale regulatory process is such that the Exchange may need an expedited process with respect to the implementation of certain policies and operations, particularly related to more recent federal guidance, *e.g*., application counselors.	Administration

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	submitted as proposed regulations within 6 months of adoption; and 3) interim policies shall sunset within one year of AELR submission as proposed regulations. *Pages 59, 60*	from current expectations.		
XVII. HealthStat Process	**PENDING**	A. Establish a stakeholder advisory process to identify consensus quality measurement standards to be used as the basis for a HealthStat process, and then implement this process to measure the Exchange's effectiveness with respect to health outcomes, quality of care, *etc*.	Maryland could again be a national leader in evaluating and enhancing the effectiveness of its Exchange with respect to a range of objectives related to costs and the health of all Marylanders.	Senator Rob Garagiola
XVIII. Captive Producers *(These are proposed amendments to the Administration's captive producer amendment proposal and not amendments to the bill itself.)*	**ACCEPT** *Page 33, 34*	A. In the disclosures a captive producer must make to an individual, add the requirement that the captive producer: 1) disclose that there may be a producer of record in connection with the policy, and; 2) if so, provide any information to the individual available in the carrier's records about that producer of record.	Carriers do not always have accurate records regarding producers of record, so before providing information and assistance to the individual, the captive producer should make the individual aware of the possibility that there may be a producer of record and to provide any information available about that producer.	Maryland Association of Health Underwriters (MAHU); National Association of Insurance and Financial Advisors of Maryland (NAIFA-MD)

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	ACCEPT *Page 35*	B. Apply to the captive producer the same restrictions applicable to navigators under §31-113(f)(8) regarding providing information about products not sold by the captive producer's carrier, and referring individuals to resources maintained by the Exchange (including navigators), or other carriers and insurance producers.	These restrictions are consistent with the balance achieved under the navigator program and should be replicated in this context.	MAHU; NAIFA-MD
	Unnecessary since producers of record may request corrections without statutory permission, and consumers may also want to make appropriate corrections.	C. Allow a producer to request a carrier to correct any inaccuracies in the carrier's records regarding producers of record.	However unintentionally, carriers do not always keep accurate records and may inadvertently change an account to inaccurately remove a producer of record, so producers should be given the opportunity to correct these errors.	MAHU; NAIFA-MD
	ACCEPT *Page 35*	D. Rather than requiring an attestation that required disclosures have been made by the captive producer, require instead that the captive producer note and retain in documentation that the individual has received all disclosures, did not want to be referred, *etc*.	The attestation requirement is unrealistic; most of the assistance will be provided by telephone, and attestations typically require a witness and a signature. The suggested documentation approach is more practical and would be sufficient.	CareFirst
	ACCEPT *Page 33, 34*	E. Rather than prohibiting the captive producer from providing assistance to any member with a producer of record, import language from the	Both the carrier and the producer have a relationship with the member, so the carrier should be able to assist the member under	CareFirst

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		navigator section to require that when a member acknowledges having a producer of record, the captive producer shall refer the individual back to the producer unless the producer is not authorized to sell in the Exchange or the individual does not want to seek assistance from the producer.	these enumerated circumstances.	
	ACCEPT *Page 32, 33*	F. Add to the purposes of the producer authorization training program the objectives that it impart the skills necessary to facilitate, where appropriate, referral of individuals and families to Medicaid or MCHP, or to the appropriate connector entity, independent producer, or the CSC.	Facilitating appropriate referrals is a critical component of ensuring that consumers are protected and made aware of the full panoply of rights and options under the Medicaid expansion and Exchange offerings.	Coalition of consumer advocates
	ACCEPT *Page 33*	G. Ensure that a captive producer's appointment with a carrier is current.	Necessary to assure accountability.	Coalition of consumer advocates
	MODIFY to provide generally that a carrier and a captive producer shall act in the best interests of the individual to whom they are providing assistance. *Page 34*	H. Require that any qualified plan a captive producer sells to a member must best meet the individual's needs.	Because the captive producer is selling only those plans offered by its carrier, there must be assurance that among those plans is one that best suits the needs of the consumer.	Coalition of consumer advocates

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	MODIFY by imposing a December 31, 2015 sunset on the ability of captive producers to sell to individual who initiate contact with the carrier but are not current members. *Page 33*	I. Limit the ability of the captive producer to sell plans to existing enrollees only, and do not allow them to sell to individuals who initiate contact with the carrier but are not current members.	Allowing carriers to capture individuals not currently enrolled in their plans would give them an unfair advantage over producers and new carrier entrants into the market, particularly coops with stringent marketing restrictions. Allowing carriers to enroll individuals not currently in one of their plans would also undermine the ability of consumers to be assured of receiving objective information about all health insurance options offered in the Exchange. Finally, giving carriers this advantage is unnecessary, since individuals can easily be referred to a navigator, producer, or the CSC.	Coalition of consumer advocates; Evergreen Health Cooperative, Inc.
	MODIFY by requiring the captive producer, upon request, to provide written or electronic information about the Exchange, the Connector Program, and the CSC. *Page 34, 35*	J. In the disclosures a captive producer must provide to the individual, include 1) information that the Exchange may offer qualified plans that not only meet the consumer's needs, but may also meet those needs more effectively than plans offered by the captive producer's carrier; and 2) information about the Exchange, the Connector Program, the CSC, and a list of all carriers selling in the Exchange.	Utmost care must be taken to ensure that the consumer is made fully aware of all available options and potential downsides of receiving assistance from the individual's existing carrier and information only about plans offered by that carrier.	Coalition of consumer advocates

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	ACCEPT except for the requirement regarding attestation. *Page 34, 35*	K. Ensure that when an individual wants to be referred for help elsewhere, the referral be made to the appropriate Connector entity rather than to an individual navigator, in addition to the referral to a producer or the CSC, and that the attestation requirement reflect this change.	This requirement will better ensure that the individual receive the assistance appropriate to the consumer's circumstances.	Coalition of consumer advocates
	MODIFY by requiring carriers to submit a list of current captive producers. *Page 34*	L. Require carriers to submit monthly to the Exchange all attestation documentation and a list of current captive producers.	Necessary to ensure compliance and accountability.	Coalition of consumer advocates
	ACCEPT *Page 35*	M. Make non-compliance with the disclosure and attestation requirements grounds for the Exchange to suspend, revoke, or refuse to renew a captive producer's authorization.	Such a penalty is necessary to enforce compliance.	Coalition of consumer advocates
	MODIFY to sunset the authority of captive producers to sell Exchange qualified plans to individuals who initiate contact with the captive producer or the captive producer's carrier. *Page 33*	N. Sunset the captive producer program on December 31, 2015.	Two years will be sufficient time to transition all existing carrier members into the Exchange who want to be there, and after two years, all existing and new carriers should operate on a level playing field.	Coalition of consumer advocates

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	Allowing the sale, solicitation and negotiation of insurance policies without a license would compromise the MIA's ability to regulate this activity and ensure appropriate consumer protections.	O. Allow a carrier's member services call center staff to enroll a carrier's current members as assisters rather than producers, and eliminate the requirement that personnel performing this function must have a producer's license. Call center staff do not have producer's licenses, but they are highly trained to answer complex questions regarding every aspect of their members' policies, and they also have access to input from licensed direct sales staff when needed.	Enrolling a carrier's current members into Exchange plans is not a sale's transaction per se, but rather a transfer from one of the carrier's plans to a comparable plan in the MHBE. Call center staff are trained to do exactly this type of function, they receive training annually, and they are subject to criminal background checks and drug screening, among other requirements.	Kaiser Permanente
	ACCEPT *Page 19*	P. Define "captive insurance producer."	It is a new term in Title 31.	Administration
	ACCEPT *Page 34*	Q. Prohibit a carrier and its captive producers to use marketing practices or provide assistance to its current enrollees in a manner which would have the effect of enrolling a disproportionate number of its enrollees with significant health needs in Exchange qualified plans.	The captive producer program should not put the Exchange at risk of becoming a high risk pool.	Administration
XIX. Application Counselors *(These are proposed amendments to the Administration's application*	**ACCEPT** with modification that the Exchange make consider its needs and resources generally. *Page 35*	A. Give the Exchange discretion to make its authorization of application counselor entities dependent upon the needs of its Individual Exchange Connector Program.	The Exchange will have the full picture of how enrollment needs are being met throughout the State and should be able to make judgments accordingly regarding the need for application counselors to supplement the connector program.	Coalition of consumer advocates

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counselor amendment proposal and not amendments to the bill itself.)				
	ACCEPT and clarify that, pursuant to the federal application counselor regulation, the Exchange may "designate" sponsoring entities. *Page 35, 36*	B. Distinguish between connector entities and application counselor (or "sponsoring") entities.	Maintaining a distinction through different names will reduce confusion.	Coalition of consumer advocates
	ACCEPT *Page 36*	C. Make more explicit the prohibition that an application counselor or entity may not be compensated by a carrier, producer, 3rd party administrator, or MCO for its enrollment services.	Although the navigator program, to which the application program is subject, does not allow compensation from these entities for enrollment services, a more express prohibition would protect further against this conflict of interest.	Coalition of consumer advocates
	This requirement is important because an application counselor or entity may have a relationship with one of these entities, even though they may not be compensated by such entities for their	D. Eliminate the requirement that an application counselor or entity disclose its relationship with a carrier, producer, TPA, or MCO.	Unnecessary because the application counselor or entity is not permitted to be compensated by any of these entities.	Coalition of consumer advocates

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	enrollment services.			
	With some minor clarifications, language is sufficiently comprehensive in scope, sponsoring entities may need different *etc*., requirements depending upon the type of entity, its relationship to application counselor, and Exchange should coordinate requirements with Medicaid/MCHP application counselor sponsoring entities. *Page 36*	E. Amplify to make more comprehensive the language making application counselors subject to all laws and regulations applicable to connectors/navigators/entities, and explicitly include application counselor entities.	This amplification will ensure that the consumer is protected to the same extent and in the same manner as under the protections offered by the Connector program.	Coalition of consumer advocates
	ACCEPT *Page 19*	F. Amend the section governing fraudulent insurance acts to include application counselors in the category of personnel who may not hold themselves out as application counselors without required certification from the Exchange.	Consumers need the same protections from application counselors in this regard as are required from navigators and producers.	Administration
	ACCEPT *Page 19*	G. Define "application counselor" and "application counselor sponsoring entity."		Administration

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XX. Health Information Exchange	**ACCEPT** *Page 9*	A. Give the Secretary of DHMH authority to make grants to the State-designated Health Information Exchange.	Discretionary authority will enable the State to make federal matching funds available to support development and operation of the HIE.	Administration
XXI. Pediatric Dental Benefits	ACCEPT *Page 60*	A. Require the Exchange and the MIA to conduct a study of the impact of recent federal regulations permitting medical plans to carve out pediatric dental benefits if a stand-alone option is available, and not to require that everyone purchase pediatric dental benefits despite their inclusion in EHB under the ACA.	Many are concerned that the effect of these regulations will be to degrade the affordability and accessibility of pediatric dental coverage, which will in turn affect children's access to dental care.	Administration
XXII. Association and Student Health Plans	**PENDING**			

❖ Coalition of consumer advocates: Members

Advocates for Children and Youth
Asian American Center of Frederick
Baltimore Healthy Start
Healthcare Access Maryland
Community Health Integrated Partnership
Drug Policy and Public Health Strategies Clinic, University of Maryland Francis King Carey School of Law
Maryland Addiction Directors Council
Maryland Assembly for School Based Health Care
Maryland Community Health System

Maryland Dental Action Coalition
Maryland Occupational Therapy Association
Maryland Women's Coalition for Health Care Reform
Medicaid Matters! Maryland
Mental Health Association of Maryland
Montgomery County Department of Health and Human Services
National Association of Social Workers
National Council on Alcoholism and Drug Dependence – Maryland Chapter
Progressive Cheverly Health Committee
Public Justice Center
Sisters Together and Reaching