Joshua M. Sharfstein, M.D., Chairman
Rebecca Pearce, Executive Director

Maryland Health Benefit Exchange

August 17, 2012

The Honorable Thomas M. Middleton
Chair, Finance Committee
Miller Senate Office Building, East Wing
11 Bladen Street
Annapolis, MD 21401

RE: Maryland Health Benefit Exchange Draft Interim Procedures

Dear Chairman Middleton:

Pursuant to Section 10 of the Maryland Health Benefit Exchange Act of 2012, the Maryland Health Benefit Exchange (the Exchange) submits the attached Draft Interim Procedures for its insurance plan management and certification. As directed, the Exchange is submitting these comments to three legislative committees: the Joint Committee on Administrative, Executive & Legislative Review, the Senate Finance Committee, and the House Health and Government Operations Committee. The Exchange appreciates the Committees' review and looks forward to your comments.

Attached, you will find:

1) Draft Interim Procedures for insurance plan management and certification. These procedures cover the essential steps needed for insurers to offer health plans in the Exchange.

To provide you with context on these draft procedures, we are also attaching:

2) Proposed policies for plan management and certification, as posted publicly by the Exchange in July 2012.
3) Public comments on the proposed policies, received during a 3-week public comment period in July 2012.
4) Comments on the proposed policies by the Exchange's Plan Management Advisory Committee, a broadly representative group of stakeholders. The Advisory Committee met six times in June and July 2012 to develop these comments.

The Exchange intends to revise the draft procedures, based on the comments from the public and the legislative Committees. The Exchange will then adopt the procedures by September 30, 2012. This timeline is needed to provide enough time for insurers to develop qualified health plans for review and approval by the Exchange and the Maryland Insurance Administration in time for open enrollment in the fall of 2013.

The Interim Procedures will guide the initial year of qualified health plan development and oversight. In 2013, the Exchange will promulgate regulations covering these topic areas to cover the second and subsequent years.

We respectfully ask for comments by September 17, 2012.

Our staff is arranging for briefings of Committee staff on the Draft Interim Procedures. I would be happy to provide any additional information you may require. If you have questions regarding this information, please contact me at (410) 764-5986 or via email at rebecca.pearce@maryland.gov.

Sincerely,

Rebecca Pearce
Executive Director
Maryland Health Benefit Exchange

Joshua M. Sharfstein, M.D., Chairman
Rebecca Pearce, Executive Director

August 17, 2012

The Honorable Anne Healey
House Chair, Joint Committee on Administrative,
Executive & Legislative Review
House Office Building, Room 350
6 Bladen Street
Annapolis, MD 21401

RE: Maryland Health Benefit Exchange Draft Interim Procedures

Dear Chairwoman Healey:

Pursuant to Section 10 of the Maryland Health Benefit Exchange Act of 2012, the Maryland Health Benefit Exchange (the Exchange) submits the attached Draft Interim Procedures for its insurance plan management and certification. As directed, the Exchange is submitting these comments to three legislative committees: the Joint Committee on Administrative, Executive & Legislative Review, the Senate Finance Committee, and the House Health and Government Operations Committee. The Exchange appreciates the Committees' review and looks forward to your comments.

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Sincerely,

Rebecca Pearce
Executive Director
Maryland Health Benefit Exchange

Joshua M. Sharfstein, M.D., Chairman
Rebecca Pearce, Executive Director

Maryland
Health
Benefit
Exchange

August 17, 2012

The Honorable Peter A. Hammen
Chair, Health and Government Operations
House Office Building
Room 241
6 Bladen Street
Annapolis, MD 21401

RE: Maryland Health Benefit Exchange Draft Interim Procedures

Dear Chairman Hammen:

Pursuant to Section 10 of the Maryland Health Benefit Exchange Act of 2012, the Maryland Health Benefit Exchange (the Exchange) submits the attached Draft Interim Procedures for its insurance plan management and certification. As directed, the Exchange is submitting these comments to three legislative committees: the Joint Committee on Administrative, Executive & Legislative Review, the Senate Finance Committee, and the House Health and Government Operations Committee. The Exchange appreciates the Committees' review and looks forward to your comments.

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We respectfully ask for comments by September 17, 2012.

4201 Patterson Avenue, Room 400, Baltimore, Maryland 21215
410-358-5615

Our staff is arranging for briefings of Committee staff on the Draft Interim Procedures. I would be happy to provide any additional information you may require. If you have questions regarding this information, please contact me at (410) 764-5986 or via email at rebecca.pearce@maryland.gov.

Sincerely,

Rebecca Pearce
Executive Director
Maryland Health Benefit Exchange

Joshua M. Sharfstein, M.D., Chairman
Rebecca Pearce, Executive Director

August 17, 2012

The Honorable Paul G. Pinsky
Senate Chair, Joint Committee on Administrative,
Executive & Legislative Review
James Senate Office Building, Room 220
11 Bladen Street
Annapolis, MD 21401

RE: Maryland Health Benefit Exchange Draft Interim Procedures

Dear Chairman Pinsky:

Pursuant to Section 10 of the Maryland Health Benefit Exchange Act of 2012, the Maryland Health Benefit Exchange (the Exchange) submits the attached Draft Interim Procedures for its insurance plan management and certification. As directed, the Exchange is submitting these comments to three legislative committees: the Joint Committee on Administrative, Executive & Legislative Review, the Senate Finance Committee, and the House Health and Government Operations Committee. The Exchange appreciates the Committees' review and looks forward to your comments.

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Sincerely,

Rebecca Pearce
Executive Director
Maryland Health Benefit Exchange

The Honorable Thomas M. Middleton
The Honorable Paul G. Pinsky
The Honorable Peter A. Hammen
The Honorable Anne Healy

Maryland Health Benefit Exchange Carrier and Plan Certification

Draft Interim Procedures

Authority: Insurance Article §§ 31-106(c)(1)(iv);31-108(b)(4); 31-115(b)(5)(vi); 31-115(b)(6)(ii)

.01 Scope and Definitions

A. These interim procedures apply to any carrier, licensed and in good standing with the State under the Insurance Article, Title 4, Subtitle 1 (for insurers) and Title 14, Subtitle 1 (for non-profit health service plans); and the Health General Article, Title 19, Subtitle 7 (for HMOs), that applies to receive certification by the Exchange and is required to receive certification by the Exchange under 45 C.F.R. §156.200(a) to sell qualified plans within the SHOP and Individual Exchanges.
B. Except where specifically noted, all provisions of these procedures apply to health, dental, and visions plan carriers.
C. Definitions
   (1) For purposes of this interim procedure, the following definitions apply:[i]
      (a) Carrier
      (b) Carrier Certification
      (c) Health Benefit Plan
      (d) Qualified Plans
      (e) Medically Underserved Populations
      (f) Essential Community Providers
      (g) Medically Underserved Areas
      (h) Exchange Carrier Fair Marketing Standards Policy
      (i) RELICC Data
      (j) eValue8
      (k) Exchange Accreditation
      (l) Commercial Market Service Area

.02 Exchange Plan Management Manual

The Exchange shall issue a Plan Management Manual that will include forms and additional guidance regarding all aspects of carrier and plan certification. The Plan Management Manual will be available on the Exchange website.

.03 Application Procedures

A. In order to obtain certification to participate in and sell qualified plans through the SHOP and Individual Exchanges as a certified carrier, a carrier must submit an application on the form provided by the Exchange.[ii]

B. A carrier applying for carrier certification must submit documentation satisfactory to the Exchange on the following in its application:
   (1) That the carrier is licensed and in good standing to sell health insurance plans in the State, as prescribed under the Insurance Article, Title 4, Subtitle 1 (for insurers) and Title 14, Subtitle 1 (for non-profit health service plans); and the Health General Article, Title 19, Subtitle 7 (for HMOs).
   (2) That the carrier has been deemed financially solvent by the Maryland Insurance Administration, as prescribed under the Insurance Article, Title 4, Subtitles 1 and 3; and Title 5.

C. A carrier certification applicant must attest to the following in its application for certification:
   (1) That each health benefit plan the carrier intends to offer for sale through the SHOP or Individual Exchanges will meet all requirements under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (Affordable Care Act), when the carrier applies for certification of the health benefit plan as qualified plan and at all times thereafter when the health benefit plan is sold as a qualified plan through the SHOP or Individual Exchanges.
   (2) That the carrier has reviewed the Exchange Carrier Fair Marketing Standards Policy and the carrier agrees to remain in compliance with the Policy at all times while the carrier holds the carrier certification.
   (3) That the carrier will comply with Insurance Article §31-115(g).
   (4) That the carrier will provide to the Exchange[iii] any rate change for review and approval 60 days before the carrier intends on releasing the rate change to consumers.
   (5) That the carrier, for any rate change that is a rate increase, will provide to the Exchange a justification for the rate increase 60 days before the carrier intends on releasing the rate increase to consumers.
   (6) That the network requirements for each plan the carrier sells as a qualified health plan through the SHOP or Individual Exchanges will meet the network adequacy standards as specified under 45 CFR §156.230.
   (7) That the carrier, unless exempt under 45 CFR §156.235, has contracted with essential community providers serving medically underserved areas as necessary to meet certification standards for each plan the carrier sells through the SHOP and Individual Exchanges.
   (8) That the carrier holds current and valid accreditation, as follows, fr years 2014 and 2015:
      (a) That the carrier, unless the carrier offers only dental or vision benefits, is accredited by National Committee for Quality Assurance (NCQA) or URAC as an accredited commercial or Medicaid carrier.
      (b) That the carrier, if offering only dental or vision benefits, holds a current and valid Maryland Insurance Administration Certificate of Authority.

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(9) That the carrier has contracted with essential community providers as necessary to meet certification standards for each plan the carrier sells through the SHOP and Individual Exchanges.

(10) Service Areas

(a) That any service area developed for a plan that the carrier sells through the SHOP or Individual Exchanges complies with:

(i) any processes established by the Exchange to further establish or evaluate the service area for each plan the carrier sells through the SHOP or Individual Exchanges.

(ii) service area requirements under 45 CFR §155.1055.

(b) A carrier may use a commercial market service area that meets the above requirements.

(11) Transparency Data

(a) That the carrier will provide the transparency data for 2014 plan certification, including:

(i) Claims payment policies and practices;

(ii) Financial disclosures;

(iii) Information on enrollee rights; and

(iv) Information on cost-sharing with respect to a specific benefit or service, when requested by an individual.

(b) That the carrier will provide transparency data, as a condition of maintaining plan certification and being eligible for recertification, including:

(i) Data on enrollment and disenrollment;

(ii) Data on number of claims that are denied;

(iii) Data on rating practices; and

(iv) Information on cost-sharing and payments with respect to out-of-network coverage.

(12) Quality and RELICC Data

(a) That the carrier will utilize the “eValue8” provided the Maryland Health Care Commission tool to track RELICC data as required by the Exchange.

(b) That the carrier will provide quality and RELICC data, as specified by the Exchange, to the Maryland Health Care Commission.

(13) That for each metal level for which the carrier offers a plan for sale through the SHOP and Individual Exchanges, one such plan meets the baseline benefit design as established by the Exchange.

(14) That the carrier shall offer no more than three benefit designs per metal level.

D. Notice of approval or denial of carrier certification application

(1) An application will not be deemed complete until a carrier attests to all above requirements.

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(2) The Exchange, within 45 days of receipt of a completed application, shall notify a carrier of the decision to approve or deny the application.
(3) If the application is denied, the Exchange shall provide the reasons for the denial and reapplication or appeal rights.

.04 Conditions for Participation

A. A carrier certified by the Exchange to sell plans through the SHOP and Individual Exchanges shall comply with all Affordable Care Act and Maryland Health Benefit Exchange Act requirements, including pertinent regulations and guidance, and all other applicable federal and State laws at all times while holding carrier certification by the Exchange.
B. In addition to complying with sections (C) through (F) below, a carrier certified by the Exchange to sell plans through the SHOP and Individual Exchanges shall maintain compliance with each attestation made as part of its application for certification.
C. Carrier Fair Marketing Standards
(1) The Exchange shall establish and issue a Carrier Fair Marketing Standards Policy.
(2) The Carrier Fair Marketing Standards Policy shall include:
(a) a list of marketing materials subject to review by the Exchange; and
(b) the procedure for submission of marketing materials that the carrier shall submit to the Exchange for review and approval 30 days prior to the intended date of usage.
(3) For marketing materials subject to review by the Exchange carrier shall only use the marketing materials upon approval from the Exchange
(a) For 2014 only, a non-accredited carrier may request a grace period of one year to acquire accreditation.
D. Service Area
For 2014, a carrier holding carrier certification by the Exchange shall provide:
(1) documentation of the service area of each plan the carrier sells through the SHOP and Individual Exchanges; and
(2) data on demographics and health status of areas served by the each plan the carrier sells within the SHOP and Individual Exchanges
E. Transparency Data
(1) For 2014 plan certification, the carrier shall provide the following transparency data:[iv]
(a) Claims payment policies and practices
(b) Financial disclosures
(c) Information on enrollee rights
(d) Information on cost-sharing with respect to a specific benefit or service, when requested by an individual
(2) That the carrier will provide transparency data, as a condition of maintaining plan certification and being eligible for recertification, including:

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(b) Data on number of claims that are denied
(c) Data on rating practices
(d) Information on cost-sharing and payments with respect to out-of-network coverage

F. Quality and RELICC Data
Carriers shall provide quality and RELICC data, as specified by the Exchange at least on an annual basis.

.05 Exchange Annual Review Procedures

A. The Exchange shall review the performance of certified carriers on an annual basis.
B. The annual review shall include review of the following performance areas:
   (i) Enrollment data;
   (ii) Network adequacy;
   (iii) Quality information; and
   (iv) Complaints and Grievances
C. The Exchange may develop criteria for imposing sanctions on carriers for noncompliance with the attestations made during the application process.
D. Failure to cure noncompliance may result in corrective action.[v]

.06 Plan Certification Procedures

A. To obtain certification for a health benefit plan as a qualified plan to be sold through the SHOP and Individual Exchanges, a carrier shall submit an application for health benefit plan certification on the form provided by the Exchange.
B. In support of the application for health plan certification, the carrier shall submit documentation satisfactory to the Exchange:
   (i) of its compliance with Insurance Article §31-115(b);
   (ii) on the plan network;
   (iii) on any contracts that the carrier has entered into with Essential Community Providers as necessary to meet certification standards for the plan; and
   (iv) the transparency data the carrier has attested to providing under the certification application
C. Exchange Determination Upon Receipt of a Complete Qualified Plan Certification Application
   (i) The Exchange, upon receipt of a completed application, shall determine, for each application, whether certification is in the best interests of qualified individuals and qualified employers, pursuant to standards to be adopted by the Exchange and issued through Exchange policy or guidance.

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(ii) The Exchange shall determine whether the carrier has satisfied such other requirements as may be issued from time to time through policy or guidance.
(iii) The Exchange shall notify the carrier of the decision to approve or deny the application, and if the application is denied, the Exchange shall provide the reasons for the denial and appeal rights.

.07 Plan Recertification

A. A plan certification expires two years after the date it is issued unless the plan is recertified.
B. At least 90 days before a plan certification expires, the carrier shall apply for recertification of the plan in accordance with the Plan Management Manual.
C. The Exchange shall review all original and existing certification data when determining whether the plan continues to meet the certification requirements.
D. A plan that is not in full compliance with recertification requirements may be subject to a corrective action plan, the purpose of which is to enable the plan to reach full compliance within 60 days of receipt of the corrective action plan.
E. The Exchange shall determine, for each application, whether recertification is in the best interests of qualified individuals and qualified employers, pursuant to standards to be adopted by the Exchange and issued through Exchange policy or guidance.
F. The Exchange shall notify the carrier of the decision to approve, deny, or require corrective action.
G. If the application is denied, the denial notice shall include the reasons for the denial and appeal rights.

.08 Plan Decertification

The Exchange may decertify any plan that:

A. fails to meet the requirements for recertification.
B. Fails to comply with a corrective action plan.

.09 Plan Certification and Decertification Appeals

A. The Exchange will develop procedures for appeals of Exchange determinations regarding certifications and decertifications of plans.

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[i] These will be defined as the Exchange moves towards final interim procedures.
[ii] The application will take the shape of an agreement with uniform language for participation terms, conditions and requirements that will be applicable to all carriers.

[iii] The HSS Final Rule requires that rates be submitted to the Exchange. The Maryland Insurance Administration will analyze all rate changes and increases and a Memorandum of Understanding between the Exchange and the Maryland Insurance Administration will reflect Maryland Insurance Administration's ownership of this function. Still, for purposes of these Draft Interim Procedures and subsequent regulations, the rates are noted as being submitted to the Exchange, so as to stay consistent with federal law.

[iv] The Exchange is awaiting further federal guidance on data submission requirements.

[v] If decertification of carriers is a potential corrective action, the Exchange will consider the need for legislative authority.

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The Honorable Thomas M. Middleton
The Honorable Paul G. Pinsky
The Honorable Peter A. Hammen
The Honorable Anne Healy

Maryland Health Benefit Exchange Carrier and Plan Certification

Draft Interim Procedures

Authority: Insurance Article §§ 31-106(c)(1)(iv);31-108(b)(4); 31-115(b)(5)(vi); 31-115(b)(6)(ii)

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(b) A carrier may use a commercial market service area that meets the above requirements.

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(a) That the carrier will provide the transparency data for 2014 plan certification, including:

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(iv) Information on cost-sharing with respect to a specific benefit or service, when requested by an individual.

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(14) That the carrier shall offer no more than three benefit designs per metal level.

D. Notice of approval or denial of carrier certification application

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(2) The Exchange, within 45 days of receipt of a completed application, shall notify a carrier of the decision to approve or deny the application.
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F. Quality and RELICC Data
Carriers shall provide quality and RELICC data, as specified by the Exchange at least on an annual basis.

.05 Exchange Annual Review Procedures

A. The Exchange shall review the performance of certified carriers on an annual basis.
B. The annual review shall include review of the following performance areas:
   (i) Enrollment data;
   (ii) Network adequacy;
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C. The Exchange may develop criteria for imposing sanctions on carriers for noncompliance with the attestations made during the application process.
D. Failure to cure noncompliance may result in corrective action.[v]

.06 Plan Certification Procedures

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B. In support of the application for health plan certification, the carrier shall submit documentation satisfactory to the Exchange:
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   (ii) on the plan network;
   (iii) on any contracts that the carrier has entered into with Essential Community Providers as necessary to meet certification standards for the plan; and
   (iv) the transparency data the carrier has attested to providing under the certification application

C. Exchange Determination Upon Receipt of a Complete Qualified Plan Certification Application
   (i) The Exchange, upon receipt of a completed application, shall determine, for each application, whether certification is in the best interests of qualified individuals and qualified employers, pursuant to standards to be adopted by the Exchange and issued through Exchange policy or guidance.

(ii) The Exchange shall determine whether the carrier has satisfied such other requirements as may be issued from time to time through policy or guidance.
(iii) The Exchange shall notify the carrier of the decision to approve or deny the application, and if the application is denied, the Exchange shall provide the reasons for the denial and appeal rights.

.07 Plan Recertification

A. A plan certification expires two years after the date it is issued unless the plan is recertified.
B. At least 90 days before a plan certification expires, the carrier shall apply for recertification of the plan in accordance with the Plan Management Manual.
C. The Exchange shall review all original and existing certification data when determining whether the plan continues to meet the certification requirements.
D. A plan that is not in full compliance with recertification requirements may be subject to a corrective action plan, the purpose of which is to enable the plan to reach full compliance within 60 days of receipt of the corrective action plan.
E. The Exchange shall determine, for each application, whether recertification is in the best interests of qualified individuals and qualified employers, pursuant to standards to be adopted by the Exchange and issued through Exchange policy or guidance.
F. The Exchange shall notify the carrier of the decision to approve, deny, or require corrective action.
G. If the application is denied, the denial notice shall include the reasons for the denial and appeal rights.

.08 Plan Decertification

The Exchange may decertify any plan that:

A. fails to meet the requirements for recertification.
B. Fails to comply with a corrective action plan.

.09 Plan Certification and Decertification Appeals

A. The Exchange will develop procedures for appeals of Exchange determinations regarding certifications and decertifications of plans.

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[i] These will be defined as the Exchange moves towards final interim procedures.
[ii] The application will take the shape of an agreement with uniform language for participation terms, conditions and requirements that will be applicable to all carriers.

[iii] The HSS Final Rule requires that rates be submitted to the Exchange. The Maryland Insurance Administration will analyze all rate changes and increases and a Memorandum of Understanding between the Exchange and the Maryland Insurance Administration will reflect Maryland Insurance Administration's ownership of this function. Still, for purposes of these Draft Interim Procedures and subsequent regulations, the rates are noted as being submitted to the Exchange, so as to stay consistent with federal law.

[iv] The Exchange is awaiting further federal guidance on data submission requirements.

[v] If decertification of carriers is a potential corrective action, the Exchange will consider the need for legislative authority.

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The Honorable Thomas M. Middleton
The Honorable Paul G. Pinsky
The Honorable Peter A. Hammen
The Honorable Anne Healy

Maryland Health Benefit Exchange Carrier and Plan Certification

Draft Interim Procedures

Authority: Insurance Article §§ 31-106(c)(1)(iv);31-108(b)(4); 31-115(b)(5)(vi); 31-115(b)(6)(ii)

.01 Scope and Definitions

A. These interim procedures apply to any carrier, licensed and in good standing with the State under the Insurance Article, Title 4, Subtitle 1 (for insurers) and Title 14, Subtitle 1 (for non-profit health service plans); and the Health General Article, Title 19, Subtitle 7 (for HMOs), that applies to receive certification by the Exchange and is required to receive certification by the Exchange under 45 C.F.R. §156.200(a) to sell qualified plans within the SHOP and Individual Exchanges.

B. Except where specifically noted, all provisions of these procedures apply to health, dental, and visions plan carriers.

C. Definitions
   (1) For purposes of this interim procedure, the following definitions apply:[i]
      (a) Carrier
      (b) Carrier Certification
      (c) Health Benefit Plan
      (d) Qualified Plans
      (e) Medically Underserved Populations
      (f) Essential Community Providers
      (g) Medically Underserved Areas
      (h) Exchange Carrier Fair Marketing Standards Policy
      (i) RELICC Data
      (j) eValue8
      (k) Exchange Accreditation
      (l) Commercial Market Service Area

.02 Exchange Plan Management Manual

The Exchange shall issue a Plan Management Manual that will include forms and additional guidance regarding all aspects of carrier and plan certification. The Plan Management Manual will be available on the Exchange website.

.03 Application Procedures

A. In order to obtain certification to participate in and sell qualified plans through the SHOP and Individual Exchanges as a certified carrier, a carrier must submit an application on the form provided by the Exchange.[ii]

B. A carrier applying for carrier certification must submit documentation satisfactory to the Exchange on the following in its application:
   (1) That the carrier is licensed and in good standing to sell health insurance plans in the State, as prescribed under the Insurance Article, Title 4, Subtitle 1 (for insurers) and Title 14, Subtitle 1 (for non-profit health service plans); and the Health General Article, Title 19, Subtitle 7 (for HMOs).
   (2) That the carrier has been deemed financially solvent by the Maryland Insurance Administration, as prescribed under the Insurance Article, Title 4, Subtitles 1 and 3; and Title 5.

C. A carrier certification applicant must attest to the following in its application for certification:
   (1) That each health benefit plan the carrier intends to offer for sale through the SHOP or Individual Exchanges will meet all requirements under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (Affordable Care Act), when the carrier applies for certification of the health benefit plan as qualified plan and at all times thereafter when the health benefit plan is sold as a qualified plan through the SHOP or Individual Exchanges.
   (2) That the carrier has reviewed the Exchange Carrier Fair Marketing Standards Policy and the carrier agrees to remain in compliance with the Policy at all times while the carrier holds the carrier certification.
   (3) That the carrier will comply with Insurance Article §31-115(g).
   (4) That the carrier will provide to the Exchange[iii] any rate change for review and approval 60 days before the carrier intends on releasing the rate change to consumers.
   (5) That the carrier, for any rate change that is a rate increase, will provide to the Exchange a justification for the rate increase 60 days before the carrier intends on releasing the rate increase to consumers.
   (6) That the network requirements for each plan the carrier sells as a qualified health plan through the SHOP or Individual Exchanges will meet the network adequacy standards as specified under 45 CFR §156.230.
   (7) That the carrier, unless exempt under 45 CFR §156.235, has contracted with essential community providers serving medically underserved areas as necessary to meet certification standards for each plan the carrier sells through the SHOP and Individual Exchanges.
   (8) That the carrier holds current and valid accreditation, as follows, fr years 2014 and 2015:
      (a) That the carrier, unless the carrier offers only dental or vision benefits, is accredited by National Committee for Quality Assurance (NCQA) or URAC as an accredited commercial or Medicaid carrier.
      (b) That the carrier, if offering only dental or vision benefits, holds a current and valid Maryland Insurance Administration Certificate of Authority.

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(9) That the carrier has contracted with essential community providers as necessary to meet certification standards for each plan the carrier sells through the SHOP and Individual Exchanges.

(10) Service Areas

(a) That any service area developed for a plan that the carrier sells through the SHOP or Individual Exchanges complies with:

- (i) any processes established by the Exchange to further establish or evaluate the service area for each plan the carrier sells through the SHOP or Individual Exchanges.
- (ii) service area requirements under 45 CFR §155.1055.

(b) A carrier may use a commercial market service area that meets the above requirements.

(11) Transparency Data

(a) That the carrier will provide the transparency data for 2014 plan certification, including:

- (i) Claims payment policies and practices;
- (ii) Financial disclosures;
- (iii) Information on enrollee rights; and
- (iv) Information on cost-sharing with respect to a specific benefit or service, when requested by an individual.

(b) That the carrier will provide transparency data, as a condition of maintaining plan certification and being eligible for recertification, including:

- (i) Data on enrollment and disenrollment;
- (ii) Data on number of claims that are denied;
- (iii) Data on rating practices; and
- (iv) Information on cost-sharing and payments with respect to out-of-network coverage.

(12) Quality and RELICC Data

(a) That the carrier will utilize the "eValue8" provided the Maryland Health Care Commission tool to track RELICC data as required by the Exchange.

(b) That the carrier will provide quality and RELICC data, as specified by the Exchange, to the Maryland Health Care Commission.

(13) That for each metal level for which the carrier offers a plan for sale through the SHOP and Individual Exchanges, one such plan meets the baseline benefit design as established by the Exchange.

(14) That the carrier shall offer no more than three benefit designs per metal level.

D. Notice of approval or denial of carrier certification application

(1) An application will not be deemed complete until a carrier attests to all above requirements.

(2) The Exchange, within 45 days of receipt of a completed application, shall notify a carrier of the decision to approve or deny the application.
(3) If the application is denied, the Exchange shall provide the reasons for the denial and reapplication or appeal rights.

.04 Conditions for Participation

A. A carrier certified by the Exchange to sell plans through the SHOP and Individual Exchanges shall comply with all Affordable Care Act and Maryland Health Benefit Exchange Act requirements, including pertinent regulations and guidance, and all other applicable federal and State laws at all times while holding carrier certification by the Exchange.
B. In addition to complying with sections (C) through (F) below, a carrier certified by the Exchange to sell plans through the SHOP and Individual Exchanges shall maintain compliance with each attestation made as part of its application for certification.
C. Carrier Fair Marketing Standards
   (1) The Exchange shall establish and issue a Carrier Fair Marketing Standards Policy.
   (2) The Carrier Fair Marketing Standards Policy shall include:
      (a) a list of marketing materials subject to review by the Exchange; and
      (b) the procedure for submission of marketing materials that the carrier shall submit to the Exchange for review and approval 30 days prior to the intended date of usage.
   (3) For marketing materials subject to review by the Exchange carrier shall only use the marketing materials upon approval from the Exchange
      (a) For 2014 only, a non-accredited carrier may request a grace period of one year to acquire accreditation.
D. Service Area
   For 2014, a carrier holding carrier certification by the Exchange shall provide:
   (1) documentation of the service area of each plan the carrier sells through the SHOP and Individual Exchanges; and
   (2) data on demographics and health status of areas served by the each plan the carrier sells within the SHOP and Individual Exchanges
E. Transparency Data
   (1) For 2014 plan certification, the carrier shall provide the following transparency data:[iv]
      (a) Claims payment policies and practices
      (b) Financial disclosures
      (c) Information on enrollee rights
      (d) Information on cost-sharing with respect to a specific benefit or service, when requested by an individual
   (2) That the carrier will provide transparency data, as a condition of maintaining plan certification and being eligible for recertification, including:

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(a) Data on enrollment/disenrollment
(b) Data on number of claims that are denied
(c) Data on rating practices
(d) Information on cost-sharing and payments with respect to out-of-network coverage

F. Quality and RELICC Data
Carriers shall provide quality and RELICC data, as specified by the Exchange at least on an annual basis.

.05 Exchange Annual Review Procedures

A. The Exchange shall review the performance of certified carriers on an annual basis.
B. The annual review shall include review of the following performance areas:
   (i) Enrollment data;
   (ii) Network adequacy;
   (iii) Quality information; and
   (iv) Complaints and Grievances
C. The Exchange may develop criteria for imposing sanctions on carriers for noncompliance with the attestations made during the application process.
D. Failure to cure noncompliance may result in corrective action.[v]

.06 Plan Certification Procedures

A. To obtain certification for a health benefit plan as a qualified plan to be sold through the SHOP and Individual Exchanges, a carrier shall submit an application for health benefit plan certification on the form provided by the Exchange.
B. In support of the application for health plan certification, the carrier shall submit documentation satisfactory to the Exchange:
   (i) of its compliance with Insurance Article §31-115(b);
   (ii) on the plan network;
   (iii) on any contracts that the carrier has entered into with Essential Community Providers as necessary to meet certification standards for the plan; and
   (iv) the transparency data the carrier has attested to providing under the certification application

C. Exchange Determination Upon Receipt of a Complete Qualified Plan Certification Application
   (i) The Exchange, upon receipt of a completed application, shall determine, for each application, whether certification is in the best interests of qualified individuals and qualified employers, pursuant to standards to be adopted by the Exchange and issued through Exchange policy or guidance.

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(ii) The Exchange shall determine whether the carrier has satisfied such other requirements as may be issued from time to time through policy or guidance.
(iii) The Exchange shall notify the carrier of the decision to approve or deny the application, and if the application is denied, the Exchange shall provide the reasons for the denial and appeal rights.

.07 Plan Recertification

A. A plan certification expires two years after the date it is issued unless the plan is recertified.
B. At least 90 days before a plan certification expires, the carrier shall apply for recertification of the plan in accordance with the Plan Management Manual.
C. The Exchange shall review all original and existing certification data when determining whether the plan continues to meet the certification requirements.
D. A plan that is not in full compliance with recertification requirements may be subject to a corrective action plan, the purpose of which is to enable the plan to reach full compliance within 60 days of receipt of the corrective action plan.
E. The Exchange shall determine, for each application, whether recertification is in the best interests of qualified individuals and qualified employers, pursuant to standards to be adopted by the Exchange and issued through Exchange policy or guidance.
F. The Exchange shall notify the carrier of the decision to approve, deny, or require corrective action.
G. If the application is denied, the denial notice shall include the reasons for the denial and appeal rights.

.08 Plan Decertification

The Exchange may decertify any plan that:

A. fails to meet the requirements for recertification.
B. Fails to comply with a corrective action plan.

.09 Plan Certification and Decertification Appeals

A. The Exchange will develop procedures for appeals of Exchange determinations regarding certifications and decertifications of plans.

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[i] These will be defined as the Exchange moves towards final interim procedures.
[ii] The application will take the shape of an agreement with uniform language for participation terms, conditions and requirements that will be applicable to all carriers.

[iii] The HSS Final Rule requires that rates be submitted to the Exchange. The Maryland Insurance Administration will analyze all rate changes and increases and a Memorandum of Understanding between the Exchange and the Maryland Insurance Administration will reflect Maryland Insurance Administration's ownership of this function. Still, for purposes of these Draft Interim Procedures and subsequent regulations, the rates are noted as being submitted to the Exchange, so as to stay consistent with federal law.

[iv] The Exchange is awaiting further federal guidance on data submission requirements.

[v] If decertification of carriers is a potential corrective action, the Exchange will consider the need for legislative authority.

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Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	
Marketing Standards	Carriers must comply with all applicable State law governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	

Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for "qualified" plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	

Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	

Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the “outside” commercial market.	

Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	

Quality	The Exchange must evaluate carriers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commision (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	

Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to disclose the price of adult dental/vision benefits to consumers separately?	

3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	

Maryland Health Benefit Exchange
Plan Management Public Comments Form

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- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Kimberly Robinson	**Alliance of Maryland Dental Plans**	**krobinson@fblaw.com**	**410-659-7761**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	
Solvency	Carriers must meet State	Use MIA current policy.	

	financial and solvency standards.	The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	Current law allows for review of marketing materials and practices and enforcement action to be taken by the Maryland Insurance Administration. While we understand the Exchange's need to create reasonable guidelines regarding use of its brand name and materials, we believe that a prior approval process will add cost to the products sold on the Exchange. There is no history of marketing abuses in Maryland suggesting that an aggressive prior approval process is warranted. We believe that a prior approval process will increase needs for staff to review multiple filings, limit carriers abilities to update marketing plans within their normal advertising cycles and potentially delay the ability to bring plans to market. Any complaints about carriers that come into the Exchange should be handled through the process that is already in place under the MIA. Exchange complaints should be referred to the MIA for normal processing rather than the Exchange and the MIA developing separate, collaborative processes to handle exchange complaints.
Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for "qualified"	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels)	We believe that the metal level requirements for dental and vision should be considered with an objective of simplicity and clarity in view of the limited nature of these benefits and limited impact on the overall QHP package they may be coupled with. Currently they are not separately identified on the Actuarial Value calculators.

	plans.	○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	The National Association of Dental Plans, of which most Alliance members are also members, is planning to inform CCIIO staff of the need for guidance to states on this topic ensure that actuarial value is always applied separately to dental, whether sold as standalone, or embedded in a QHP, and that requiring essential pediatric oral services to meet any AV level below gold (80%) would require the application of cost sharing to diagnostic and preventive services, which is neither typical of any small group or individual commercial dental program, and runs counter to the ACA prohibition on cost sharing for preventive services, even though current HHS guidance on this topic does not name dental services that occur in a dentist office on the list of affected services.
Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted	It is important to note that although rates for dental products must be filed, reviewed and approved by the MIA, they are not subject to the provisions related to review of unreasonable rate increases. It would appear that the exemption from the provisions related to review of unreasonable rate increases applies even to the essential pediatric dental benefits but it is not entirely clear.

		online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	
Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1 year grace period to become accredited (for 2014 only). • For 2016 and beyond, Exchange specific accreditation could be required. • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	

Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the "outside" commercial market.	
Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service. For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage.	We believe that the Exchange should make use of the existing resources at the Maryland Health Care Commission. Further, the committee's discussion suggested that the Exchange should collect information on carrier's medical management policies and reasons for denial. Maryland law requires that all medical management be performed on behalf of a carrier be done by a certified Private Review Agent (PRA) (see Insurance Article Title 15, Subtitle10C). The Maryland Insurance Administration requires all PRAs to file all medical management criteria it uses with the MIA. In addition, the MIA collects information regarding the reason for denials through its complain process. We believe that utilizing the resources at the MIA rather than developing a parallel process through the Exchange would be the most effective and efficient way to proceed. Similarly, Maryland law addresses how and when a carrier may cancel a policy of health insurance for non-payment of premium. The Maryland Insurance Administration has the ability to adjudicate complaint over such cancellations and is best equipped to continue in that role
Quality	The Exchange must evaluate carriers' quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and	Use the existing Maryland Health Care Commission (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings For October 2013 open enrollment, and	We believe a closer look needs to be taken at the AHRQ survey before the Exchange elects to apply it to dental carriers in the State for purposes of assessing quality. It is our understanding that the AHRQ measures are fairly new and have only been piloted in a limited number and limited type of plans. It is not yet clear whether these measures can be easily translated to the dental preferred provider organizations and dental plan organizations which function

	outcomes.	2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before November). For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings. Use the AHRQ enrollee satisfaction survey for dental plans. Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey. The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	in the State. Further, it is our understanding that the assessment requires diagnosis codes which are not used by many dental carriers and are typically not used by dental providers. There are other options that may be available to measure dental carrier quality that the Exchange may wish to further explore. Reporting requirements could be introduced that assist in demonstrating the care provided by dental plans (to parallel QHP policies) for Exchange consumers. Utilization reporting could be submitted by dental plans. For example, in HEDIS there are measures on dental office visits and sealant applications for children which would be reflected in utilization data. In addition, enrollee satisfaction surveys can be incorporated if they are dental specific. Note: In the future, measurements on pediatric dental may be available as the Dental Quality Alliance, initiated by HHS through the ACA and CHIP Reauthorization, is currently reviewing potential quality measures for the dental industry.
Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results.	Dental and vision plans do not currently collect and obtain such data and it would be expensive to do so. It may be more efficient for the Exchange to collect basic demographic information enrollee application forms and maintain this at the Exchange rather than require both medical QHPs and dental and vision QHPs to collect redundant data

	be addressed in future years.	Note: Data would be used internally only and not displayed on the consumer portal.	
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status	It is important that any recertification process include appropriate due process rights for carrier's who may be aggrieved by an adverse recertification decision.

• Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.	

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification.	It is important that any decertification process include appropriate due process rights for carrier's who may be aggrieved by a decertification decision. In addition, the decertification process needs to clearly address what would occur if the basis for a proposed decertification is an enforcement action before the MIA that is being appealed by the carrier. Decertification prior to a final disposition of the underlying matter may irrevocably harm the carrier if the carrier is forced to leave the Exchange marketplace but later prevails in the underlying action. The Exchange should carefully construct its policy so as not to unnecessarily disrupt policyholder's coverage before a final outcome has been reached.

3. Quality performance issues The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	We support supplemental dental and vision coverage (non-essential benefits and adult benefits) being offered in a variety of ways including in conjunction with a medical plan or on a stand alone basis.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to <u>disclose the price</u> of adult dental/vision benefits to	We support supplemental dental and vision coverage (non-essential benefits and adult benefits) being priced transparently.

consumers separately?	
3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	We believe the Exchange must provide a meaningful way for consumers to compare and understand pricing of the various options available to them.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	We believe what is important is that there be an adequate selection, but at least one medical plan offered without dental benefits. Without medical only plans on the Exchange, the benefits under a stand alone plan would always be redundant. Models for inclusion of adult and non-essential benefits, pediatric essential benefits, or any combination of these benefits could include embedded, in conjunction with a medical plan or on a stand alone basis.

Tequila Terry (DHMH) <tequila.terry@maryland.gov>

: Web Content Accessibility Guidelines and other comments

1 message

Eileen Rivera Ley <Eileen@leyandassociates.com> Tue, Jul 31, 2012 at 11:57 PM
To: "Tequila Terry (DHMH)" <tequila.terry@maryland.gov>, "Justin Stokes (DHMH)" <justin.stokes@maryland.gov>

Tequila and Justin,

Five Quick Points:

1. In order to assure that the new Healthcare Exchange interface is as accessible as possible for users with disabilities, they should follow the WCAG guidelines rather than the 508 Standards. The WCAG Guidelines can be found at: http://www.w3.org/TR/WCAG20/ Many products claim to be accessible but are not.
2. Once designed, the interface should be thoroughly tested by real users with a wide array of visual conditions. Consumers should include both those who use assistive computer technology and those who do not. Include seniors in this test group.
3. The site should apply for NFB Nonvisual Certification. This is the gold standard to make sure that the system will work well with standard screen reader applications. I am attaching information about this certification with this email.
4. The marketing materials, videos, brochures an web content should also be available in accessible formats including e-text versions, very large print, and Braille.
5. Finally, I wanted to send along a link to an excellent e-news letter about accessibility. It may be a great help to the techies on the team. Read this newsletter online at http://webaim.org/newsletter/2012/july News

Eileen Rivera Ley
443.253.5595 mobile
410.321.7278 land

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Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Jeff Album	**Delta Dental of CA, NY, PA & Affiliates**	**jalbum@delta.org**	**415-972-8418**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	If a carrier is considered by the MIA as holding a current certificate of authority and is allowed to offer, issue, or deliver coverage in Maryland, the Exchange should consider the plan in good standing for purposes of participating in the Exchange. The Exchange should consider the existing records of plan performance against such oversight activities and enforcement provisions currently at the disposal of the MIA, including routine financial and operational survey results, market conduct reports, audits, grievance metrics, claims processing metrics, sanctions, and enforcement actions.

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	The Exchange should consider the existing financial standing of licensed dental plans currently at the disposal of the MIA.
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	Carriers offering stand-alone dental plans in an exchange should be no less compliant.
Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for “qualified” plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design	The regulatory oversight that exists in today’s marketplace is largely driven by product type, which determines the level of rate, benefit and form oversight. This approach has well served the consumers of Maryland. Therefore, the Exchange should defer to the current regulation of the MIA based on the type of product being offered and the level to which ACA requirements apply.

		Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	The Exchange must ensure that plans do not design benefits in order to attract a healthier demographic and discourage enrollment by sicker individuals. Also, the Exchange should examine the use of frequency and visit limitations to be sure that the design does not discourage the enrollment of those with unhealthier status. As to actuarial value, Delta Dental recommends that states apply a single AV level (gold) to all children's dental, and that all children's dental always be offered separately, as a stand-alone plan that can be coupled with any separate medical-only plan available on the exchange. A single, independently developed dental-only AV calculator based on child-only data needs to be developed, and we are hopeful that HHS will undertake this for all states. Allowing essential pediatric oral services to be offered at any level below gold requires the application of cost sharing to children's preventive and diagnostic services, which runs counter to a typical small group or individual dental program, and counter to the spirit of the ACA, which prohibits cost sharing for preventive services – though HHS has been unclear on whether this provision applies to services provided in a dentist's office.
Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on	Stand-alone dental plans are expressly exempted from the rating market reform as an "excepted benefit" (45 CFR 154.103(b)), and in fact premium volatility is not associated with stand-alone dental plans. Exchanges should consider setting a dental-specific threshold for increases significant enough to trigger a justification requirement for stand-alone dental plans under the QHP certification requirement. (We suggest 10%.) Otherwise, this requirement is likely to increase administrative costs

		January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	without yielding significant protections for consumers of dental plans. Dental plans will continue to comply with rate filing requirements imposed otherwise by MIA.
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	Ensuring timely access to care from plan enrollees is a fundamental responsibility in the administration of dental programs, and therefore needs to be made a central part of Exchange standards. Access and availability to dental care are elements that should be measured and trended by evaluating data collected through survey instruments, network adequacy reports, on-site assessment results, availability of language assistance services reports and through the review and tracking of grievances. The Exchange should consider that dental plans meet a dental specific network adequacy standard due to the unique nature of the dental provider community.
Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and	We agree dental should not be subject to accreditation in reliance on the MIA Certificate of Authority.

		instead would be required to have the MIA Certificate of Authority.	
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	While Essential Community Providers can provide a variety of services, there is no guarantee that contracting with an essential community provider will provide access to dental services for enrollees. The unique nature of dental makes it difficult to increase access to dental care through ECP's, since many safety net providers and organizations do not provide dental services. It is our position that dental carriers should not have to comply with this requirement.
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the "outside" commercial market.	Modifying existing service areas could cause significant changes in cost for existing business, so while it is important to aim for consistency between inside and outside exchange markets, large scale changes to existing service areas could cause serious market disruption. It is our position that we can comply with non-discriminatory service areas requirements, under the condition that standards do not unduly restrict current business.
Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service	Such data reporting requirements are feasible for stand-alone dental plans, if the data requested is specific to dental coverage.

		For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	
Quality	The Exchange must evaluate carrier's quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commission (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new	Enrollee satisfaction surveys have proven to be an effective measure to gauge carrier performance in several areas. However, the Exchange should develop a uniform dental-specific survey since the AHRQ measures are fairly limited with respect to dental. A key distinction should be made so that it is clear to all stakeholders that the AHRQ survey assesses enrollee satisfaction more than dental quality or outcomes.

		vision plan survey The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	
Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	Our experience with certain state Medicaid populations is that underrepresented populations look to their community for most of their information about health services. Therefore outreach through social services agencies, clinics, community programs and public schools is advisable. Carriers should demonstrate an ability to service non-English speaking populations. The Exchange should continue to encourage the offering of such services, where available, through the bilingual capabilities of provider office staff. The Exchange should focus on assuring sufficient capacity with navigators to fulfill this need as well.
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address “churn” as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	No response requested.

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data	Agree that dental plans can be subject to these annual review, but, as mentioned above, certain standards are required to be dental-specific for there to be any true value in reviewing performance, or in the formal recertification process.

• Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require	We agree that the exchange should provide carriers with due process rights, and sufficient time should be provided for carriers to respond to sanctions from the exchange.

corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	We recommend that a single AV level of gold for all essential pediatric oral services will greatly simplify and reduce the number of benefit designs submitted.
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	All dental services, whether essential or supplemental, should be offered and priced separately from medical (as they are in the marketplace today) so as not ot overwhelm the consumer and to provide the most easily comparable list of options within a simple to understand “mix and

	match" format.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to disclose the price of adult dental/vision benefits to consumers separately?	See above.
3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	If embedded, these benefits should at the very least be priced transparently for comparison purposes, and no discount should be allowed when purchased in tandem with a QHP, as this leads to price "gaming."
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	All dental products in the exchange, both essential pediatric oral services, and supplemental dental services, should always be priced separately from medical. A dental-specific summary of benefit coverage form should be utilized for all dental benefits purchased in the exchange.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	All pediatric oral services should always be offered on a stand-alone basis, whether by a standalone dental carrier, or a QHP. Embedded pediatric oral services should be prohibited.

Plan Management Advisory Committee's Recommendations

1 message

Debra Turkat <debraturkat@gmail.com> Mon, Jul 30, 2012 at 10:11 PM
To: tequila.terry@maryland.gov

Good morning:

As a Maryland resident and concerned clinical social worker, I believe that Qualified Health Plans (QHPs) must demonstrate compliance with federal Mental Health Parity Law, and that there must be clear standards for network adequacy. Neither of these important requirements is adequately addressed in the Summary document.

Thank you,
Debra Turkat LICSW, MSW, MBA
3587 Hamlet Place
Chevy Chase, MD 20815
Geriatric-therapy.com

Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Deborah Rivkin	**CareFirst BlueCross BlueShield**	**Deborah.rivkin@carefirst.com**	**410-528-7054**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	CareFirst believes that the Maryland Insurance Administration (MIA) should apply and enforce the existing licensing process for carriers selling policies on the Exchange. It is unnecessary and inefficient for the Exchange to duplicate this function.

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	CareFirst believes that the MIA should apply and enforce the existing policy for solvency for carriers selling on the Exchange.
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	CareFirst believes that existing Maryland insurance law governing marketing standards and enforced by the MIA is appropriate to be used for both health plans offered on- and off- the Exchange. There should be consistent marketing rules for all policies sold in the State of Maryland. The relevant Maryland insurance law provisions include: • §27-202 to §27-205 • §27-303 to §27-304 • COMAR: • 31.12.01.09 • 31.10.32.04
Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for “qualified” plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value	CareFirst believes that the MIA should apply and enforce the existing rate, benefit and form review process to policies sold by carriers on the Exchange. It is unnecessary and inefficient for the Exchange to duplicate this function. Moreover, using the MIA rate, benefit and form review process will ensure consistency among plans sold on- and off- the Exchange.

		requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	

Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	CareFirst believes that the MIA should apply the existing rate, benefit and form review process to policies sold by carriers on the Exchange. It is unnecessary and inefficient for the Exchange to duplicate this function. Moreover, using the MIA rate, benefit and form review process will ensure consistency among plans sold on- and off- the Exchange. .
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	The Exchange should allow maximum flexibility in defining networks, subject to existing Maryland network adequacy laws and regulations as outlined in: • MCO Networks – Health – General §15-102, §15-103; COMAR 10.09.64 • HMO Networks – Health-General §19-705.1 (b) (1) (ii), Insurance Article §15-112 (b) (1) (i); COMAR 31.10.16.01 *et seq;* COMAR 31.10.34.01 *et seq.* • PPO Networks – Insurance Article §15-112 (b) (1) (i); Insurance Article §14-205.1; COMAR 31.10.16.01 *et seq;* COMAR 31.10.34.01 *et seq.*

Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	CareFirst agrees that the Exchange should accept NCQA or URAC commercial or Medicaid accreditation standards. These organizations are nationally recognized standards that have been widely implemented by all carriers and have proven to be effective. The Exchange need not go beyond these national standards. Moreover, there should be consistency in accreditation standards for carriers offering products on- and off- the Exchange.
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	CareFirst agrees that carriers should contract with Essential Community Providers in medically underserved areas, provided that these providers meet the same credentialing standards required for all providers participating in the carrier's network.
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the "outside" commercial market.	CareFirst agrees that the Exchange should require carriers offering QHPs on- the Exchange to use the same service areas as the "outside" commercial market. Permitting carriers to develop different service areas on- and off- the Exchange would encourage adverse selection between the two market service areas.
Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights	Carriers must report this information to HHS, under the ACA. Since the Exchange is requesting the same information that carriers will provide to HHS, the Exchange should accept the same information in the same format as it is sent to HHS to avoid duplication of efforts and the creation of an undue burden.

	on key policies, practices and data on cost sharing.	• Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	
Quality	The Exchange must evaluate carriers' quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commission (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction	CareFirst agrees that the Exchange should use the existing Maryland Health Care Commission (MHCC) quality and performance process to provide clinical performance data and enrollee satisfaction ratings.

		survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	
Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	CareFirst supports the use of MHCC's RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. However, there is no need for the Exchange to duplicate MHCC's efforts to collect and report RELICC data.
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial	The Exchange should adopt robust notice and hearing procedures by which a carrier may appeal adverse decisions by the Exchange relating to plan or carrier certification, recertification, or decertification. The Exchange should develop a streamlined process that relies upon previous approvals by the MIA, as appropriate (such as licensure, solvency, or actuarial value of existing plans). Such procedures provide appropriate due process and ensure that the Exchange's decisions are not perceived as arbitrary, political, or not grounded in fact. Decisions by the Exchange with respect to carriers or qualified health plans are similar in kind to actions that may be taken by the Maryland Insurance Commissioner regarding health insurers and policies. As such, the Exchange should model its procedures on the existing process rights established in the Insurance Article, which govern when the Insurance Commissioner seeks to sanction a carrier. At a minimum, these procedures should provide for: • Issuance by the Exchange of a written initial decision, stating the grounds for the Exchange's action. *See* Ins. Art. § 2-204. • The right of a carrier to seek a quasi-judicial hearing. *See* Ins. Art. § 2-210. • Upon request by the carrier, stays of enforcement until

Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	administrative hearing procedures are complete. *See* Ins. Art. § 2-212. • Effective notice of the hearing. *See* Ins. Art. § 2-211. • Quasi-judicial hearing procedures, including the right to present and cross-examine witnesses and to receive a final decision based on findings of fact and law. *See, e.g.,* Ins. Art. § 2-213 & 2-214; COMAR 31.02.01.01 *et seq.*

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure*	See response, above. If the Exchange opts to develop additional decertification criteria based on quality performance issues, that additional decertification criteria should be established by regulation to ensure there is consistent, established criteria upon which decertification is based.

If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	Maryland law requires each carrier to offer products on the Exchange in order to offer products off the Exchange (subject to an exception for carriers whose total business in a holding company falls below a set dollar threshold). A "carrier" is an individual licensed entity – e.g., CFMI, GHMSI, or BlueChoice, under CareFirst, Inc. For example, each of CareFirst, Inc.'s three licensed carriers would be required to offer a silver and a gold level product on the Individual and SHOP Exchanges in order to participate in the off-Exchange market. An Exchange could establish a policy to permit carriers to submit a maximum of 3 benefit designs (plans) per metal level, but it would be unduly restrictive to impose a limit on the number of plans at the holding company level, which may have one or several

	carriers. Setting the threshold limit at the holding company level is too narrow since many insurance holding companies have multiple carriers; each carrier within a holding company should be able to sell plans on the Exchange. Maryland law requires every carrier to offer products on the Exchange in order to offer products off the Exchange. We suggest that the carrier submission limits be consistent with this requirement. Moreover, the three benefit designs should not restrict the number of variations required of a QHP at the silver metal level in the individual market to satisfy the cost sharing subsidy requirement.
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	CareFirst believes the Exchange should not require carriers to sell a standardized plan. The ACA brings new standardization to the Individual and Small Group markets. All products must offer the ACA's essential health benefits. ACA also established annual limitations on cost-sharing and in the group market annual limitations on deductibles. The actuarial value assigned to each coverage level (e.g., bronze, silver, gold and platinum) places further limitations on the variations in cost-sharing (e.g., copayments and coinsurance). Given the standardization inherent in the ACA, further standardization creates the risk of increased homogenization of products that makes it difficult for carriers to develop products that meet the differing needs of consumers and employers. Additional limitations on product design may stifle benefit design innovations that could lead to lower costs and better health outcomes. While there may be a concern that consumers may find it difficult to evaluate different products, many tools exist today to help consumers identify key product features and

	to sort product offerings on the basis of these key features. By providing such search capabilities, the Exchange can make it easier for consumers and employers to compare different products. If, however, the Exchange chooses to require a standard plan, it should be in addition to the maximum benefit plan designs allowed per metal level. Thus, if three plans are permitted, then the standard plan should be the fourth.

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	The Exchange should ensure that there are sufficient choices among all Exchange dental/vision products for consumers. To that end, the Exchange should permit stand-alone dental/vision and medical-only policies to be combined as options in addition to the option of a single QHP with embedded dental/vision benefits. Consumers should be able to use the web portal to compare and contrast the dental/vision offerings that are embedded in a QHP or offered on a stand-alone basis. As the Exchange develops policies regarding pricing, consideration should be given to the specific nature of dental/vision policies, including network design and cost sharing. Ultimately, the Exchange should strive to determine how to provide a reasonable degree of choice between QHP's with embedded benefits, dental/vision plans sold in conjunction with medical-only plans, and stand-alone options, without overwhelming the consumer. Under ACA, Exchanges are required to permit QHPs

	associated with dental/vision plans – HHS has interpreted the language quoted above from ACA 1311(d) to mean that an Exchange must allow a dental package to be offered in conjunction with a qualified health plan or to be sold separately, at the carrier's option. As stated by HHS in the preamble to its final Exchange regulation: "We interpret the phrase regarding the offering of stand-alone dental/vision plans ''either separately or in conjunction with a QHP'' to mean that the Exchange must allow stand-alone dental/vision plans to be offered either independently from a QHP or as a subcontractor of a QHP issuer, but cannot limit participation of stand-alone dental products in the Exchange to only one of these options." Final Exchange Rules, 77 Fed. Reg. 18310, 18411 (Mar. 27, 2012). Some MD QHPs must contain pediatric dental coverage, but the Exchange also must allow some other QHPs to exclude it. In Maryland, some QHPs will have to include pediatric dental benefits while others will not: 1. Exchanges are required to permit QHPs without built-in dental plans (if a stand-alone dental plan is available). The Exchange cannot require a QHP to include the pediatric dental benefit if there is an available stand-alone dental plan (which will surely be the case). The Exchange must permit QHPs that do not contain a pediatric dental benefit to be sold on the Exchange. Under ACA 1302(b)(4)(F), the Secretary's rules for minimum essential health benefit must provide that if a stand-alone dental plan "is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of

	benefits offered through the stand-alone plan that are otherwise required" under the pediatric dental benefit. Under this interpretation, Maryland's Exchange cannot require carriers to include pediatric dental benefits in their QHPs, unless they maintain stand-alone dental plans off the Exchange. 2. Some QHPs must include pediatric dental benefits. Each carrier must offer at least two QHPs in Maryland with a pediatric dental benefit. Maryland law requires every carrier to offer a silver and gold QHP in the off-Exchange market. Those two QHPs would have to include the pediatric dental benefit, since the exception noted above refers only to QHPs sold through an Exchange. A plan certified as a QHP but not sold through the Exchange still must have the full minimum essential health benefits package. Because on-Exchange and off-Exchange plans must be priced the same, a carrier would not be permitted to offer a pediatric dental benefit at an additional charge when off-Exchange. Nor could a carrier discriminate among insureds by offering the pediatric dental benefit for free to off-Exchange purchasers but not to on-Exchange purchasers. Thus, the only way to meet Maryland law is for each carrier to develop a silver and gold QHP that includes pediatric dental benefits that is offered both on- and off-Exchange.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to <u>disclose the price</u> of adult dental/vision benefits to consumers separately?	See above.

3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	See above.
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	See above.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a standalone basis when a carrier offers them as part of the Essential Health Benefits package?	Mandating a separate stand-alone pediatric benefit is not permitted under the ACA.

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COMMUNITY BEHAVIORAL HEALTH

CBH

ASSOCIATION OF MARYLAND

CBH is the professional association for Maryland's network of community mental health programs serving children and adults who use the public mental health system. Our member agencies operate outpatient clinics, rehabilitation programs, and a variety of housing, vocational, crisis, and related support services that help people stay out of hospitals and participate in community life as independently and productively as possible.

Because our comments cross committee jurisdiction and reference topics not listed on the public input form, we have chosen to submit our comments in this text. We would appreciate the Exchange Board's indulgence in giving our comments full consideration, even though our remarks are not submitted in the desired format.

CBH is very concerned that individuals in the Exchange may not have access to needed mental health benefits unless the benchmark plan is carefully scrutinized and chosen based on its actual provision of mental health benefits. Adequate oversight must be built in to ensure the ongoing provision of essential health benefits (EHBs), including an appropriate array of mental health services. It is important to note that benefits listed on paper do not equate to benefits easily accessed by consumers. Much of the current discussion involving the Exchange and EHBs has revolved around cost – and appropriately so. However, concerns about cost must involve more than simply the cost of premiums; consideration must be given to the potential costs incurred by Maryland's Medicaid program if the EHB package is inadequate or consumers are not able to access EHBs, particularly for individuals with mental illness. Failure to provide needed mental health services can result in rapid declines in functioning that culminate in job loss, subsequent loss of health benefits, and long-term hospitalization or institutionalization. The public system ultimately pays the price for this cost shift.

Unfortunately for Maryland's taxpayers and for individuals needing services, commercial carriers have a long history of creating barriers to access for individuals needing mental health treatment. These barriers take the form of inadequate provider panels, complicated authorization hoops, and benefit packages that come nowhere near to meeting parity standards with somatic coverage. As the Exchange becomes a reality, Maryland must chart a new, proactive course in ensuring that commercial carriers comply with federal and state parity laws, and that individuals with behavioral health needs have access to adequate treatment, including a sufficient prescription drug formulary.

Network adequacy is also a concern for mental health advocates. Because of the high hassle factor and low reimbursement for mental health services, many providers have chosen to opt out of commercial carriers' networks, preferring to focus strictly on the Medicaid market. Other mental health providers have been frustrated by onerous and arbitrary paneling processes. We expect that there will be churning of individuals from

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Medicaid into the Exchange and vice versa, and strongly urge the Exchange Board to adopt network adequacy standards that will encourage paneling of mental health providers who have experience serving the Medicaid population. We also urge adoption of protections that will allow individuals to continue treatment with their mental health provider, regardless of their movement across the public/private sector. Effective mental health treatment relies on a strong trusting relationship between the consumer and the clinician. Failure to provide for continuity across the public sector and the Exchange will jeopardize fragile treatment gains and will ultimately encourage dumping onto the public sector as conditions worsen due to inadequate or disrupted treatment.

In order to ensure that individuals with mental health needs are adequately served, CBH urges the following:

1. **There must be strong network adequacy standards adopted for mental health, and these standards must be strictly enforced.**
   It is not enough to allow carriers to simply state that their panels are adequate. Carriers should be required to demonstrate how their panels meet geographic and cultural adequacy. Network adequacy standards for the Medicaid HealthChoice program may serve as a guideline. CBH futher suggests that a crosswalk between the public mental health system and carriers' panels in the exchange be conducted to check for continuity between the two systems. The Maryland Insurance Administration (MIA) should periodically contact behavioral health providers listed on the carriers' panels to ensure that they are indeed accepting that carrier's members. We also suggest that carriers in the Exchange adopt the same credentialing standards for outpatient treatment providers as Maryland's public mental health system in order to allow for continuity of care between the two systems.
2. **Carriers operating in the Exchange should be required to demonstrate their ability to conform to federal mental health parity requirements.**
   Carriers have long ignored statutory requirements involving mandated benefits (such as the mandate to provide residential crisis services that has existed in Maryland since 2002). They should not be allowed to give lip service to parity while continuing to erect barriers to mental health treatment. The MIA has relied on a complaint-driven process to ensure that consumers are getting access to their health benefits. Mental illness is often characterized by disruption and disorganization of thought processes, making it difficult for a consumer to follow through with a complaint. Carriers should be required to proactively demonstrate to the MIA how they comply with mental health parity standards.
3. **Individuals undergoing mental health treatment must be able to continue in that course of treatment without disruption, even if they have moved from the public sector to the Exchange, or vice versa.**
4. **Migration of individuals from the Exchange to the public mental health system should be tracked to ensure that there are no systemic barriers to behavioral health treatment by plans in the Exchange.**

5. **Carrier concerns about adverse selection should be offset by appropriate risk adjustment and reinsurance provisions as allowed under the Affordable Care Act.**
6. **The prescription drug formulary offered by carriers participating in the Exchange should be scrutinized for adequacy, as compared with the public sector, in terms of coverage for drugs used to treat mental illness.** Fail first and other discriminatory and restrictive medical management processes should be banned.

Improving access to mental health benefits for enrollees in commercial health insurance plans has been the subject of various workgroups and legislative initiatives over the years. Health care reform provides a unique opportunity to design a system that recognizes the critical role of mental health treatment in reaching individual and aggregate health and cost containment outcomes. We look forward to working with you, and appreciate the opportunity to comment on this important effort.

Plan Management Advisory Committee
Comments – Qualified Health Plan Certification Standards
Submitted 31 July 2012

The Maryland Women's Coalition for Health Care Reform, an alliance of 84 organizations, and the specific organizations cited below, are pleased to submit the following comments to the Plan Management Advisory Committee (PMAC). We hope that these comments are helpful as the Advisory Committee and the Exchange Board consider how to establish parameters for qualified health plans (QHPs).

We appreciate the work of the Exchange and Plan Management Advisory Committee to establish a structured process for public comment. We believe that this process will help the Exchange Board continue the successful stakeholder model used to develop Exchange legislation in the past two legislative sessions. All of the signatories to these comments are committed to working with you and other stakeholders to ensure that Maryland establishes an Exchange program that "gets it right" for Marylanders.

Introduction

To formulate the following recommendations we went back to the principles developed by the Health Reform Coordinating Council, the Exchange Board, and the Maryland General Assembly. We found the following items particularly useful:

- In its 2012 Interim report, The Health Care Reform Coordinating Council stated that the ACA offers a "once-in-a-generation opportunity to make a profound impact on the health and well-being of every Marylander."
- The Exchange Board has stated as the overarching principle of the Exchange that the Exchange serves a broad public good.
- The Health Benefit Exchange Act of 2012 authorizes the Exchange as follows: the Exchange **"**(2) may exercise its authority under § 31–115(B)(9) of this title to establish minimum standards for qualified health plans and qualified dental plans in addition to those required by the Affordable Care Act.**"**

All of these speak to the fact that the PMAC, and the Exchange Board in its final decision-making, should use the QHP certification standards as an opportunity to make a positive impact on the health and well being of Marylanders by adopting standards that achieve that goal. In some cases, the Exchange should consider standards that go above and beyond the minimum standards set by the ACA. Both the ACA and State law allow States the flexibility for going above and beyond the standards of the ACA to make sure that they "get implementation right" for their communities. As in the past, Maryland should take the lead to ensure that consumers, who purchase insurance both inside and outside the Exchange, are assured of the highest quality and most affordable plans. We recognize and appreciate the importance of building a strong and sustainable Exchange with full carrier participation. However, we believe that we should balance this goal with ensuring that the needs of consumers are

addressed. Otherwise, our overall efforts to transform the health care landscape will be less meaningful.

In organizing our comments we have not adhered to the construct of the Certification Matrix. We do not believe that these items, as set out, address the full scope of issues. In addition, some critical issues such as compliance with the Mental Health Parity and Addiction Equity Act were not included at all. Therefore, we have set out eight broad categories – Adverse Selection, Coordination of Care, Essential Community Providers, Health Equity, Network Adequacy, Nondiscrimination, Mental Health Parity and Addiction Equity Act Compliance, and Ensuring Consumer Choice, and within each category we have integrated specific sections of the Matrix as appropriate. In each case, we have set out the issues and provided specific recommendations for the standards. We have not included model language, although we would be prepared to do so if that is requested.

I. Adverse Selection

We believe that the Exchange has the opportunity to address adverse selection through the work of the Plan Management Advisory Committee and the Coordinating Council's Essential Health Benefit Advisory Committee. We would suggest that the Exchange and Council consider a process by which both committees can address adverse selection issues.

There are legitimate concerns about the risks of adverse selection in the Exchange and there are a number of ways to mitigate that risk. One of the fundamental ways to mitigate adverse selection is through the establishment of a uniform benefit under the EHB that would allow consumers to make choices based on quality in addition to a specific set of benefits. The current HHS guidance on the EHB suggests that plans will have flexibility to alter benefits although the scope of that flexibility is not yet defined and is limited by other laws, including the federal Mental Health Parity and Addiction Equity Act, discussed below. **If the final HHS rule permits States to set parameters on flexibility, the Maryland Exchange should establish a core set of benefits and encourage flexibility only where it reflects value-based design.**

In addition to a consistent EHB, the Exchange can use its plan management tools to mitigate adverse selection. Plan management tools for adverse selection mitigation include (1) strict monitoring of issuer plan design, medical management, marketing and other potentially discriminatory practices, and (2) strict rules and monitoring of network adequacy in all categories of care in order to ensure that plans do not steer clients away by offering less that adequate provider coverage.

The importance of plan management tools is highlighted by a recent study on adverse selection relating to individuals with mental health conditions that generally have higher than average medical and behavioral health care costs. (Barry C. et al, 2012. Risk Adjustment in Health Insurance Exchanges for Individual With Mental Illness, *Am J. Psychiatry* 169:7, 704-709). This study shows that the ACA risk adjustment measures may not be adequate to reallocate the costs to plans that have a large number of high-cost users. The results of this study suggest that the Exchange should implement threshold mechanisms – restricting discriminatory plan

design and marketing practices and enforcing network adequacy– in order to avoid initial uneven distribution of high-cost individuals in some plans and not others.

Finally, there are additional long-term strategies for adverse selection mitigation that the Exchange may want to consider implementing or recommending to the General Assembly. Some of these strategies include: (1) establishing a defined set of cost sharing options for each metal level; (2) requiring issuers to offer QHPs in all four metal levels within the Exchange; (3) extending all QHP requirements to all individual and small group plans outside of the Exchange; (4) restricting the sale of catastrophic plans to the Exchange; and (5) requiring issuers to offer all metal plans inside and outside the Exchange.

II. Coordination of Care

We recognize that there will be a Continuity of Care Advisory Committee that will study coordination of services when consumers switch plans. We plan to work with this committee, but we wanted to note that coordination of care is a critical component of ensuring positive health outcomes when consumers stay within their plan or switch plans.

QHP certification is a key opportunity for the Exchange to promote improved clinical care and patient outcomes by establishing standards for coordination of care. Coordination of care is particularly important for people with disabilities, people with complex chronic conditions such as HIV/AIDS, co-occurring mental illness or substance use disorders, diabetes, and individuals and families with limited access to a steady source of insurance coverage.

Coordination of care will be important to Maryland's exchange enrollees both in terms of care provided to an individual over time (related to continuity of care) and various clinical services needed by an individual patient at the same time. For example, it is anticipated that many individuals will move between the Exchange and Medicaid coverage and they will need their care to be coordinated over time to promote optimum health outcomes and seamless access to high-quality services. For enrollees who need a variety of simultaneous treatments, such as those with cancer, plans must also promote coordination of care across providers treating the individual at a given time in order to prevent contraindications, avoid duplicate services, and promote positive long-term health outcomes.

To ensure that QHPs in Maryland's Exchange promote coordination of care, the Plan Management Advisory Committee should recommend the inclusion of the following care coordination provision in the state's QHP certification standards.

RECOMMENDED STANDARD: Require QHPs to implement policies that promote and support effective coordination of care.

III. Essential Community Providers

March 2012 federal regulations require certified QHPs to provide access to a sufficient number of essential community providers (ECPs), including those with experience serving low-income and medically underserved populations, to ensure "reasonable and timely access" to health care services in the QHP's service area.[i]

The regulations define ECPs as "(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111– 8." The regulations also provide that any providers that met the criteria outlined in the PHS Act on March 27, 2012 will always be considered an ECP. The regulations also allow States to expand the definition of ECP beyond those 340 (B) and 340 (B) look-alike providers outlined in the PHS Act. The ACA also specifically states that "A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider."

The current Exchange proposal is to require QHPs to contract with all ECPs within MUAs. This proposal is inconsistent with the HHS intent to ensure that QHPs have a sufficient number of ECPs within its entire service area. The Exchange proposal does not address the definition ECPs.

To ensure that QHPs in Maryland's exchange provide adequate access to a range of essential community providers, the Plan Management Advisory Committee should recommend the inclusion of the following ECP provision in the state's QHP certification standards.

RECOMMENDED STANDARDS:

A. **Require QHPs to contract with all essential community providers within a medically underserved area (MUA) and health professional shortage area (HPSA); and outside of MUAs and HPSAs, require QHPs to maintain provider networks that include a sufficient number of essential community providers to provide services to medically underserved individuals within the QHP's service area.**

B. **Define Essential Community Providers consistently with the ACA and HHS Regulations so that it is clear who is included as an essential community provider. As allowed by HHS regulations, expand the definition to include other providers who are culturally and clinically competent to serve diverse populations, including providers that specialize in mental health and substance use disorder services, school-based health centers and other community health centers providing services to underserved populations.**

C. **Require QHP provider networks to include a sufficient number of mental health and substance use disorder treatment providers at all levels of services.**

D. **Require QHPs to track and report on the number of ECPs within MUAs, HPSAs, and other areas given that accrediting bodies have not yet developed or incorporated ECP requirements within accreditation standards. Require QHPs to report on how they have met the sufficiency requirements in HHS regulations.**

E. **To be consistent with the ACA, clarify that a QHP may not be prohibited from contracting with an essential community provider.**

IV. Health Equity

The Health Benefit Exchange Act of 2012 in its preamble sets out the seven principles adopted by the Exchange Board, which include health equity. To ensure health equity in the Maryland Exchange, the Plan Management Advisory Committee should propose the inclusion of standards that protect and assist a number of populations, such as persons re-entering communities from prison or LGBT individuals, who have traditionally not been adequately served by the health care system.

A. **Criminal Justice Population – Ensure Equity in Access to Health Services on Re-entry.** The overwhelming majority of persons released from state prisons in Maryland are persons of color (78% black and 21% white). Persons reentering communities from prison have a range of chronic health problems, most notably substance use disorders and mental health problems and higher rates of HIV infection, and should have access to health care services in or close to their homes. The Urban Institute's 2003 report, "A Portrait of Prisoner Reentry In Maryland" (Nancy G. La Vinge and Vera Kachnowski), determined that the majority of persons released from state prisons in 2001 returned to Baltimore City (59%), 10% returned to Baltimore County, 6% to Prince Georges, 3% to each of Anne Arundel, Wicomico and Worcester Counties and the remaining population to the other counties.

   For persons returning to Baltimore City, six communities received the largest numbers of returning prisoners: Southwest Baltimore; Greater Rosemont; Sandtown-Wichester/Harlem Park; Greenmount East; Clifton-Berea; and Southern Park Heights. These communities are among those with the highest rates of poverty in Baltimore City. The Urban Institute found that, while many organizations that provide social and health services to former prisoners were located in and around the communities of highest concentration, a significant number of services are located in central Baltimore - a distance from those communities. The report emphasized that this population may not be aware of the services and may be unable to access them because of transportation issues and the cost of the services. The failure to provide health care for this population affects the health and safety of the entire community. (A Portrait of Prisoner Reentry at 52-61).

   RECOMMENDED STANDARD: Through RELICC, or other means, data tracking should gather data on the services the reentry population needs and accesses and the timeframe for enrollment in a health plan and first

appointment with a PCP or SUD/MH provider (as needed); network adequacy standards should ensure that sufficient numbers of substance use disorder and mental health service providers are in the networks and accepting patients on a timely basis; and the State should ensure that all areas of the state and targeted communities within Baltimore City are served by these types of health providers (adopting standards that will incentivize new issuers to enter geographic areas that are underserved generally or with regard to particular services).

B. Data Collection: Maryland's Health Benefit Exchange Act of 2011 requires an annual report that shall "(III) include data to identify disparities related to gender, race, ethnicity, geographic location, language, disability, or other attributes of special populations…"

Comprehensive and reliable data on exchange enrollee demographics and QHP performance are crucial underpinnings of effective plan design and management.

Health disparities also exist for LGBT individuals. Sources such as the Institute of Medicine,[ii] Healthy People 2020,[iii] and the *National Healthcare Disparities Report* from the Agency for Healthcare Research and Quality[iv] report that LGBT people, particularly LGBT people of color, are more likely than the general U.S. population to face significant health disparities. These disparities include higher rates of substance use and mental health concerns such as depression, anxiety, and suicide. Enforcing parity in QHPs will allow LGBT individuals and other Maryland exchange consumers to access the mental and behavioral health care services they need, which will promote individual health and wellness, reduce population-level disparities, and help control the high costs of untreated mental and behavioral health conditions.

To ensure that QHPs in Maryland's exchange are prepared to optimally serve diverse consumer populations, the Plan Management Advisory Committee should recommend the inclusion of the following data collection provisions in the state's QHP certification standards.

RECOMMENDED STANDARDS:

1. **Require QHP issuers to collect and report information on the race, ethnicity, primary language, sex, disability status, sexual orientation, age, and gender identity of their QHP enrollees.**

   Recognizing the importance of data for advancing health reform efforts, Affordable Care Act Section 4302 requires federally supported health surveys and programs to collect information on race, ethnicity, sex, primary language, and disability status, as well as any other factors deemed relevant to health disparities. In response to the March 2011 Institute of Medicine report that recommended the routine collection of demographic and health data on LGBT populations in order to address LGBT health disparities,[v] the Secretary of Health and Human Services has used the authority granted by ACA Section 4302 to initiate a process for also collecting information on

sexual orientation and gender identity on federal surveys.[vi] This initiative buttresses existing efforts by numerous divisions across the Department of Health and Human Services to collect confidential sexual orientation and gender identity information from program participants.

Collection of this range of demographic data will enhance the ability of Maryland's exchange to assess health disparities in the exchange population, promote better understanding of the diverse backgrounds of exchange consumers, help monitor compliance with nondiscrimination requirements, and facilitate the functioning of other operations of the exchange, including outreach, consumer assistance, and navigator programs.

This information should be collected through claims data and optional questions on plan enrollment forms and should be subject to the same rigorous privacy protections as other sensitive health information.

2. **Require QHP issuers to collect and report information on the cultural competency initiatives of its QHPs.**

In order to measure the quality and performance of QHPs, Maryland's QHP certification standards should also require QHP issuers to collect and report information on the cultural competency initiatives they incorporate into the care provided to enrollees in their QHPs. An example of such an initiative is Kaiser Permanente's National Diversity Department, which includes Centers of Excellence in Culturally Competent Care and the Institute for Culturally Competent Care (ICCC). The department oversees a range of cultural competency initiatives for Kaiser providers and enrollees focused on "cultural groups who share beliefs, practices, and values based on race, ethnicity, sex, religion, age, disability, sexual orientation, gender identity, and other characteristics."[vii] According to the ICCC, "Acknowledging and understanding a patient's cultural values can lead to effective communication, promote treatment adherence, and positively affect health outcomes."

V. Network Adequacy

We believe that network adequacy is one of the most critical components of ensuring the success of the Exchange's implementation. As we understand from the experience of Massachusetts as well as our own State's work in establishing the HealthChoice program, it is absolutely critical to ensure that the newly insured have access to a comprehensive and appropriate network of providers starting on January 1, 2014. We are concerned that the Exchange staff's initial recommendation to adopt the current standards of the commercial market will be setting up the Exchange for failure. As outlined in our remarks, we have noted numerous examples of the inadequacy of the current commercial networks in Maryland. We also note that the population under the Exchange will be distinctly different from the typical commercial market. This market will include individuals who have persistent access issues because of their previous lack of insurance or preventive care and/or other economic barriers. The pent-up demand for services from this population will overwhelm the system unless we

ensure there are adequate networks to provide services.

A. **Scope of Certification Standards.** We are concerned that the certification standards recommended by the Exchange staff are insufficient both in detail and scope and will result in inadequate provider networks that jeopardize access to care, frustrate newly insured persons who purchase insurance thinking they will be able to receive care, and force individuals to pay higher non-network cost-sharing. We recommend that the Exchange establish:

    1. The specific parameters that demonstrate network adequacy, consistent with the metrics in Medicaid, that take into consideration wait time and travel distance for appointments, and include up-to-date information about providers that are accepting new patients and network status of specialists and hospital-based providers; and

    2. The process by which QHPs must demonstrate compliance with those parameters (e.g. network adequacy analysis process as a part of annual review of plan) and the process by which members can access this information. HHS Exchange regulations identify the NAIC Model Act as a guide for network adequacy standards (See NAIC Draft Network Adequacy White paper, 6.17.2012). *The Exchange has flexibility to build on this model and align with other federal standards (NCQA and URAC) and State standards, e.g. Medicaid.*

B. **Defining Parameters of Network Adequacy in order to achieve a Measurable Standard.** Underserved (and overlapping) populations such as LGBT people, racial and ethnic minorities, and rural communities frequently face significant financial, physical, cultural, and other barriers to appropriate health care services. To address these barriers, federal regulations require the exchanges to ensure that certified QHP issuers maintain a provider network "sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." To ensure that QHPs maintain provider networks sufficient to serve diverse consumer populations, we recommend that the Plan Management Advisory Committee adopt the following network adequacy standards:

    RECOMMENDED STANDARD: **QHPs must maintain provider networks that are adequate to serve Maryland's diverse population of exchange consumers, without unreasonable barriers or delays in receiving clinically appropriate and culturally competent care.**

    Examples of network adequacy standards may include:

    1. Require QHP provider networks to include specialists in the management of complex conditions such as HIV/AIDS and diabetes.

    2. Require QHP provider networks to include providers that are culturally competent in working with diverse populations, such as the providers listed in the Gay & Lesbian

Medical Association's provider directory (https://glmaimpak.networkats.com/members_online_new/members/dir_provider.asp).

3. Require QHP provider networks to include a variety of provider types, including primary care providers, specialists, and non-physician providers.

C. Defining a Standard for Mental Health and Substance Use Disorder Treatment. HHS regulations explicitly require that QHPs provide adequate numbers and types of providers of *mental health and substance use disorder treatment services* in order to ensure network adequacy. 45 C.F.R. § 156.230. The State's certification standards must identify these providers as designated essential community providers and confirm inclusion in provider networks.

RECOMMENDED STANDARDS:

1. **Referral Patterns and Coordination of Care.** QHPs must ensure that primary care providers are performing preventive and early identification services relating to MH/SUD conditions, including screening, intervention and referral, consistent with the U.S. Preventive Task Force Recommendations, and coordinating appropriate care with MH/SUD providers.

2. **Types of MH/SUD Providers**. Exchange certification standards must address the need for adequate numbers of MH/SUD providers/facilities that meet the continuum of services (i.e. different levels and settings of care) and treat specific populations, e.g. mental health services for children or SUD services for adolescents. Standards must also address the frequency for plans to update information on whether providers are accepting new patients.

3. **Adequate Numbers of MH/SUD Providers in Networks**. There is a shortage of SUD providers in many service areas in the State, and, historically, commercial plans have limited the number of MH/SUD providers that are credentialed to participate in their networks. Some carriers have implemented burdensome and time-consuming processes for becoming a panel member, even when the provider meets the plan's eligibility standards. Limited provider panels affect the continuity of care for MH/SUD patients who move between jobs with frequency and are not in a position to advocate for inclusion of their providers in the plan's network. Patients with limited resources are, therefore, placed in the difficult position of paying higher out-of-pocket charges to retain the same care provider, if he or she is not included in the full range of various carrier networks.

   In order to achieve network adequacy of MH/SUD providers, certification standards must require QHPs to: (1) maintain specific network adequacy standards for MHSUD providers; (2) maintain open panels for all qualified MH/SUD providers until the network is certified as adequate; (3) complete credentialing of MH/SUD providers within a reasonable timeframe; (4) permit all credentialed MH/SUD providers to perform services within their scope of practice authorized under such

provider's State license, certification or other authorization, and (5) require in-network cost-sharing for services provided to a member who must use an out-of-network provider due to inadequate network in plan.

4. **Reasonable Access**. Exchange certification standards must address reasonable access in the context of MH/SUD services, e.g. immediate access for SUD detoxification and intensive outpatient services, referral access to an MH/SUD provider within a reasonable time depending on condition.

5. **Special Populations with Identified Behavioral Health Services Needs**. Network Adequacy standards should require assessment of service needs of individuals who have identified high needs for behavioral health services and ensure that for those individuals there is increased network capacity to coordinate care and meet those needs.

6. **Cultural and Language Competency**. Network adequacy standards must include assessment of cultural and language competency of providers serving in ethnically and racially diverse communities and service areas. QHPS must be able to demonstrate that they have sufficient providers who have the cultural and language competence to serve the needs of the identified services area. In addition, network adequacy standards should ensure network capacity to adequately serve those persons with MH/SUD conditions who also have physical or cognitive disabilities.

VI. Nondiscrimination

The Health Benefit Exchange Act of 2012 requires that "The Exchange shall be administered in a manner designed to (1) prevent discrimination…"

Federal regulations issued in March 2012 prohibit qualified health plans (QHPs) and QHP issuers from discriminating against any QHP consumer on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity.[viii]

To ensure that Maryland's QHPs and QHP issuers comply with these regulations, the Plan Management Committee should recommend the inclusion of the following nondiscrimination provisions in the state's QHP certification standards.

Note: It is advisable that the committee recommend to the Maryland Insurance Administration and the Maryland Health Care Reform Coordinating Council that these nondiscrimination requirements also be applied to all plans that include the essential health benefit standard, both inside and outside the exchange. This will protect the Exchange from adverse selection and to protect consumer access to the essential benefits.

RECOMMENDED STANDARDS:

A. Notify QHP issuers that, with respect to their QHPs, they may not discriminate in any of their activities against any consumer on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity.

This proposed standard implements the nondiscrimination requirements in federal regulations and is essential to ensuring the exchange serves all Marylanders equally. This rule includes activities such as marketing, outreach, rate setting, benefit design, conditions of coverage, and coverage determinations by QHP issuers with respect to their QHPs.

For example, QHP issuers may not deny transgender enrollees coverage for benefits offered to similarly situated nontransgender consumers, as this would constitute unlawful discrimination on the basis of gender identity. Similarly, plans that offer spousal benefits for different-sex couples must offer identical plans to same-sex couples whose relationships are recognized under Maryland law.

B. Prohibit arbitrary condition-based exclusions in QHPs.

Affordable Care Act Section 1302(b)(4) establishes nondiscrimination requirements for plans offering the essential health benefits. This necessarily includes QHPs, as all QHPs must cover the essential benefits. According to this section, the Secretary of Health and Human Services (and, by extension, the states, since states must submit their essential benefit standards to HHS for approval) shall—

1. not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;
2. take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
3. ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life…

The 2011 Institute of Medicine report on the essential benefits clarifies that Congress intended "to ensure that insurers do not make arbitrary and discriminatory decisions based on certain characteristics of people rather than assessing the individuality of each case when making medical necessity decisions and applying clinical policies."[ix]

Implementing this standard requires reasonable limits on the use of condition-based exclusions. Specifically, the Plan Management Committee should recommend that QHP issuers be prohibited from using *arbitrary* condition-based exclusions as utilization management tools in their QHPs. Under this ban on arbitrary condition-based

exclusions, carriers will still be permitted to exclude coverage for benefits that are not medically necessary, that are experimental, or that are comparatively more expensive than other treatments. A prohibition on arbitrary condition-based exclusions simply prohibits QHP issuers from discriminating in coverage of otherwise included plan benefits solely on the basis of diagnosis or medical condition, without a reasonable justification.

C. **Require QHP issuers to incorporate a statement in their QHP materials affirming that the plan provides coverage for the insured individual, without discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, diagnosis, or medical condition.**

This statement should include information for consumers about their rights to grievance and appeals processes available under state and federal law. For example, Affordable Care Act Section 1557 allows consumers to sue in federal court or file a complaint with the Office for Civil Rights at the Department of Health and Human Services alleging discrimination by any exchange actor on the basis of race, color, national origin, age, disability (including HIV status), or sex.

VII. Mental Health Parity and Addiction Equity Act Compliance

A. **The Parity Standard**. The ACA requires QHPs for both the individual and small group markets to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), which sets standards to ensure that cost-sharing, duration of care and medical management standards for mental health and substance use disorder benefits are comparable to those standards for medical/ surgical benefits. (Affordable Care Act Sections 1311(j) and 1563(c)(4)). The Maryland Health Benefit Exchange Act of 2012 specifically requires QHPs to comply with the MHPAEA. To enforce federal and state standards, the State's QHP certification requirements should require plans to annually demonstrate compliance with MHPAEA.

B. **Qualified Health Plan Compliance**. Although the benchmark plan must be parity compliant, we are not confident that all relevant compliance data (e.g. medical management standards) will be considered under the short deadlines in place for the benchmark plan determination. We expect that the benchmark plan will be compliance with parity in terms of types and scope of benefits and quantitative treatment limitations but will lack specificity in non-quantitative treatment limitations, such as medical management standards, fail first requirements and medical necessity standards. The task of analyzing the specific benefit design of each QHP, including all non-quantitative treatment limitations, as defined in the MHPAEA regulations, will be the responsibility of the Exchange and the Maryland Insurance Administration.

C. **No Additional Burden to Plans.** Carriers must collect the plan data and perform the parity analysis as required by the MHPAEA. In addition, under the June 1, 2012 proposed rules on plan data collection, QHPs will be required to collect and report data sets (e.g. quantitative and non-quantitative treatment limitations) that are the same

data sets required for a MHPAEA analysis. URAC, one of two entities that will perform plan accreditation, currently requires demonstration of MHPAEA compliance for plan accreditation. Imposing a certification standard for demonstrated parity compliance imposes **no** additional burden on States or carriers for data collection or reporting.

D. **Benefit to the Exchange and consumers**. MHPAEA is meant to address long-standing disparities in plan benefit and services for mental health and substance use disorder treatment. Failure to provide adequate coverage for MH/SUD translates into a significant cost in terms of poorer health outcomes. Consumers are not able to identify parity violations because the data needed to determine compliance are solely in the hands of the plans and difficult to obtain. The Exchange should take a leadership role in affirming the importance of parity of mental health and substance use disorder benefits and require QHPs to demonstrate compliance as a condition of certification and recertification.

RECOMMENDED STANDARD: QHPs should be required to demonstrate annual compliance with the MHPAEA as a condition of certification and recertification as a QHP.

VIII. Ensuring Informed Consumer Choice

As documented by numerous consumer groups, including Consumer Union and the Pacific Business Group on Health, consumers are often overwhelmed by the daunting task of purchasing health insurance. The Health Benefit Exchange must take steps to alleviate confusion and enable consumers to make informed decisions about their health care coverage.

RECOMMENDED STANDARDS:

A. **The Exchange should adopt a standard limiting the number of QHPs that each carrier can offer at each distinct metal level, thereby requiring carriers to market plans that have meaningful differences at each actuarial value. The proposed standard would decrease the likelihood of a carrier using marketing strategies to "cherry-pick" healthier consumers or steer them into a specific plan. A limit on the number of plans available at each level will also enable plan comparison, as consumers will be able to make informed decisions using criteria important to them rather than weed through multiple plans that have small differences in cost-sharing or limits on benefits.**

B. **The Exchange should implement a web architecture that facilitates informed consumer choice and plan comparison. Making the shopping experience less confusing for consumers will not only decrease the reticence of consumers to purchase health insurance but may become a factor driving individuals to purchase insurance from the Exchange. One way of simplifying the online shopping experience is to ensure that consumers have access to all of the necessary information for plan comparison. Consumers must be not be required to visit separate websites,**

(including carrier websites) to complete their purchase; linking to a carrier site on the Exchange portal only increases the likelihood that a consumer will "get lost" in the selection process. Carriers who decide to participate in the Exchange market must make information, such as provider networks, available to the Exchange for uploading to the Exchange website.

Conclusion

As we stated above, our primary goal in submitting these comments is to ensure that all consumers have access to the full range of health care services they need in a timely and effective manner and that through this process we can reduce health disparities across all populations. The ACA provides a vehicle to achieve this. At the same time, Maryland's long-standing commitment to expanding access to health care and its leadership on the ACA implementation provides a model for its approach to QHP certification standards.

We recognize the complexity of the issues we have raised and the time constraints within which the Exchange Board and staff must make its own recommendations and decisions. However we urge you to consider that Maryland can and should go beyond the minimum called for in the ACA and the HHS regulations in order to take full advantage of this once in a lifetime opportunity for transformational change.

The undersigned are grateful for the opportunity to submit these comments. We would be happy to provide further clarifications and/or information as would be deemed useful and we look forward to working with you in the future.

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- **NAMI Lower Shore**
- **NAMI Metropolitan Baltimore**
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[i] 45 CFR 156.23

[ii] Ibid.

[iii] Department of Health and Human Services. 2010. "Healthy People 2020 Topic Area: Lesbian, Gay, Bisexual, and Transgender Health." Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

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[vii] Chong N. 2002. "A Model for the Nation's Health Care Industry: Kaiser Permanente's Institute for Culturally Competent Care." *The Permanente Journal* vol. 6, no. 3.

[viii] 45 CFR 156.200

[ix] Institute of Medicine. 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Al Schubert	**VSP Vision Care, Inc.**	**AlSc@vsp.com**	

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	

Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for “qualified” plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	

Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	

Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the "outside" commercial market.	

Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	

Quality	The Exchange must evaluate carriers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commision (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey	

		The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	

Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment	

period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	90% of vision care delivered in the State of Maryland today is offered through Stand-Alone Vision Plans (SAVP). There would be little impact if adult, non-essential vision benefits were always offered separately, based on the above fact. Most health plans contract out their vision services to SAVP organizations, so any additional administration on the part of the health plan is negligible. Most importantly, it has been proven that the utilization of

	preventive vision care through a SAVP is twice what it is when vision care is delivered through a health plan delivery channel. That will mean higher cost for the State of Maryland downstream.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to disclose the price of adult dental/vision benefits to consumers separately?	Yes, all carriers must be required to disclose the price of adult dental/vision benefits separately to consumers. Maximum consumer choice and transparency is achieved, as long as such benefits are separately priced and disclosed. Consumers need to understand what they are buying and therefore all sides need to fully disclose pricing. I can't imagine the State of Maryland or the Maryland Health Benefit Exchange being party to a lack of transparency and disclosure?
3) Adult Dental/Vision Stand Alone Options If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	Since the overwhelming majority of vision benefits in the State of Maryland are delivered by SAVP and most health plans sub-contract out for vision services utilizing SAVP's, we don't believe there is a need for a requirement where medical carriers would be required to offer stand-alone vision, too. However, it is very important the Exchange require medical QHPs to offer plans without adult or pediatric dental or vision. This will allow Exchange participants to choose coverage through a standalone plan without having to worry about duplicative coverage.
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	Yes, all carriers must be required to disclose the price of pediatric dental/vision benefits separately as part of their EHB package. This follows the same logic indicated above. This is the way that vision benefits embedded in major medical plans are typically offered today. The State of Maryland and the Maryland Health Benefit Exchange should require the complete disclosure of individual benefit pricing as it relates to vision and dental care.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential	Stand-Alone Vision Plans (SAVP) are able to provide care through the Maryland Exchange because we are duly licensed companies in Maryland that specialize specifically

Health Benefits package?	in the delivery of vision care. Vision care is often the only business of SAVP's. Requiring a medical carrier to provide something that they would rather not do, or do not specialize in, would be a disservice to Marylanders seeking care. At the same time, the Exchange must require health plans to offer plans without pediatric or adult dental or vision care. This will avoid un-necessary and costly duplicative coverage.

Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Colleen C. Cohan	**UnitedHealthcare**	**colleen_cohan@uhc.com**	**240-632-8109**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	For purposes of the commercial market, we believe that licensure of qualified health plans should remain based upon current state law.

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	For purposes of the commercial market, we believe that financial and solvency standards for qualified health plans should remain based upon current state law.
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	In 2014 and beyond, the health care marketplace will have many mechanisms in place to prevent inappropriate health plan steerage, such as adjusted community rating, guaranteed issue, pooling of risk inside and outside the Exchange, and risk sharing programs. General commercial health plan marketing standards that have been historically used in states should also be adequate for Exchange oversight of QHP marketing activities. The Exchange can play an important role by ensuring the Exchange participants are required to follow the existing standards and support the available anti-steering mechanisms.

Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for "qualified" plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	For purposes of the commercial market, we believe that the benefit and form review process for qualified health plans should remain based upon current state law.

Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	For purposes of the commercial market, we believe that rates and benefit reporting standards for qualified health plans and submission of rates should remain based upon current state law.
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	For purposes of the commercial market, we believe network adequacy standards should remain based on current state law. It is also important to consider the network adequacy combined with the small business rating zones so a commercial carrier cannot choose to only participate in one section of the state geography. An issuer should have an adequate network within the respective rating zone, not just a portion of the rating zone. Our intent is to use an existing commercial network in the exchange which meets state law according to the current standards.

Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	The availability of a grace period for achieving accreditation is intended to allow sufficient time for a new health plan to put quality program processes in place, if it does not already have quality program in place prior to being evaluated on it. More importantly, to have valid HEDIS & CAHPS results, the plan must have sufficient # of members (>15,000). With the high cost of fielding the CAHPS survey and collecting HEDIS data every year, to do so without a sufficient mass of members is not cost-effective and will negatively impact affordability to the consumer. Cost of accreditation is particularly burdensome for small to mid-size issuers. States' Departments of Insurance have criteria for admitting companies today, and these are a good starting place. Current NCQA practice is to issue an annual reassessment of accreditation determinations/status based on that year's HEDIS and CAHPS results submitted in June in addition to the triennial survey of compliance with the written standards. Every accredited health plan is reassessed in August, regardless of when it underwent a full NCQA survey. UHC recommends a reporting cycle to mirror the annual reassessment timeline. To do it more frequently would not yield any new information. The format for submitting accreditation status could be a copy of the original letter from NCQA with the accreditation determination and then each annual reassessment letter to the health plan thereafter.
Essential Community Providers	Carriers must include in the provider network Essential Community	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs)	The commercial health plan will make reasonable efforts to contract with available ECP's in counties where the health plan is offered on the benefit exchange.

	Providers that serve low-income and medically underserved populations	unless they are exempted by criteria established in the final rule.	Mandatory contracting with ECPs could be an issue if these providers are not ready to contract with commercial carriers. ECPs will need to establish certain minimum administrative capabilities (e.g., claims administration, electronic billing, insurance eligibility verification, credentialing requirements, and quality reporting requirements).
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the “outside” commercial market.	For purposes of the commercial market, we support using the same service areas as the “outside” commercial market.
Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied	We support consumer transparency, but caution requiring carriers to publicly disclose proprietary data which could have an anti-competitive effect.

		• Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	
Quality	The Exchange must evaluate carriers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commision (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of	2013 is the first year that plans will be reporting to MHCC on Maryland members only, so it will be a baseline year. With the Exchange starting in 2014, this will be another year of transition. We recommend further consideration of the use and timing of the MHCC data and consider these factors. Issues that need to be addressed include confirming that there will be an adequate number of members to make reporting the measure valid, analyzing the differences between populations inside and outside the Exchange, and the relationship with future federal regulations on quality reporting. We also recommend that the MHCC efforts be consistent NCQA on components including the measures, methodology, and rotation schedules.

		Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	Member perception is an important measure of certain aspects of quality, such as customer service, but most patients do not have sufficient knowledge to judge clinical quality. Clinical quality is evidence-based and best left to industry standards. Criteria, such as access and cost, should be measured using empirical data, not subjective perceptions. Importantly, cost has many components, such as premium, out-of-pocket and total costs, which should all be considered. Grievances and appeals, which are monitored by many states, may be an additional indicator of quality. If a survey is developed, we believe it should be reviewed and include input from plans.
Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer	We support efforts to identify disparities and improve health in underserved populations. Collecting this data would: • Help identify, measure and track disparities • Develop an expanded portfolio of tailored health and wellness resources • Engage translation and interpretation services, as appropriate • Facilitate improved utilization of health services through culturally and linguistically appropriate communications, clinical programs and benefit offerings. However, there are many challenges related to the collection of this data. Primarily:

		portal.	A voluntary, non-required member reporting effort would lead to limited collection of data For the Exchange population, the Exchange could consider: • Asking plan enrollees to report their RELCC as part of the Exchange enrollment process • Implementing a public education and awareness regarding the personal benefits to providing RELCC data.
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	We support collaborative efforts between the Department of Health and Mental Hygiene, Medicaid Managed Care Organizations and health plans offered on the Exchange to establish policies and processes to facilitate sharing of members' health care utilization data, care management plans, and/or health risk assessments, and monitor movement of persons as they may move from Medicaid to the Exchange and vice versa.

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments

Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	It is important that any recertification process include appropriate due process rights for carriers who may be aggrieved by an adverse recertification decision.

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further	It is important that any decertification process include appropriate due process rights for carriers who may be

clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	aggrieved by a decertification decision. In addition, the decertification process should clearly address what would occur if the basis for a proposed decertification is an enforcement action before the MIA that is being appealed by the carrier. Decertification prior to a final disposition of the underlying matter may irrevocably harm the carrier if the carrier is forced to leave the Exchange marketplace, but later prevails in the underlying action. The Exchange should carefully construct its policy so as not to unnecessarily disrupt the policyholder's coverage before a final outcome has been reached.

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits	We support providing the consumer with choices and

The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	letting the marketplace dictate the appropriate number of plans offered. We do not support arbitrary limits on the number of plans offered to the consumer, and recommend linking the Exchange portal to the qualified health plan websites for selection of plans.
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	We support allowing flexibility and innovation in plan designs offered within the prescribed number of plans at each metallic level.

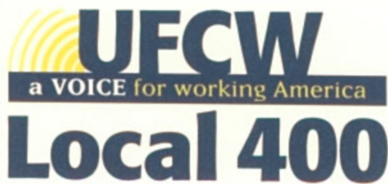
V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	Allowing an embedded or bundled option with adult dental and vision will provide consistency and a more seamless experience for family coverage, as well as create administrative efficiencies which will be passed onto the consumer as savings.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to disclose the price of adult dental/vision benefits to consumers separately?	Today, issuers file prices for a product, but not for different components within that product. We believe that dental benefits do not need to be priced separately to provide transparency. Price and benefit comparisons can continue as they do today in the marketplace for stand-alone benefits, by adding medical and dental pricing together and comparing the result to bundled products. Exchange tools, such as the calculator and website, will help facilitate these comparisons.

3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	Issuers cannot simply remove the dental/vision portion of an embedded or bundled product and create a stand-alone product and price. Embedded dental benefits have different pricing because of different utilization patterns, a different expense structure and varying consumer protections (e.g. appeals rights) that we believe, based on current federal guidance, apply to embedded benefits, but not to stand-alone benefits. We believe that issuers should have the option to offer embedded, bundled, or stand-alone options to encourage Exchange participation from a variety of issuers.
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	Today, issuers file prices for a product, but not for different components within that product. Embedded dental benefits have different pricing because of different utilization patterns, a different expense structure and varying consumer protections (e.g. appeals rights) that we believe, based on current federal guidance, apply to embedded benefits but not to stand-alone benefits. We do not believe that a separate price for these essential benefits would contribute to transparency; we consider EHB benefits that are subject to the same global out-of-pocket limit (such as pediatric dental and vision) part of the 2014 benefits package that should be considered as a unit, similar to the marketplace outside the Exchange.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	We consider EHB benefits that are subject to the same global out-of-pocket limit (such as pediatric dental and vision) part of the 2014 benefits package that should be considered as a unit, similar to the marketplace outside

	the Exchange. Due to the EHB global out-of-pocket limit, if the pediatric dental benefit is administered through a separate policy, it would create challenges and confusion for the consumer related to two policies and a single EHB out-of-pocket limit. A consumer may need to pay out-of-pocket and get reimbursed if it is later determined that they have reached their out-of-pocket maximum. Outside the Exchange, pediatric oral and vision services must be embedded in the medical policy, and inside the Exchange, pediatric vision services must be embedded as well. To require an issuer to separate just the pediatric dental benefits within the Exchange would create inconsistencies with the number and type of medical policy offerings inside and outside the Exchange, and cause additional confusion for consumers and groups.



United Food & Commercial Workers Union

Thomas P. McNutt,
President

Chartered by:
UFCW International Union

Mark P. Federici,
Secretary-Treasurer

Serving Members in MD, VA, DC, WV, TN, NC, KY, OH

July 30, 2012

Ms. Tequila Terry
Director, Plan & Partner Management
Maryland Health Benefit Exchange
4201 Patterson Avenue
Baltimore, MD 21215

Re: Availability of Non-Essential Dental and Vision Benefits on Maryland Exchange

Dear Ms. Terry:

On behalf of the members of United Food and Commercial Workers Union, Local 400 ("Local 400"), we appreciate the opportunity to address the following points raised in the Plan Management Advisory Committee Meetings.

1. Non-Essential Dental and Vision Benefits

As you know, a hallmark of the Affordable Care Act is that it ensures individuals will be able to receive minimum essential coverage, including benefits such as hospital, major medical and prescription drug coverage. Adult dental benefits and adult vision benefits, on the other hand, are not minimum essential coverage under the Act. Local 400 respectfully requests that the Maryland Exchange Board allow adult dental benefits and adult vision benefits to be offered on the Exchange only in the form of separate endorsements or separately purchased coverage to the qualified health plans available on the Exchange. This unbundled structure would benefit Maryland residents by giving them the flexibility to elect and pay for only those non-essential benefits that they specifically choose.

Absent intervention by Maryland's Exchange Board, the statutory provisions governing the operation of Maryland's Exchange will give insurance companies, rather than Maryland's residents, the power to decide whether to bundle these non-essential benefits, and this could result in added costs or restricted access to coverage. Giving insurance companies the ability to limit their offerings on the Exchange to more expensive coverage that combines essential and non-essential benefits leaves open the possibility that Maryland residents will have no choice but to elect a benefit plan containing dental and vision coverage they do not want to purchase. For example, if these non-essential benefits are included as a non-severable part of an essential benefits plan on the Exchange, members would not be able to select that plan without being required to pay a premium on the Exchange for adult dental and vision care benefits, even though they may currently have these benefits free of charge as a result of collective bargaining.

Main Office: 4301 Garden City Drive, Landover, MD 20785-2298 • 301-459-3400 • fax 301-459-2780
West Virginia Office: 412 Tennessee Ave., Suite 100, Charleston, WV 25332-2338 • 304-346-9679 • fax 304-346-9670
www.ufcw400.org

Maryland's recently enacted Health Benefit Exchange Act of 2012 gives the Exchange Board the discretion to determine how non-essential adult dental and vision benefits will be made available on the State's Exchange. Local 400 urges the Plan Management Advisory Committee to advise the Exchange Board that the choice of purchasing non-essential health benefit coverage on Maryland's Exchange should be placed in the hands of the consumer, rather than in the hands of the insurance companies, given the importance of allowing individuals to select the insurance coverage that is best for them, including the ability to decline non-essential coverage that they do not need or cannot afford.

2. Network Adequacy

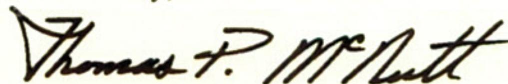
The on-line materials indicate that there was considerable discussion concerning network adequacy. As individuals attempt to select a Qualified Health Plan ("QHP") that is right for them, it is critical that the networks are sufficiently regulated so that there is an adequate amount of choice and meaningful insurance coverage at various metal levels. The only way to accomplish this is through some level of regulation by the Exchange. Additionally, the depth and scope of a network offered by an issuer must be completely transparent to the consumer and we suggest that this can only be accomplished through minimum standards of disclosure.

3. Decertification of Plans

To the extent the Exchange determines that a QHP offered by an issuer does not meet the minimum standards established by the Exchange, we urge that any administrative hearing and adjudication be performed expeditiously and with notice to the public. A prolonged adjudication process involving whether a plan should continue to be offered would be adverse to the interests of Marylanders who deserve high quality comprehensive health care from the Exchange.

Thank you for your attention to these important matters.

Sincerely,



Thomas P. McNutt
President
International Vice President

TPMcN/lla

Dear Plan Management Advisory Committee:

Thank you for the opportunity to submit these comments on the plan certification requirements for qualified health plans (QHPs). Planned Parenthood of Maryland is looking forward to being a partner with the Exchange and QHPs in ensuring that people who are newly insured will have access to high-quality health care services.

We have focused our comments on the proposed requirements pertaining to essential community providers (ECPs) and network adequacy. We would suggest that the Committee and Exchange Board consider: 1) how to ensure that the State ECP requirements reflect minimum federal requirements; and 2) where State requirements could be more robust than federal requirements with the goal of strengthening the QHPs ability to meet the needs of underserved individuals.

Ensuring ECP Requirements Reflect Federal Standards

When drafting State requirements related to ECPs, we would recommend that those requirements include all federal requirements. This will help ensure that both QHPs and ECPs understand the federal parameters for ECP requirements. The State requirements should include these essential elements:

- **Definition of ECP:** While the State could expand the definition (see comments in next section) of essential community providers, federal regulations (45 CFR § 156.235 (c)**)** require that the definition to at least include "(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111– 8."

  This same section of federal regulations also delineates that any health care provider meeting the federal definition as of March 27, 2012 should be considered an ECP.

- **Requirements for QHP Networks:** Federal regulations (45 CFR § 156.235 (a)) specify that a QHP "must have a sufficient number and geographic distribution of essential community providers . . . in the QHP's service area".

  In draft documents for the Plan Management Advisory Committee, there is indication that the Exchange is considering only requiring QHPs to include ECPs in their networks within

medically underserved areas (MUA). We would highlight that the federal regulations require QHPs to include ECPs within the plan's *entire* service area. The Exchange could consider requiring QHPs to have more robust ECP networks within MUAs. However, to meet minimum federal requirements, the Exchange must also require QHPs to have a sufficient number of ECPs outside of MUAs.

In addition, the federal regulations make clear that QHPs must include a range in the type of ECPs included in the network. This is why federal law makes clear the ECPs include both 340B and 340B look-alike providers.

- **Nondiscrimination in Network Adequacy:** Federal regulations (45 CFR § 155.1050 (c)) specify that a "QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider" when that provider meets the federal definition of an ECP. We would recommend that Maryland ensure that this requirement is met be clarifying that a QHP may contract with any essential community provider meeting the federal ECP definition. If Maryland expands the definition of an ECP, it could consider specifying that a QHP may contract with any essential community provider meeting the Maryland ECP definition.

More Robust State ECP Requirements

The federal requirements pertaining to ECPs are minimum requirements. The Exchange may want to consider making State requirements more robust. If QHPs have larger number of ECPs in their networks, they will be better equipped to meet the needs of underserved Marylanders. The Exchange could consider strengthening requirements in two ways:

- **Definition of ECPs:** The State could consider expanding the definition of ECPs to include more providers who have traditionally served low-income and Medicaid populations. We understand that one possible definition would include providers who serve a high number of Medicaid beneficiaries and/or provide services for free or on a sliding fee scale to low-income individuals. We would support using this definition as it would ensure that medically underserved populations could continue to receive services from their community-based providers;

- **Network Adequacy:** The Exchange could consider requiring more robust representation of ECPs in provider networks in areas in which individuals have historically encountered access problems. The Exchange could consider these more robust requirements in areas with federal designations, such as medically underserved areas (MUAs), medically underserved populations (MUPs), or health professional shortage areas (HPSAs). In addition, the Exchange could consider including more robust requirements in Health Enterprise Zones (HEZs), a designation currently under development by the Department of Health and Mental Hygiene and the Community Health Resources Commission.

Conclusion

Thank you again for the opportunity to provide comments to the Committee. We appreciate all the work of Committee member and Exchange staff in bringing Maryland to the forefront of implementing the Affordable Care Act. If you should have any questions about our comments, please contact our public policy and governmental affairs consultant, Ms. Robyn Elliott, at (443) 926-3443 or relliott@policypartners.net.

Plan Management Advisory Committee Recommendations

1 message

Nancy Rosen-Cohen <Nancy@ncaddmaryland.org>
To: "tequila.terry@maryland.gov" <tequila.terry@maryland.gov>

Mon, Jul 30, 2012 at 12:01 PM

I am Executive Director of NCADD-MD which represents individuals in recovery.

I would like to strongly recommend that the Network Adequacy standard should include specific requirements that Qualified Health Plans must maintain accurate network listings and must maintain which network providers are accepting new outpatients in a timely manner.

It is essential that consumers understand this so that they can access providers in a clear and concise manner.

Dr. Nancy Rosen-Cohen

Executive Director

NCADD-Maryland

410 625-6482, ext. 101

Donate: United Way Central Maryland

http://www.uwcm.org/uwcm #978181

Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Julian Roberts	**National Association of Vision Care Plans (NAVCP)**	jroberts@navcp.org	**404-634-8911**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	NAVCP has no comment on this element at this time.

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	NAVCP has no comment on this element at this time.
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	NAVCP has no comment on this element at this time.

Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for “qualified” plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	NAVCP supports metal level requirements for dental and vision to be considered with objective of simplicity and clarity in view of the limited nature of these benefits and limited impact on the overall QHP package they may be coupled with. Currently they are not separately identified on the Actuarial Value calculators.

Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	Although dental and vision insurance rates are subject to review under current MD law, the ACA provisions related to review of unreasonable rate increases do not apply to dental and vision. It is not clear how this will be applied to the pediatric essential benefits.
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	NAVCP has no comment on this element at this time.

Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	NAVCP appreciates the recognition of exemption for dental and vision.
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	NAVCP has no comment on this element at this time.
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the “outside” commercial market.	NAVCP has no comment on this element at this time.

Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	NAVCP has no comment on this element at this time.

Quality	The Exchange must evaluate carriers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commision (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	Dental and vision plans likely utilize unique satisfaction surveys and would need to change to the AHRQ enrollee satisfaction survey.

Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	Dental and vision plans do not currently collect and obtain such data and it would be expensive to do so. It would be more efficient for the Exchange to require this information on enrollee application forms and maintain this at the Exchange rather than carrier level. Otherwise both medical QHPs and dental and vision QHPs would be collecting redundant data
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	NAVCP has no comment on this element at this time.

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	NAVCP has no comment on this element at this time.

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment	NAVCP has no comment on this element at this time.

period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	NAVCP has no comment on this element at this time.
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	For simplicity and clarity, it may not be useful for the limited scope pediatric dental and vision benefits to be offered at multiple metal levels.

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	NAVCP's position is that both should be allowed to preserve choice for the individual and small business consumer.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to disclose the price of adult dental/vision benefits to consumers separately?	NAVCP believes that consumers should have the information they need to make an informed choice between stand-alone and embedded benefits. Accordingly, carriers should disclose the price separately.

	The NADP White Paper (recognizing difficulty in gaining consensus on this issue between multi-line and standalone issuers) recommended that pricing transparency can be accomplished through requiring medical QHPs to offer plans without dental, as well as plans with dental. Same would seem to be acceptable for vision. It should be noted that the medical deductible may have an impact on utilization, and thus pricing, of dental or vision services in an embedded model. Accordingly, a separate deductible for dental and vision, whether they are sold embedded or in separate plans, would allow for full transparency in pricing
3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	No, individual carriers should be free to offer vision as a stand-alone if they choose. NAVCP believes that competition and consumer choice will determine which embedded and stand-alone plans will succeed in the Exchange. However, the Exchange should require medical QHPs to offer plans without adult or pediatric dental or vision, so that consumers can purchase coverage through a standalone plan without obtaining duplicative coverage.
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	NAVCP believes that families, just like individual consumers, should have the information they need to make an informed choice between stand-alone and embedded benefits. Additionally, families should have the choice to be in the same network if that is what benefits them and their children. Carriers should disclose their prices for dental and vision so that consumers can weigh whatever additional cost (if any) there may be for choosing one network for all family members.
5) Pediatric Dental/Vision Stand Alone Options	No, individual carriers should be free to offer vision as a

Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	stand-alone if they choose. As mentioned concerning adult benefits, NAVCP's position is that competition and consumer choice will determine which embedded and stand-alone plans will succeed in the Exchange. However, the Exchange should require that medical QHPs that do not provide vision benefits for adults offer plans without pediatric dental or vision. This will allow parents to obtain coverage through standalone plans without buying duplicative coverage.

NASBHC National Assembly on School-Based Health Care
Bringing Health Care To Schools For Student Success

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9989-P
Mail Stop C4-26-05, 7500
Security Boulevard, Baltimore, MD 21244-1850

September 28, 2011

TO: The Department of Health and Human Services
FROM: The National Assembly on School-Based Health Care
Re: CMS-9989-P

School-Based Health Centers Are Essential Community Providers

The National Assembly on School-Based Health Care is grateful for the opportunity to submit comments regarding school-based health centers' (SBHCs) logical and seamless inclusion as essential community providers ("ECP") in the Affordable Insurance Exchanges (§156.235).

The Affordable Care Act requires that an ECP "provide care to predominantly low-income and medically-underserved populations" (Affordable Care Act, Sec. 1311(c)(1)(C)), such as those programs that participate in the 340B Drug Pricing Program. The law does not explicitly limit ECP's to 340B participants.

The Department seeks "to look at other types of providers that may be considered essential community providers to ensure that we are not overlooking providers that are critical to the care of the population that is intended to be covered by this provision … [T]he definition should include other similar types of providers that serve predominantly low-income, medically-underserved populations and furnish the same services as the providers referenced in section 340B(a)(4) of the PHS Act" (76 Fed. Reg. 41866-41929 at 41899).

Our rationale for SBHC inclusion is supported by the following:

(1) Many SBHCs are already eligible to participate (and do participate) in the 340B Drug Pricing Program through their sponsoring organization.
(2) There is legal and historic precedent recognizing SBHCs as an eligible entity under the 340B program.
(3) SBHCs are a part of the health care safety net that the essential community provider definition is intended to encompass.

Every school day, more than 1,900 SBHCs provide access to services to 1.7 million children and adolescents. SBHC users are predominantly members of minority and

ethnic populations who have historically experienced under-insurance, uninsurance, or other health care access disparities. (Strozer, J., Juszczak, L., & Ammerman, A. 2007-2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care: 2010). SBHCs function as a key piece of the health care safety net and ought to be further recognized as such under the Affordable Insurance Exchanges.

(1) Many SBHCs are already eligible to participate (and do participate) in the 340B Drug Pricing Program through their sponsoring organization.

Although many SBHCs are beneficiaries of the 340B drug pricing program by virtue of their medical sponsor (including federally qualified health centers, disproportionate share hospitals, children's hospitals, and sole community hospitals), not all are covered by this designation. Local health departments sponsor 15 percent of SBHCs. School systems sponsor 12 percent of SBHCs. Private nonprofit organizations sponsor 9 percent of SBHCs. It is arbitrary to narrowly define essential community providers as those programs eligible for the 340B program given that all SBHCs serve similar populations of vulnerable, under-insured, uninsured, or publicly insured children and adolescents, regardless of their sponsor.

The Department can eliminate this unnecessary distinction of 340B-eligible versus non-eligible SBHCs by defining all SBHCs as essential community providers.

(2) There is legal and historic precedent recognizing SBHCs as an eligible entity under the 340B program.

In 1992, when the 340B program commenced, there were separate funding streams (and thus separate entity identifiers) for a group of similarly situated programs that included community health centers, migrant health centers, health care for the homeless programs, and public housing primary care programs. SBHCs were included in this group with a “340S” identifier. The Health Centers Consolidation Act of 1996 collapsed the aforementioned entities under Section 330 of the Public Health Service Act; as a group, they were assigned a Consolidated Health Center identifier. Therefore, for four years, from 1992-1996, SBHCs with 340S designation were an independently recognized 340B entity.

Despite the disuse of the 340S designation, SBHCs continue to be grouped with other similarly situated programs as “entities eligible to participate in the PHS 340B Drug Pricing Program.” A 2004 report solicited by HRSA lists 340B-eligible programs, among them “Section 340S school-based programs” (Limpa-Amara, Milliner-Waddell, Frank Potter, and Robert Schmitz. The PHS 340B Drug Pricing Program: Results of a Survey of Eligible Entities. Cambridge, MA: Mathematica Policy Research, 2004). In addition, the HRSA Office of Pharmacy Affairs continues to list School Based Program (Healthy Schools, Healthy Communities) as an “entity type.”

There are a total of sixteen 340B “covered entities” as prescribed by law; however, HRSA recognizes additional organizations eligible for the 340B benefit including SBHCs

(3) SBHCs are a part of the health care safety net that the essential community provider definition is intended to encompass.

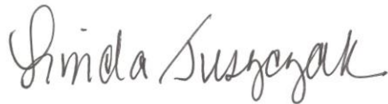
Lastly, the proposed rule notes that “We continue to look at other types of providers that may be considered essential community providers to ensure that we are not overlooking providers that are critical to the care of the population that is intended to be covered by this provision” (76 Fed. Reg. 41866-41929 at 41899). As such, HHS need not be limited

in defining essential community provider solely as the sixteen programs prescribed by law as a 340 Drug Pricing Program "covered entity." Indeed, SBHCs are critical to the care of the population that is intended to be covered by the ECP provision.

Congress continuously recognizes the crucial role SBHCs serve as safety net providers. SBHCs are supported in the Affordable Care Act in two sections: section 4101(a) and 4101 (b). In a press release announcing the issuance of the section 4101(a) $95 million in grants for SBHC capital needs, HRSA administrator Mary Wakefield said, "These grants will improve access to care for children" (HRSA Press Office, "HHS announces new investment in school-based health centers," July 14, 2011; available at http://www.hhs.gov/news/press/2011pres/07/20110714a.html). Section 4101(b) of the Affordable Care Act authorizes appropriations for SBHC operations, with express preference for "Communities with high per capita numbers of children and adolescents who are uninsured, underinsured, or enrolled in public health insurance programs" (section 4101(b), adding Sec. 399Z-1(d)(1)(B) to the Public Health Service Act.

Congress and HHS have been clear: SBHCs expand access to care for vulnerable populations of children and adolescents and function as safety-net providers. We respectfully request that ECP regulations reflect this position by including SBHCs as essential community providers.

Sincerely,



Linda Juszczak, DSNc, MPH, CPNP
Executive Director
National Assembly on School-Based Health Care

Tequila Terry (DHMH) <tequila.terry@maryland.gov>

Plan Management Advisory Committee's Recommendations

1 message

Linda Friskey <lindafriskey@comcast.net>
To: tequila.terry@maryland.gov

Tue, Jul 31, 2012 at 12:52 PM

I am a Columbia, Maryland resident and am a licensed clinical social worker practicing in Columbia. I believe that QHPs must demonstrate compliance with federal Mental Health Parity Law and must set clear standards for network adequacy requirements, neither of which is adequately addressed in the Summary Report. Sincerely, Linda Friskey, LCSW-C

Tequila Terry (DHMH) <tequila.terry@maryland.gov>

Plan Management Advisory Committee's Recommendations URGENT

1 message

Kristina MacGaffin <kmacgaffin.macgaffin@gmail.com> Tue, Jul 31, 2012 at 9:51 AM
To: tequila.terry@maryland.gov

As a Maryland resident and concerned clinical social worker, I believe that Qualified Health Plans (QHPs) must demonstrate compliance with federal Mental Health Parity Law, and that there must be clear standards for network adequacy. Neither of these important requirements is adequately addressed in the Summary document.

This is URGENT

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Kristina C. MacGaffin, MSW, FIPA
kmacgaffin.macgaffin@gmail.com
410 886 2636: Tilghman, MD office
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PO Box 340
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Tequila Terry (DHMH) <tequila.terry@maryland.gov>

Plan Management Advisory Committee's Recommendations

1 message

Irene Walton <irenewalton@gmail.com> Tue, Jul 31, 2012 at 9:49 AM
To: tequila.terry@maryland.gov

Dear Ms. Tequila,

I am writing to express my concern about the requirements for participating insurers in the Qualified Health Plans. In particular I am concerned about two things.

1. I believe that Qualified Health Plans (QHPs) must demonstrate compliance with federal Mental Health Parity Law.
2. There must be clear standards for network adequacy.

Neither of these important requirements is adequately addressed in the Summary document.
As a resident of Maryland and Social Worker working on Maryland I know how difficult it can be for people with mental health problems to find adequate, affordable treatment. Insurance companies often say that they offer it, but when one actually tries to access it is out of reach financially and/or there are no available providers accepting patients.

Thank you,

Irene Walton, MSW, LCSW-C

--
Irene Walton, LCSW-C
Individual and Couple's Therapy
301-589-0209
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Tequila Terry (DHMH) <tequila.terry@maryland.gov>

Plan Management Advisory Committee's Recommendations

1 message

Brooke Morrigan <spiritbear@rcn.com> Tue, Jul 31, 2012 at 3:17 PM
To: tequila.terry@maryland.gov

As a Maryland resident and concerned clinical social worker, I believe that Qualified Health Plans (QHPs) should be required to demonstrate compliance with the federal Mental Health Parity Law, and that there must be clear standards for network adequacy. Neither of these important requirements is addressed in the Summary document.

Thank you.

Brooke Morrigan, LCSW-C, LICSW

8830 Cameron Street

Suite 207

Silver Spring MD 20910

Tequila Terry (DHMH) <tequila.terry@maryland.gov>

Summary of Stakeholder Feedback

1 message

Pat Hanberry <phanberry@fcmha.org> Mon, Jul 30, 2012 at 4:00 PM
To: tequila.terry@maryland.gov

Dear Ms. Tequila –

I have reviewed the Plan Management Advisory Committee's Summary Report to the Maryland Health Benefit Exchange Board.

As the CEO of a mental health organization, I would like to see two additional points emphasized.

First, it is important that an additional plan certification standard be added which explicitly requires compliance with the Mental Health Parity and Equity Act, which is included in the Federal Accountable Care Act.

Secondly , the URAC's standards include the requirement to be compliant with the Mental Health Parity Act; the NCQA standards do not include this requirement. I believe it is important for providers to be held to the same accreditation standards, and that the standards should include compliance with MHPAEA.

Thank you for what must have been a tremendous amount of work that you put into the development of this document.

Pat Hanberry

Please note our new address:

Patricia G. Hanberry, CEO

Mental Health Association of Frederick County

226 South Jefferson Street, Frederick, MD 21701

Direct: (240) 215-0415 Main: (301) 663-0011

Fax: 301-663-5738

Building a Strong Foundation of Emotional Wellness

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Penny Anderson Executive Director	**Maryland Dental Action Coalition**	**panderson@mdac.us**	**410-884-8294**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	

Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for "qualified" plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	Adult dental coverage is a priority for MDAC. If coverage is not included in the Essential Health Benefits package, we would suggest that the Exchange consider whether current or future standards for QHP's could increase coverage of adult dental services.

Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	Does the "MIA current policy" comply with ACA requirements regarding benefit reporting? The information submitted by carriers should be easily understandable and transparent.
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	For dental plans, we believe that whether plans are bundled or stand-alone, they should be evaluated for adequacy in three areas: Volume - number of providers to assure that services are accessible without reasonable delay Specialty – number of providers of specialty services (pediatric dentists, orthodontists, etc.) to assure that services are accessible without reasonable delay Geography – arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients Additionally, there should be an ongoing monitoring process to ensure sufficiency of the network for enrollees.

			There should also be a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider who can provide that service is accessible in a timely manner.
Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	Consideration should be given to contracting with Essential Community Providers in not only the MUA's, but also the Health Professional Shortage Areas (HPSA) and the newly developing Health Enterprise Zones (HEZ's). Additionally, expanding the definition of essential community providers to include school-based health centers and other safety net providers will enhance provider networks. QHPs should be required to maintain provider networks that include a sufficient number of essential community providers to provide services to these areas within the QHP's service area.
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the "outside" commercial market.	

Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	Dental plan details should be easily available and understandable to all consumers, whether the plan is bundled or stand-alone. Details about the services included and the cost of the plan should be completely and totally transparent, and should be monitored and verified by the Maryland Insurance Administration.

Quality	The Exchange must evaluate carriers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commision (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey The existing MHCC quality reports for the commercial health plan market can be found:	The dental industry currently lacks nationally-standardized quality measures and data. However, many dental insurers and care management companies have implemented quality improvement strategies, diagnostic codes, and quality measures on their own. Additionally, organizations such as the National Quality Forum have approved dental quality measures and the Dental Quality Alliance (established by the American Dental Association) is currently focusing on developing dental quality measures. There is a clear need for these quality improvements and quality measures to ensure quality care, improved health outcomes and reduced costs for insurers and patients. Until such time as quality measures are adopted, dental plans should be required to report on their incorporation of, and compliance with, the National Committee for Quality Assurance (NCQA) dental quality measures. A review of evidence-based best practices regarding quality measures, and progress toward adoption of industry standards, should be monitored annually and assessed for implementation by the Exchange. As an organization with strong linkages to local, state and national providers, regulatory and policy organizations, both public and private, MDAC is well suited to spearhead such a process.

		http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	
Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	The Plan Management Advisory Committee should be allowed to review the findings of the Continuity of Care Advisory Committee so that appropriate "input on this topic" can be incorporated into the certification requirements for Qualified Health, Dental and Vision Plans.

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information	

• Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require	

corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	Adult dental benefits should be allowed to be embedded with a qualified health plan as long as the benefits and related costs are detailed and easily available to consumers. Stand-alone plans should also be offered if carriers so choose and should be subject to the same

	transparency standards.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to disclose the price of adult dental/vision benefits to consumers separately?	Yes, see response immediately above.
3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	No, not necessarily. If they choose to do so, fine, but it should not be required.
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	Yes, all benefit and cost information should be disclosed.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	No, but carriers should be able to offer them as stand-alone plans if they so choose.

Per earlier written testimony to the Maryland General Assembly and to the Health Benefit Exchange, MDAC is committed to the assurance of consumer protections for all plans, stand-alone or bundled, and implementation of transparency standards regarding the details of all plans.

Maryland School Based Health Center Policy Advisory Council

July 31, 2012

Maryland Health Benefits Exchange
Plan Management Advisory Committee

Dear Committee Chairs and Members:

The Maryland School Based Health Center Policy Advisory Council (SBHC PAC) welcomes the opportunity to submit comments to the Plan Management Advisory Committee. The SBHC PAC is established in COMAR to support coordination of interagency efforts and quality school based health centers in Maryland.

We wish to call attention to School Based Health Centers, important safety-net providers of primary health care to underserved children and adolescents. Because of their location, in schools or on the school campus, in underserved communities, they provide unique access to primary health care for difficult to reach and minority populations. There are 71 school based health centers in Maryland. Nurse practitioners, social workers, physicians, dentists and other health care personnel provide primary health care, oral health and mental health services, with a focus on prevention. There were 27,739 students in Maryland that had access to primary health care at school based health centers in their schools during 2010-11. National data shows that school based health centers effectively contribute to the reduction of hospital and emergency utilization and costs, and a reduction of medical assistance expenditures. School Based Health Centers help keep children in school and allow parents to minimize lost time from work. Medicaid standards recognize School Based Health Centers as approved medical providers and include non-physician providers in their networks.

We encourage the Committee's consideration of two recommendations:

- **Expand the definition of essential community provider to include School Based Health Centers.** We understand that states may opt to expand beyond the federal definition and encourage Maryland to do this. School Based Health Centers are essential to providing health care access to underserved and minority populations.
- **Include non-physician providers in the QHP networks.** Nurse practitioners and other mid level providers currently serve as the primary care providers at school based health centers and many other care facilities. We urge that Maryland recognize all health care providers (both physician and non physician) and include them in the QHP networks.

Additionally, it is anticipated that there will be significant movement of patients between Medicaid and the Exchange plans. We encourage the Committee to consider the impact of the standards that the Committee recommends for maintaining and encouraging continuity of care as patients move between Medicaid and the Exchange plans.

We appreciate the work of the Committee and thank you for your consideration of our comments. If you have any questions you may reach me at 301 651 4858 or covich@comcast.net

Sincerely,

Judith R. Covich, RN, BSN, MA
Chairperson

Tequila Terry (DHMH) <tequila.terry@maryland.gov>

PMAC Public Comments from Maryland Psychiatric Society

1 message

Steve Daviss MD <drdaviss@gmail.com> Tue, Jul 31, 2012 at 11:36 PM
To: Tequila Terry <tequila.terry@maryland.gov>

Tequila,
Thank you for the opportunity to submit public comments about the Plan Management Summary.

The Maryland Psychiatric Society, representing over 700 psychiatrists, is very interested in the development and design of Maryland's Health Benefit Exchange program. There are so many people who lack adequate access to care for their mental health and addiction problems, and we hope that the Exchange will expand access and reduce suffering.

The MPS hopes that the Exchange Board will address three important deficiencies in the current Plan Certification criteria. These three main points each relate to federal and state requirements of the Exchanges that are not adequately addressed in the Plan Certification criteria.

1. The Plan Management Advisory Committee Summary Report lists under Plan Certification twelve (12) standards (Licensure & Solvency, Benefit Design, etc) that are each based on Federal Requirements listed in the Accountable Care Act. *One important Federal Requirement standard is missing: the ACA requires QHPs to be compliant with the Mental Health Parity and Addiction Equity Act (MHPAEA)*. This requirement is also included in the Maryland Health Benefit Exchange Act signed by the Governor this year.
A thirteenth standard should be added to the Plan Certification section requiring "demonstration of compliance with MHPAEA".

2. Under Plan Certification, the Accreditation standard indicates acceptance of either *NCQA or URAC accreditation*. URAC updated its standards this year to include detailed requirements to plan for and demonstrate compliance with the Mental Health Parity Act (MHPAEA); however, NCQA has not yet done so and it is unclear if or when it will update its standards. QHPs who use either NCQA or URAC accreditation would thus be held to different standards. To maintain equivalence, and to reduce the compliance monitoring load on MIA, **the Accreditation requirement should either use only URAC accreditation, or it should include the detailed standards developed by URAC as a requirement for all QHPs.** This would also reduce adverse selection between plans using differing accreditations.

3. Under Plan Certification, the Network Adequacy standard includes *inadequate initial requirements for adequacy of the provider network*. If networks appear to be similar in size and geography between two QHPs, but the network listing in one QHP is more accurate than the other, then the consumer will not learn of this imbalance until he or she attempts to access providers in the network. Only then will they learn that there is a much smaller number of actual providers who are actually accepting new patients. This goes against the Transparency standard, while also potentially contributing to adverse selection. **The Network Adequacy standard should include specific requirements that (a) QHPs must maintain accurate network listings and (b) QHPs must maintain current indicators of which network providers are currently accepting new outpatients in a timely manner.** This latter requirement is also a Federal Requirement under the ACA.

The MPS thanks the Exchange Board for its careful attention to these three areas. The DHMH Behavioral Health Integration Data Committee recently released 2011 data for HealthChoice enrollees showing that adults with mental health and addiction diagnoses were hospitalized for medical conditions (e.g., asthma, diabetes) up to **15 times more frequently** than adults with neither condition, costing in excess of $83M annually. Requiring full mental health parity

and truly transparent and accurate provider networks for the exchanges will go far in reducing these extraordinarily high excess costs by treating people earlier so that they can better manage their chronic health problems and stay out of the hospital more often.

Sincerely,

Steven R. Daviss, MD, DFAPA
MPS Assembly Representative to the APA
410-625-0232

To: Plan Management Advisory Committee

From: Ed Suddath, Executive Director

RE: Public Comments on Plan Certification

Date: July 31, 2012

Thank you for the opportunity to comment on the Plan Certification standards. The Maryland Nurses Association (MNA) appreciates the efforts of Committee members and the Exchange to ensure that Maryland is in the forefront of implementing the Affordable Care Act.

The Maryland Nurses Association (MNA) has been supportive of efforts to ensure that all registered nurses can play a role in the success of health reform implementation. The work of the Plan Management Committee offers an opportunity to specifically highlight the importance of Advanced Practice Registered Nurses (APRNs), including Clinical Nurse Specialists, in establishing network adequacy standards and the definition of essential community providers.

Network Adequacy Standards

Advanced Practice Registered Nurses (APRN) play a critical role in ensuring access to primary care in Maryland. In considering network adequacy standards, MNA would recommend that the Committee consider whether those standards support the inclusion of APRNs as primary care providers in the networks of qualified health plans (QHPs).

We understand that the Committee is considering two different models for network adequacy standards: 1) commercial market standards; and 2) Maryland Medicaid standards. In the Committee's consideration of these options, MNA would like to highlight some observations for your consideration.

MNA thinks that Medicaid might be a good starting point for developing network adequacy standards. Commercial standards are largely up to individual carriers. Thus the standards for commercial plans vary widely. Medicaid standards, required of all managed care organizations, offer a better model of ensuring that QHPs uniformly have strong provider networks.

Medicaid standards were developed, in accordance with federal regulations, to support access to care for individuals who have faced many barriers in obtaining health care services. We think it makes sense to develop strong network adequacy standards for QHP because: 1) QHPs will be serving individuals who also have been uninsured and underserved, and thus there will be a strong pent-up demand for services; and 2) QHPs will be serving a large number of

individuals who are churning between Medicaid and the Exchange. Those individuals would be better served if the networks of QHPs were similar to the Medicaid managed care networks.

If the Committee recommends using Medicaid standards as the starting point for QHPs, MNA would suggest that the Committee consider strengthening the requirements regarding APRNs. Currently, Medicaid standards permit MCOs to include APRNs in the definition of primary care providers. For QHPs, MNA would suggest that standards **require** APRNS to be included in the definition.

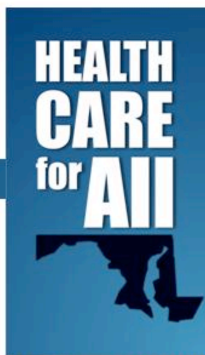
Essential Community Providers

The Committee is considering options for establishing requirements for essential community providers (ECPs) for inclusion in QHP networks. Federal regulations allow States to expand the definition of essential community providers to include other providers that States consider to be important in ensuring medically underserved individuals have access to care. MNA would like to suggest three additional provider types for the Committee to consider including in the ECP definition:

- School-Based Health Centers: These health centers are essential providers of primary care and mental health services in communities across Maryland. Maryland should ensure that they are included in QHP networks;
- Free Standing Birth Centers: The ACA supports free standing birth centers by requiring Medicaid reimbursement for those centers. It makes sense to ensure that QHPs include these centers in their networks:;
- Nurse Managed Health Clinics: The ACA supports the development of nurse managed health clinics through funding from the Health Resources and Services Administration. These clinics provide essential services to medically underserved individuals, and therefore, it makes sense for QHPs to include these centers as part of their networks.

Conclusion

Thank you for the opportunity to submit these comments. All MNA members greatly appreciate the work of the Committee and the Exchange. If you should have any questions, please contact our legislative representative, Ms. Robyn Elliott, at (443) 926-3443 or relliott@policypartners.net.



2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

Maryland Exchange Plan Management Committee: June 2012 Recommendations from the Maryland Citizens' Health Initiative Education Fund, Inc.

1. Nondiscrimination

Federal regulations issued in March 2012 prohibit qualified health plans (QHPs) and QHP issuers from discriminating against any QHP consumer on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity.[i]

To ensure that Maryland's QHPs and QHP issuers comply with these regulations, the Plan Management Committee should recommend the inclusion of the following nondiscrimination provisions in the state's QHP certification standards. *Note: it is advisable that the committee recommend to the Maryland Insurance Administration and the Maryland Health Care Reform Coordinating Council that these nondiscrimination standards also be applied to all plans based on the essential health benefit standard, both inside and outside the exchange, in order to protect the exchange from adverse selection and to protect consumer access to the essential benefits.*

a. **Notify QHP issuers that, with respect to their QHPs, they may not arbitrarily discriminate in any of their activities against any consumer on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity.**

This proposed standard implements the nondiscrimination requirements in federal regulations and is essential to ensuring the exchange serves all Marylanders equally. This rule includes activities such as marketing, outreach, rate setting, benefit design, conditions of coverage, and coverage determinations by QHP issuers with respect to their QHPs.

For example, QHP issuers may not deny transgender enrollees coverage for benefits offered to similarly situated nontransgender consumers, as this would constitute unlawful discrimination on the basis of gender identity. Similarly, plans that offer spousal benefits for different-sex couples must offer identical plans to same-sex couples whose relationships are recognized under Maryland law.

b. **Prohibit arbitrary condition-based exclusions in QHPs.**

Affordable Care Act Section 1302(b)(4) establishes nondiscrimination requirements for plans offering the essential health benefits. This necessarily includes QHPs, as all QHPs must cover the essential benefits. According to this section, the Secretary of Health and Human Services (and, by extension, the states, since states must submit their essential benefit standards to HHS for approval) shall—

> (B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their

age, disability, or expected length of life;
(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life…

The 2011 Institute of Medicine report on the essential benefits clarifies that Congress intended "to ensure that insurers do not make arbitrary and discriminatory decisions based on certain characteristics of people rather than assessing the individuality of each case when making medical necessity decisions and applying clinical policies."[ii]

Implementing this standard requires reasonable limits on the use of condition-based exclusions. Specifically, the Plan Management Committee should recommend that QHP issuers be prohibited from using *arbitrary* condition-based exclusions as utilization management tools in their QHPs. Under this ban on arbitrary condition-based exclusions, carriers will still be permitted to exclude coverage for benefits that are not medically necessary, that are experimental, or that are comparatively more expensive than other treatments. A prohibition on arbitrary condition-based exclusions simply prohibits QHP issuers from discriminating in coverage of otherwise included plan benefits solely on the basis of diagnosis or medical condition, without a reasonable justification.

Model language:

(a) NO DISCRIMINATION IN ENROLLMENT OR COVERAGE. Any issuer certified by the Exchange as a Qualified Health Plan issuer shall not, with regard to a Qualified Health Plan, refuse to insure, refuse to enroll, refuse to continue to insure, refuse to renew insurance, cancel insurance, or limit the amount, duration, or scope of coverage or benefits available to an individual in a manner arbitrarily discriminating on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, disability, diagnosis, or medical condition.

(b) NO DISCRIMINATION IN RATE SETTING OR UNDERWRITING. No issuer certified by the Exchange as a Qualified Health Plan issuer shall, with regard to a Qualified Health Plan, permit arbitrary discrimination against an applicant or an insured individual on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, disability, diagnosis, or medical condition with regard to:

(1) Underwriting standards and practices or eligibility requirements; or
(2) Rates; however, nothing in this subdivision shall prevent any person who contracts to insure another from setting rates for such insurance in accordance with reasonable classifications based on relevant actuarial data or actual cost experience.

(c) LIMITATION ON CONDITION-BASED EXCLUSIONS. No issuer certified by the Exchange as a Qualified Health Plan issuer shall, with regard to a Qualified Health Plan, arbitrarily deny or reduce the amount, duration, or scope of an otherwise covered benefit solely because of the diagnosis, type of illness, or condition for which such benefit is sought. This section shall not be construed to prohibit a limitation or exclusion of coverage based on criteria of medical necessity, appropriateness, or comparative cost effectiveness.

c. Require QHP issuers to incorporate a statement in their QHP materials affirming that the plan provides coverage for all essential health benefits deemed medically necessary for the insured individual, without arbitrary discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, diagnosis, or medical condition.

This statement should include information for consumers about their rights to grievance and appeals processes available under state and federal law. For example, Affordable Care Act Section 1557 allows consumers to sue in federal court or file a complaint with the Office for Civil Rights at the Department of Health and Human Services alleging discrimination by any exchange actor on the basis of race, color, national origin, age, disability (including HIV status), or sex. A trend in case law and federal agency policies, including the Equal Employment Opportunity Commission, interprets the sex protections available under federal law to include gender identity and sex-based stereotypes.

Model language:

(a) ASSURANCE OF NONDISCRIMINATION IN COVERAGE. Any issuer certified by the Exchange as a Qualified Health Plan issuer shall provide affirmation, in Qualified Health Plan documents, that such issuer shall not utilize arbitrary exclusions, limitations, or reductions in the amount, duration, or scope of coverage or benefits available to an insured individual in a manner arbitrarily discriminating on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, diagnosis, or medical condition.

(b) ASSURANCES RELATED TO USE OF CONDITION-BASED EXCLUSIONS. Any issuer certified by the Exchange as a Qualified Health Plan issuer shall provide affirmation, in Qualified Health Plan documents, that such issuer shall not arbitrarily deny or reduce the amount, duration, or scope of an otherwise covered benefit solely because of the diagnosis, type of illness, or condition for which such benefit is sought. This requirement shall not be construed to prohibit a limitation or exclusion of coverage based on criteria of medical necessity, appropriateness, or comparative cost effectiveness.

2. Data Collection

Comprehensive and reliable data on exchange enrollee demographics and QHP performance are crucial underpinnings of effective plan design and management.

To ensure that QHPs in Maryland's exchange are prepared to optimally serve diverse consumer populations, the Plan Management Committee should recommend the inclusion of the following data collection provisions in the state's QHP certification standards.

a. Require QHP issuers to collect and report information on the race, ethnicity, primary language, sex, disability status, sexual orientation, and gender identity of their QHP enrollees.

Recognizing the importance of data for advancing health reform efforts, Affordable Care Act Section 4302 requires federally supported health surveys and programs to collect information on race, ethnicity, sex, primary language, and disability status, as well as any other factors deemed relevant to health disparities. In response to the March 2011 Institute of Medicine report that recommended the routine collection of demographic and health data on LGBT populations in order to address LGBT health disparities,[iii] the Secretary of Health and Human Services has used the authority granted by ACA Section 4302 to initiate a process for also collecting information on sexual orientation and gender identity on federal surveys.[iv] This initiative buttresses existing efforts by numerous divisions across the Department of Health and Human Services to collect confidential sexual orientation and gender identity information from program participants.

Collection of this range of demographic data will enhance the ability of Maryland's exchange to assess health disparities in the exchange population, promote better understanding of the diverse backgrounds of exchange consumers, help monitor compliance with nondiscrimination requirements, and facilitate the functioning of other operations of the exchange, including outreach, consumer assistance, and navigator programs.

This information should be collected through claims data and optional questions on plan enrollment forms and should be subject to the same rigorous privacy protections as other sensitive health information.

b. Require QHP issuers to collect and report information on the cultural competency initiatives of its QHPs.

In order to measure the quality and performance of QHPs, Maryland's QHP certification standards should also require QHP issuers to collect and report information on the cultural competency initiatives they incorporate into the care provided to enrollees in their QHPs. An example of such an initiative is Kaiser Permanente's National Diversity Department, which includes Centers of Excellence in Culturally Competent Care and the Institute for Culturally Competent Care (ICCC). The department oversees a range of cultural competency initiatives for Kaiser providers and enrollees focused on "cultural groups who share beliefs, practices, and values based on race, ethnicity, sex, religion, age, disability, sexual orientation, gender identity, and other characteristics."[v] According to the ICCC, "Acknowledging and understanding a patient's cultural values can lead to effective communication, promote treatment adherence, and positively affect health outcomes."

3. Mental Health Parity

Affordable Care Act Section 1311(j) requires QHPs to comply with federal mental health parity requirements, and mental and behavioral health services are among the ten categories of services that must be covered as part of each state's essential health benefit package.

To ensure that QHPs achieve parity in the provision of mental and behavioral health services, the Plan Management Committee should recommend the inclusion of the following mental and behavioral health parity provision in the state's QHP certification standards.

a. Require QHPs to comply with the mental and behavioral health parity provisions of the Affordable Care Act.

Ensuring that QHPs comply with mental and behavioral health parity requirements is critical to promoting the highest standard of health for all QHP consumers, particularly those from disadvantaged populations that are disproportionately impacted by mental and behavioral health conditions.

For example, sources such as the Institute of Medicine,[vi] Healthy People 2020,[vii] and the *National Healthcare Disparities Report* from the Agency for Healthcare Research and Quality[viii] report that LGBT people, particularly LGBT people of color, are more likely than the general U.S. population to face significant health disparities. These disparities include higher rates of substance use and mental health concerns such as depression, anxiety, and suicide. Enforcing parity in QHPs will allow LGBT individuals and other Maryland exchange consumers to access the mental and behavioral health care services they need, which will promote individual health and wellness, reduce population-level disparities, and help control the high costs of untreated mental and behavioral health conditions.

4. Network Adequacy

Underserved (and overlapping) populations such as LGBT people, racial and ethnic minorities, and rural communities frequently face significant financial, physical, cultural, and other barriers to appropriate health care services. To address these barriers, federal regulations require the exchanges to ensure that certified QHP issuers maintain a provider network "sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[ix]

To ensure that QHPs maintain provider networks sufficient to serve diverse consumer populations, the Plan Management Committee should recommend the inclusion of the following network adequacy provision in the state's QHP certification standards.

a. Require QHPs to maintain provider networks that are adequate to serve Maryland's diverse population of exchange consumers, without unreasonable barriers or delays in receiving clinically appropriate and culturally competent care.

Examples of network adequacy standards may include:

1. Require QHP provider networks to include specialists in the management of complex conditions such as HIV/AIDS and diabetes.

2. Require QHP provider networks to include providers that are culturally competent in working with diverse populations, such as the providers listed in the Gay & Lesbian Medical Association's provider directory (https://glmaimpak.networkats.com/members_online_new/members/dir_provider.asp).

3. Require QHP provider networks to include a variety of provider types, including primary care providers, specialists, and non-physician providers.

5. Essential Community Providers

March 2012 federal regulations require certified QHPs to provide access to a sufficient number of essential community providers (ECPs), including those with experience serving low-income and medically underserved populations, to ensure "reasonable and timely access" to health care services.[x]

To ensure that QHPs in Maryland's exchange provide adequate access to a range of essential community providers, the Plan Management Committee should recommend the inclusion of the following ECP provision in the state's QHP certification standards.

a. Require QHPs to maintain provider networks that include essential community providers who are culturally and clinically competent to serve diverse populations.

Examples of essential community provider standards, which reflect those in federal regulations, include:

1. Require QHP provider networks to include a sufficient number of providers offering comprehensive care for people living with HIV/AIDS, including Ryan White providers.

2. Require QHP provider networks to include facilities with experience serving underserved populations, such as federally qualified health centers and other community health centers.

6. Coordination of Care

QHP certification is a key opportunity for Maryland's exchange to promote improved clinical care and patient outcomes by establishing standards for coordination of care. Coordination of care is particularly important for people with disabilities, people with complex chronic conditions such as HIV/AIDS or diabetes, and individuals and families with limited access to a steady source of insurance coverage.

Coordination of care will be important to Maryland's exchange enrollees both in terms of care provided to an individual over time (related to continuity of care) and various clinical services needed by an individual patient at the same time. For example, individuals who experience churning between the exchange and Medicaid coverage will need their care to be coordinated over time to promote optimum health outcomes and seamless access to high-quality services. For enrollees who need a variety of simultaneous treatments, such as those with cancer, plans must also promote coordination of care across providers treating the individual at a given time in order to prevent contraindications, avoid duplicate services, and promote positive long-term health outcomes.

To ensure that QHPs in Maryland's exchange promote coordination of care, the Plan Management Committee should recommend the inclusion of the following care coordination provision in the state's QHP certification standards.

a. Require QHPs to implement policies promoting coordination of care.

Examples of care coordination policies include:

1. Require QHPs to maintain continuously updated clinical protocols and lists of providers for the management of a range of disease- and condition-specific treatment referrals. These protocols should be considered guidance rather than prescriptive one-size-fits-all requirements for the management of any particular condition.

2. Require QHPs to build information systems that allow participating providers to easily track, manage, and report referrals and care transitions, including specialty consults, hospitalizations, ER visits, and prescription drug information.

Thank you for your leadership and for the opportunity to submit these comments. We welcome the opportunity to discuss these issues further with you as the committee prepares their recommendations.

Sincerely,

Matthew Celentano
Deputy Director

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[i] 45 CFR 156.200
[ii] Institute of Medicine. 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx
[iii] U.S. Office of Minority Health. 2011. "Improving Data Collection for the LGBT Community." Available at http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=209&id=9004
[iv] Institute of Medicine. 2011. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Available at http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay- Bisexual-and-Transgender-People.aspx
[v] Chong N. 2002. "A Model for the Nation's Health Care Industry: Kaiser Permanente's Institute for Culturally Competent Care." *The Permanente Journal* vol. 6, no. 3.
[vi] Ibid.
[vii] Department of Health and Human Services. 2010. "Healthy People 2020 Topic Area: Lesbian, Gay, Bisexual, and Transgender Health." Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25
[viii] Agency for Healthcare Research and Quality. 2012. *National Healthcare Disparities Report*. Available at http://www.ahrq.gov/qual/nhdr11/nhdr11.pdf
[ix] 45 CFR 156.230
[x] 45 CFR 156.235

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July 31, 2012

Plan Management Committee

To the committee:

MCHI submitted comments to the Plan Management Advisory Committee prior to the meeting in June. In those comments, we underscored the importance of the committee's attention to strong non-discrimination standards for qualifying health plans (QHPs) and comprehensive data collection strategies. We also offered model language for the committee's consideration relating to ensuring mental health parity, continuity of coverage and network adequacy. These issues are of particular importance to people identifying as lesbian, gay, bisexual, or transgender as well as racial and ethnic minorities or those with pre-existing conditions--all populations that are currently more likely to be uninsured and likely to gain coverage in the Exchange.

To supplement these earlier comments and address issues that have been raised in subsequent meetings of the committee, we would like to raise additional issues:

Policy Area 1: Plan Certification
e. Network adequacy

Federal Requirement: Carriers are required to maintain provider networks that are sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delays.

Proposed Exchange Policy: The Exchange will use the MIA current policy to allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet carrier-specific requirements. In 2015 and beyond, the Exchange will determine if Exchange specific standardized network requirements are appropriate.

The uninsured population that is the primary target for enrollment in the exchange is on average lower income than the insured population and by definition those who qualify for the tax subsidies and must buy through the exchange to receive those subsidies are below 200 percent of the poverty level. It is expected that at minimum this population will have pent up demand for basic services and segments of the population may have specific health needs, such as behavioral health and substance abuse services. We want carriers to insure a population that has not traditionally had insurance and so I would not expect their standard provider networks to be set up to serve this population.

Market forces are powerful way to increase public welfare in many areas, but in the case of insurance networks the underlying market forces will work to exactly the opposite result of what is desired public policy. Those persons who are relatively healthy will not care so much about an extensive network or specialty providers and probably just pick the lowest cost plan. The uninsured who are often called 'young invincibles' (that now will pay a penalty if they don't have insurance) are the most desirable population for a carrier to get. They will pay premiums and not use many if any services. Those persons with a specific health need will and should look for providers to meet that need that are open to new patients and geographically accessible. A health plan would be crazy to be the only health plan offered that has a wide network of primary care and special needs providers geographically accessible to a potentially sicker population with pent up health needs. Risk adjustment may not make them whole.

There is, in our opinion, the potential for adverse selection within the exchange based on network designs. The more network adequacy standards are in place the greater chance the most vulnerable of the target population will be served and the selection biases would be reduced within the exchange. We understand that the more the exchange looks different from the outside market there is the possibility for adverse selection to the exchange as a whole. The availability of the subsidies only inside the exchange will help but not eliminate this risk. However, on balance we believe the network adequacy requirements need to be strengthened. If possible we suggest that data on the location of the uninsured (at census track level if possible) be mapped and the networks of the carriers, particularly the primary care providers, be overlaid on the uninsured map to assure that networks are as much as possible meeting these needs and not avoiding these areas. It will be hard work to increase capacity in medically underserved areas and health professional shortage areas, and we would hope that the carriers will rise to the challenge with innovation and not just say 'there are no doctors there we can contract with'.

Transparency Data

We want to echo a point that was raised in the plan management committee report on medical management policies and reasons for denials. For consumers who purchase insurance and then have the care that their doctor recommended denied by a health plan is probably the most frustrating and aggravating experiences. We understand that medical management is necessary to control costs and when done well eliminates unnecessary care. However, the practice of medicine is constantly evolving and what may be unnecessary for one individual may be a truly needed and effective treatment for another. As a beginning, we would like to see more transparency on what the medical management policies are and the process by which they get made. This is too important an area for health plans to shroud in a veil of 'proprietary data'.

Policy Area 1: Plan Certification
b. Marketing Standards

- All marketing material including those in other languages or adjusted for accessibility by the vision (e.g. large print) and hearing impaired should be submitted and assessed.

Policy 4: Consumer Plan Choice Architecture

a. Standardization of Plans

We support the proposed exchange policy to define a baseline benefit design that carriers would be required to offer at each metal level in addition to other benefit designs they may propose. We believe some degree of standardization will help reduce consumer confusion when selecting a plan. The

baseline plan would need to be selected carefully and possibly revised in the future if we find that consumers do not chose it.

b. Carrier submission limits

We also support the proposed exchange policy to limit the number of benefit designs per metal level that a carrier could offer. The actual number allowed could be greater than 3 but the principal of not having an overwhelming number of plans is a good one.

Dental and Vision Plan Presentment

Dental

Consumers want meaningful choice and clear pricing to make comparisons. In the long run a fair market for dental plans will be the best way to keep prices low because it will allow completion between plans. We believe that stand-alone dental plans should be allowed in the exchange and that carriers that offer dental plans in addition to their medical plans should clearly separate the additional cost for the dental coverage so this can be compared fairly to the stand-alone dental plans. If they choose medical carriers, should be allowed to offer stand-alone plans that are not contingent on purchase of their medical product. We believe this most closely mimics what currently occurs in the private market. While outside the scope of the committee's task, we believe that a regulatory structure to assure the pricing of dental plans is fair is needed. The state could impose a medical loss ratio requirement on dental plans as the ACA does on medical plans. Other consumer protections for dental plans should also be considered.

Vision

Stand-alone vision plans don't exist in the individual market currently for reasons related to the size of the benefit and selection bias by those who need the services. It would make sense to allow adult vision services to be offered by carriers as an add-on to their medical benefit. The price of the vision benefit should be clear and reflect the true cost of the added service.

Policy Area 1: Plan Certification

b. Marketing Standards

- All marketing material including those in other languages or adjusted for accessibility by the vision (e.g. large print) and hearing impaired should be submitted and assessed.

***

Thank you again for the opportunity to submit comments for consideration. In addition to our earlier comments and the comments we're submitting today, we have signed on to the document submitted by the Maryland Women's Coalition. In that regard, we'd like to offer clarification that the recommendation that states "Require QHPs to contract with all essential community providers (ECP) within a medical underserved area (MUA) and health professional shortage area (HPSA)" may be too strong at this point in the implementation process. While we agree with the spirit of the recommendation, that QHPs should have ECPs in their networks, we believe that requiring QHPs to contract with all ECPs is too heavy handed at this time. First, ECPs, as you note, have not been defined and should be expanded beyond the HHS regulations to include places such as school based clinics. Second, ECPs may not be ready or able to contract with health plans. Billing for services on a claim form is a very different way of operating compared to grant funding. While the implementation of managed

care within the Medicaid program has increased the capacity of many ECPs to work with claims and health plans, all ECPs, especially if the definition is expanded, may not be ready. Also, health plans have a responsibility to credential providers as part of their quality assurance programs and this may be a new process for some ECPs. The inclusion of ECPs in health plans is needed, but a successful process by which this happens will require more a more nuanced facilitation where both sides learn how to work with each other and make accommodations.

Sincerely,

Matthew Celentano
Deputy Director

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July 31, 2012

Dear Plan Management Committee:

The Maryland Assembly on School-Based Health Care (MASBHC) has been following the work of the Maryland Health Benefit Exchange and applauds the progress that has been made thus far. We appreciate the opportunity to submit comments to the Committee for consideration in regards to two components of plan certification standards: essential community providers and network adequacy standards.

Essential Community Providers

As you know, the 71 school-based health centers across Maryland provide essential health care services, including primary care, oral health and mental health services, to underserved children and youth. We are an essential part of the provider network for children in Maryland. During the 2010-2011 school year, 27,739 Maryland students had access to health care at their school. Nearly 70,000 visits were made to Maryland School-Based Health Centers during the same time period.

Our national organization, the National Assembly on School-Based Health Care, has made this request at the Federal level through the attached correspondence submitted to the U.S. Department of Health and Human Services. Although the final federal regulations did not include school-based health centers specifically, States do have the flexibility to expand the definition of essential community providers to include other types of providers. The inclusion of School-Based Health Centers as essential community providers is a logical step for Maryland as they serve large percentages of low-income, medically-underserved populations.

In expanding the definition of essential community provider, the Committee could consider different models including:

- Specifying that the definition of essential community provider includes all the providers under the federal definition, school-based health centers, and any other specific types of health providers that are appropriate; or

- Specifying that the definition of essential community provider includes: 1) all the providers under the federal definition; and 2) all the providers who provide services to low-income populations for free or on a sliding fee-scale and provide services to individuals enrolled in Medicaid.

Network Adequacy

MASBHC supports using Medicaid's network adequacy standards as a starting point developing standards for QHP's. Given the large number of individuals who will churn between Exchange plans and Medicaid, we believe that the Medicaid standards are most appropriate for the Exchange. The Medicaid standards, which must align with federal guidelines, are designed to support access to services for populations who have been underserved. Thus, we think it would be beneficial for the Exchange to consider these standards as the basis for QHP network adequacy standards.

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In establishing network adequacy standards, MASBHC also supports careful consideration of how to ensure that non-physician providers are included in QHP networks. In our health centers, the majority of services are provided by nurse practitioners, social workers, and other non-physician providers. We are concerned about the credentialing challenges that we face with these non-physician providers, and we would suggest that QHP networks be required to include the full range of providers in their networks.

Conclusion

Thank you for your again for your consideration of our comments. If you should have any questions, please feel free to contact our public policy and governmental affairs consultant, Ms. Robyn Elliott, at (443) 926-3443 or relliott@policypartners.net.

Sincerely,

Sara Rich, MPA
President
MASBHC

Comments

1 message

Leigh Cobb <lscobb4@gmail.com> Tue, Jul 31, 2012 at 4:30 PM
To: Tequila Terry <tequila.terry@maryland.gov>
Cc: Becky Wagner <rorewagner@aol.com>, Leni Preston <lenipreston@verizon.net>, Penny Anderson <panderson@mdac.us>

Tequila,

Thank you for the opportunity to submit comments on the certification requirements for qualified health, dental and vision plans. Advocates for Children and Youth (ACY) fully supports the joint comments attached.

ACY is particularly concerned about two areas: network adequacy and the structure of dental benefits.

Clearly, qualified health, dental and vision plans—however they are constituted--must maintain provider networks that are adequate to serve Maryland's diverse population of exchange consumers, without unreasonable barriers or delays in receiving clinically appropriate and culturally competent care. If newly insured Marylanders do not have meaningful access to providers--the Exchange will fail.

QHP provider networks must include a variety of provider types, including primary care providers, pediatric and other specialists, and non-physician providers who are accessible geographically without excessivewait times. Network adequacy standards must also reflect reasonable access in the context of particular conditions/diagnoses. For example, pregnant women must be guaranteed access to a first and subsequent OB/GYN visit within a specified time frame.

The need for robust networks serves as an opportunity to increase access to providers by addressing credentialing issues and better access to advanced practice nurses, public health dental hygienists, school-based social workers, etc. Expanding the definition of essential community providers to include school-based health centers and other safety net providers will also enhance provider networks.

The State can also promote meaningful access by being vigilant in enforcing anti-discrimination provisions and prohibiting both explicit and implicit, arbitrary condition-based exclusions. For example, children with special health care needs are frequently denied access to oral health services.

With respect to dental benefits, we are afraid that the current configuration will relegate pediatric dental benefits to something less than an essential health benefit. This was not the intent of Congress nor the Maryland General Assembly, nor the Exchange staff or advisory committee, but rather the consequence of Congress'sacceptance of the myth that dental benefits are not essential to adult health. It is not too late for Maryland to remedy Congress's mistake for our residents. Maryland's children, as well as its adults, would be well served by such as decision.

On a simpler note, plan selection software must be able to segregate plans by dental, as well as medical, provider. In

addition, cost-sharing protections must be allocated between dental, medical and vision plans on a proportionate basis. To do otherwise, particularly given the anticipated dental benefit structure, would deny many children meaningful access to restorative services. Finally, ACY recommends that Maryland move to a risk-based pediatric dental benefit.

Thank you for your consideration of these comments. Please feel free to contact me if you have questions or would like additional feedback.

Leigh

Leigh Stevenson Cobb, Health Policy Director
Advocates for Children and Youth
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PMAC certification recommendations- FINAL 7.31.12.doc
121K

The
League
of
Life and
Health
Insurers
of
Maryland

July 27, 2012

Tequila Terry
Director of Plan & Partner Management
Maryland Health Benefit Exchange
4201 Patterson Avenue, 4tth Floor
Baltimore, Maryland 21215

Megan Mason
Special Assistant to the
Commissioner for Health Care Reform
Maryland Insurance Administration
2700 St. Paul Plaza, 27th Floor
Baltimore, Maryland 21201

Dear Ms. Terry and Ms. Mason:

On behalf of the League of Life and Health Insurers of Maryland, Inc. and CareFirst BlueCross BlueShield, we are writing to you today to provide information about Maryland law we believe is relevant for the work of the Plan Management Committee. The Committee is charged with evaluating several areas of significant concern to insurers doing business in our state. We hope that this information will provide some guidance on how Maryland law and regulations currently address issues such as network adequacy, marketing, provider issues, and complaints.

Should you or the committee have any questions about how carrier's comply with these laws today, we would be happy to discuss them.

Very truly yours,

Kimberly Y. Robinson, Esq.
Executive Director
The League of Life and Health
Insurers of Maryland, Inc.

Deborah R. Rivkin, Esq.
Vice President,
Government Affairs
Carefirst Blue Cross Blue Shield

cc: Dr. Joshua Sharfstein, Chair, Maryland Health Benefit Exchange Board of Directors
Rebecca Pearce, Executive Director, Maryland Health Benefit Exchange

The
League
of
Life and
Health
Insurers
of
Maryland

CareFirst

Index of statues

Appeals and complaint process for member challenging denial of a claim

Insurance Article, Subtitles 15-10A, 15-10B, 15-10C, & 15-10D

Marketing

Insurance

Insurance Article §§ 27-202 to 27-205; 27-303 to 27-304.

Health Maintenance Organizations

COMAR 31.12.01.09

Nonprofit Health Service Plans

COMAR 31.10.32.04

Network Adequacy

Managed Care Organizations (MCO)

Health – General § 15-102, 15-103, COMAR 10.09.64

Health Maintenance Organizations (HMO)

Health – General § 19-705.1(b)(1)(ii), Insurance Article §15-112(b)(1)(i); COMAR 31.10.16.01 et seq.; COMAR 31.10.34.01 et seq.

Preferred Provider Organizations (including Exclusive Proivider Organizations (EPOs)()

Insurance Article § 15-112(b)(1)(i); Insurance Article §§ 14-205.1; COMAR 31.10.16.01 et seq.;COMAR 31.10.34.01 et seq.

Out-of-Network Services

Preferred Provider Organizations (PPO)

Insurance Article §14-205.1.

Insurance Article § 15-830(d)

Health Maintenance Organizations (HMO)

Health– General\ § 19-710.1

Health - General 19-710(p)

Provider Panels

Credentialing

Insurance Article §15-112; COMAR 31.10.16.03 - .05; COMAR 31.10.26.01 et seq.

Provider Directories

Insurance Article § 15-112(j)

Provider participation requirements

Insurance Article §§ 15-112.2, 15-115

CareFirst

Summary of Select Insurance Laws of Maryland

Appeals and complaint process for member challenging denial of a claim

Insurance Article, Subtitles 15-10A, 15-10B, 15-10C, & 15-10D

The Insurance Article contains a set of detailed procedures that a carrier must follow when denying a claim. Subtitle 15-10A governs when a claim is denied for lack of medical necessity, or because it is experimental, cosmetic, or an investigative procedure. That Subtitle requires a carrier to use certain qualified personnel in making such decisions, to provide specified notices and appeal procedures, and for a complaint procedure to the MIA. Subtitles 15-10B and 15-10C specify the qualifications of the agents who review such decisions and the internal grievance process that a carrier must follow in handling appeals of such decisions. Subtitle 15-10D provides a similarly detailed procedure that must be followed when a carrier denies a claim on the grounds that it is not a covered service.

Marketing

Insurance §§ 27-202 to 27-205; 27-303 to 27-304; COMAR 31.12.01.09; COMAR 31.10.32.04

Insurance Article §§ 27-202 to 27-205 prohibit a person from making false statements, false advertisements, or misrepresentations about policies, terms of coverage, the insurance business, insurance carriers, and other matters. Sections 27-303 and 27-304 prohibit the misrepresentation of "pertinent facts or policy provisions" that relate to a member's coverage. These Insurance Article provisions apply to insurers, HMO's and non-profit health service plans. The COMAR sections listed above also include requirements that HMO's and nonprofit health service plans file their marketing plans with the MIA. These filings, while required, are NOT subject to prior approval.

Network Adequacy

Health – General § 15-102, 15-103, COMAR 10.09.64 (MCO); Health – General § 19-705.1(b)(1)(ii), Insurance Article §15-112(b)(1)(i); COMAR 31.10.16.01 et seq.; COMAR 31.10.34.01 et seq. (HMO); Insurance Article § 15-112(b)(1)(i); Insurance Article §§ 14-205.1; COMAR 31.10.16.01 et seq.;COMAR 31.10.34.01 et seq (PPO)

HMO's and MCO's are not required to operate statewide and are prohibited from doing so unless their networks are determined to support their presence in each part of the State. The networks for both MCO's and HMO's must be reviewed and approved by the Department of Health and Mental Hygiene.

For PPO's, COMAR 31.10.34.04 requires a carrier to maintain an adequate provider panel to meet its members' needs. COMAR 31.10.34.05 requires a carrier to develop and adhere to an "availability plan," to ensure that adequate numbers of providers are

CareFirst

Summary of Select Insurance Laws of Maryland

Network Adequacy (cont.)

in the carrier's network. PPO networks are within the regulatory jurisdiction of the Maryland Insurance Administration.

When Maryland created network requirements for PPO's the MIA issued this report. HB1003 Carrier Provider Panels, December 20, 2007, (Report on setting access and availability standards for hospital-based physician services)
http://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/
carrierproviderpanels12-07.pdf

Out-of-Network Services

Insurance Article §§ 14-205.1. 15-830(d) (PPO); Health– General\ §§ 19-710.1, 19-710(p) (HMO)

A PPO product in the group market must offer an optional out-of-network benefit, if the base product only includes an in-network benefit. Insurance Article §14-205.1.

A PPO or HMO must cover services on an in-network basis for a referral to a specialist outside of a carrier's provider panel if the carrier cannot provide reasonable access to specialist within the panel who has the appropriate training and expertise. Insurance Article § 15-830(d). "Reasonable access" includes not requiring unreasonable delay or travel.

If an HMO has an out-of-network benefit, § 19-710.1 of the Health-General Article requires a carrier to reimburse out-of-network providers at specified rates, and §19-710 (p) provides that out-of-network providers who submit claims to the carrier cannot balance bill the member.

A PPO product must reimburse of hospital-based physicians and on-call physicians at specified rates, and members may not be balance billed on account of such physicians. Insurance Article §14-205.2.

For a PPO product, members may assign their benefits to a physician if certain requirements are met. Insurance Article § 14-205.3.

CareFirst

Summary of Select Insurance Laws of Maryland

Insurance Laws relating to Provider Panels

Credentialing
Insurance Article §15-112; COMAR 31.10.16.03 - .05; COMAR 31.10.26.01 et seq.

The Insurance Article and related regulations lay out specific rules for the credentialing of providers and the timeline and process that must be used for credentialing.

Provider Directories
Insurance Article § 15-112(j)

The Insurance Article also lays out specific requirements for provider directories. Under Insurance Article § 15-112(j), carriers must update print directories annually and online directories every 15 days. Carriers are required to inquire whether a provider is accepting new patients at credentialing and re-credentialing. Lastly, a carrier is required to update a provider's information in a provider directory within 15 working days after receipt of written notification from the participating provider of a change in the applicable information. Notification is presumed to have been received by a carrier 3 working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice or on the date recorded by the courier, if the notification was delivered by courier.

Provider participation requirements
Insurance Article §§ 15-112.2, 15-115

Insurance Article § 15-122.2. The Insurance Article prohibits a carrier in its provider contract from requiring a provider as a condition of participating in a non-HMO provider panel, to participate in an HMO provider panel; or as a condition of participating in a fee-for-service dental provider panel, to participate in a capitated dental provider panel.

Insurance Article § 15-115 provides that a carrier operating an MCO cannot limit its PPO providers from choosing to participate in the MCO.

Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Kimberly Robinson	**The League of Life and Health Insurers of Maryland, Inc.**	**Krobinson@fblaw.com**	**410-659-7761**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	Current law allows for review of marketing materials and practices and enforcement action to be taken by the Maryland Insurance Administration. While we understand the Exchange's need to create reasonable guidelines regarding use of its brand name and materials, we believe that a prior approval process will add cost to the products sold on the Exchange. There is no history of marketing abuses in Maryland suggesting that an aggressive prior approval process is warranted. We believe that a prior approval process will increase needs for staff to review multiple filings, limit carriers abilities to update marketing plans within their normal advertising cycles and potentially delay the ability to bring plans to market. We recommend that the Maryland Insurance Administration continue in its role as the sole regulator of member materials, which could eliminate the need for a requirement to submit "Exchange specific" materials. We also recommend that the Exchange develop a clear

			definition of "marketing materials." Changes to health plan formularies and covered drugs, for example, should be excluded from the definition of "marketing materials". Overly broad definitions would result in added expenses, reduce consumer affordability, and result in significant delays to market.
Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for "qualified" plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126,	

		and Health-General §19-713.	
Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	Maryland has developed the network adequacy standards that are in place for Managed Care Organizations (MCO), Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) over many years. These standards are different for each entity and take into consideration the specific nature of each entity. It has been suggested that more stringent network adequacy standards be developed only for the Exchange. We believe that the imposition of new network adequacy standards in the Exchange that are more stringent than or inconsistent with those for the rest of the market will encourage adverse selection and potentially increase cost. Further, the short timeframe in which carriers would have to alter their existing networks would create practical

			problems that may interfere with plans ability to comply and be up and running by 2014. Further, we do not believe that maintaining the current system for assessing network adequacy will result in lower levels of provider participation for Bronze, Silver and Gold levels if no provider requirements are in place (e.g. requirement for providers to participate in all metal levels of plans which may conflict with the "anti-cram down" legislation). If the Exchange develops alternative requirements to determine network adequacy, it could limit the ability of carriers to develop innovative new products, such as those based on high performance networks or patient-centered medical homes. It could also increase health care costs, which would make plans less affordable for consumers. During the Committee's deliberations, concern was raised around a number of issues related to networks. Several of these issues are currently addressed in Maryland law. Issues such as access to out-of-network care, including emergency services, Out-of-Network Services (See (PPO) Insurance Article §§ 14-205.1, 15-830(d); (HMO) Health–General §§ 19-710.1, 19-710(p)); Credentialing of health care providers (See Insurance Article §15-112; COMAR 31.10.16.03 - .05; COMAR 31.10.26.01 et seq.), requirements for Provider Directories, including requirements that online directories be updated every 15 days and requirements that carriers inquire whether or not a provider is accepting new patients (See Insurance Article § 15-112(j)) and requirements for how carriers must contract with providers and limitations on mandating participation in panels (See Insurance Article §§ 15-112.2, 15-115) are currently addressed in statute and/or regulation.

Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1 year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	
Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the "outside" commercial market.	Maryland has developed the network adequacy standards that are in place for Managed Care Organizations (MCO), Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) over many years. These standards are different for each entity and take into consideration the specific nature of each entity. It has been suggested that more stringent network adequacy standards be developed only for the Exchange. We believe that the imposition of new network adequacy standards in the Exchange that are more stringent than or inconsistent with those for the rest of the market will encourage adverse selection and potentially increase cost. Further, the short timeframe in which carriers would have to alter their existing networks would create practical

			problems that may interfere with plans ability to comply and be up and running by 2014. Current adequacy standards do take into consideration service area and requires that the network be reviewed relative to the service area. This standard should be maintained as it exists today. If the Exchange develops alternative requirements relative to service area, it could limit the ability of carriers to develop innovative new products, such as those based on high performance networks or patient-centered medical homes. It could also increase health care costs, which would make plans less affordable for consumers.
Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	We believe that the Exchange should make use of the existing resources at the Maryland Health Care Commission. Further, the committee's discussion suggested that the Exchange should collect information on carrier's medical management policies and reasons for denial. Maryland law requires that all medical management be performed on behalf of a carrier be done by a certified Private Review Agent (PRA) (see Insurance Article Title 15, Subtitle10C). The Maryland Insurance Administration requires all PRAs to file all medical management criteria it uses with the MIA. In addition, the MIA collects information regarding the reason for denials through its complaint process. We believe that utilizing the resources at the MIA rather than developing a parallel process through the Exchange would be the most effective and efficient way to proceed. Similarly, Maryland law addresses how and when a carrier

			may cancel a policy of health insurance for non-payment of premium. The Maryland Insurance Administration has the ability to adjudicate complaint over such cancellations and is best equipped to continue in that role The annual statement is public information. Another disclosure form will add cost without providing additional value to consumers. Information about enrollee rights is already contained within member benefit materials, which are reviewed and approved by the MIA. We do not believe there is value in requiring duplicate submissions of data. We believe that it is important that enrollees have information about cost sharing for specific services. However, we believe most if not all carriers already provide this information to enrollees in a number of ways, including via customer service, the enrollee's summary plan documents and summary of benefits documents. As a result, carriers should be allowed to first fulfill this requirement by directing consumers to their customer service departments, and/or the enrollee's benefit materials. The rate cards are already public information. The rate filings submitted for approval to the MIA currently describe how the rate changes are justified. We would recommend adopting the current publicly-available rate filing information rather than requiring an additional form, which we believe would not add value to consumers. As the Exchange market is designed to supplement and not supplant the existing marketplace, creating new, separate or duplicative reporting requirements adds administrative investment and expense while only telling a part of the story within the State's insurance market.

Quality	The Exchange must evaluate carriers' quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commission (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings. For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before November). For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings. Use the AHRQ enrollee satisfaction survey for dental plans. Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey. The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	

Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	We believe that the Exchange should make use of the existing resources at the Maryland Health Care Commission. Ultimately, any standards applied should be objective, measurable and applied equally to all carriers. In addition, any such data should be audited for accuracy. Measures and standards should be developed and modified through a process that ensures robust opportunities for public comments. Further, the committee's discussion suggested that the Exchange should collect information on carrier's medical management policies and reasons for denial. Maryland law requires that all medical management be performed on behalf of a carrier be done by a certified Private Review Agent (PRA) (see Insurance Article Title 15, Subtitle10C). The Maryland Insurance Administration requires all PRAs to file all medical management criteria it uses with the MIA. In addition, the MIA collects information regarding the reason for denials through its complaint process. We believe that utilizing the resources at the MIA rather than developing a parallel process through the Exchange would be the most effective and efficient way to proceed. Similarly, Maryland law addresses how and when a carrier may cancel a policy of health insurance for non-payment of premium. The Maryland Insurance Administration has the ability to adjudicate complaints over such cancellations and is best equipped to continue in that role.
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	

	enrollees move from Medicaid to the Exchange and vice versa.		

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or	It is important that any recertification process include appropriate due process rights for carrier's who may be aggrieved by an adverse recertification decision. Further, we continue to have a concern regarding duplication of efforts generally. Several of the areas enumerated in this category are currently regulated by other state agencies. For example, network adequacy is currently reviewed biennially by the DHMH and the MIA. Every other year carriers file access and availability reports with the DHMH to show network adequacy. Changes to the existing network require resubmission of these reports. Similarly, Complaints and Grievances are reviewed and regulated by the Maryland Insurance Administration. The MIA requires complaint and grievance reporting quarterly by carriers. Also, complaints and grievances are typically the focus of market conduct examinations already conducted by the MIA. The MIA also monitors enrollment in individual products through the submission of monthly and quarterly MHIP and application/declination reports. External Quality Review Organizations review carriers' quality information. Licensure and financial solvency is already regulated by the MIA and is ascertained by monthly and quarterly reports. These reports are not triggered by changes in

benefits.*	rates or benefits. The MIA also conducts regular financial examinations of carriers which are not triggered by changes to rates or benefits. To the extent that information is already reviewed and regulated by an existing regulatory entity, we recommend the Exchange utilize that existing information. Of particular concern to carriers is the question of how a disagreement between the Exchange and a different regulatory agency regarding the same issue will be resolved if it is determined that the Exchange will duplicate certain regulatory review.

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an	It is important that any decertification process include appropriate due process rights for carrier's who may be aggrieved by a decertification decision. In addition, the decertification process needs to clearly address what would occur if the basis for a proposed decertification is an enforcement action before the MIA that is being appealed by the carrier. Decertification prior to a final disposition of the underlying matter may irrevocably harm the carrier if the carrier is forced to leave the Exchange marketplace but later prevails in the underlying action. The Exchange should carefully construct its policy so as not to unnecessarily disrupt policyholder's coverage before a final outcome has been reached.

alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	We have concerns about a "one-size-fits-all" standardization requirement. The Essential Health Benefits rules and metallic plan levels (i.e., Gold, Silver, Bronze, and Platinum) already constitute a form of standardization that will allow consumers to easily compare different plans. To the extent that the Exchange defines and requires a standard plan type, it should not count toward the three plan limit identified in "Carrier Submissions Limits." In addition, our members' experience with standardized small group plans in other markets and in the Medicare Part D market is that very few customers—either small

	businesses or Medicare beneficiaries—choose standard plans. Instead, they prefer the innovative plan benefit designs that are actuarially equivalent to the standard plan, but that are more flexible and tailored to their individual health care needs. As a result, it does not seem certain that requiring a standard plan design developed by the Exchange would benefit or provide value to consumers. Moreover, if the standard plan has a low take up rate with consumers, it would increase administrative costs, as carriers would still be required to offer and operate such plans.

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	We support supplemental dental and vision coverage (non-essential benefits and adult benefits) being offered in a variety of ways including in conjunction with a medical plan or on a stand alone basis.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to <u>disclose the price</u> of adult dental/vision benefits to consumers separately?	We support supplemental dental and vision coverage (non-essential benefits and adult benefits) being priced transparently.
3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as <u>stand alone too</u>?	Most medical carriers do not offer dental or vision benefits on a stand alone basis. Most of these products would be written by an affiliated carrier. Requiring the medical carrier who offers comprehensive medical benefits to begin offering these benefits on a stand alone basis may not be practical. It is important for the Exchange to be clear in what is meant by carrier in this circumstance.
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision	Because pediatric dental/vision are required under the EHB, the value associated with requiring carriers to

benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	disclose the price associated with those benefits is diminished.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	Most medical carriers do not offer dental or vision benefits on a stand alone basis. Most of these products would be written by an affiliated carrier. Requiring the medical carrier who offers comprehensive medical benefits to begin offering these benefits on a stand alone basis may not be practical. It is important for the Exchange to be clear in what is meant by carrier in this circumstance.

Tequila Terry (DHMH) <tequila.terry@maryland.gov>

GBHHSPC: Comments to Plan Management Advisory Committee

1 message

Laken Laird <laird@intergroupservices.com>
To: tterry@dhmh.state.md.us
Cc: Cyd Lacanienta <lacanienta@intergroupservices.com>, Katelynn McGinley <mcginley@intergroupservices.com>, Thea Lenna <lenna@intergroupservices.com>, Laken Laird <laird@intergroupservices.com>

Tue, Jul 31, 2012 at 4:36 PM

Dear Ms. Terry,

On behalf of the Greater Baltimore HIV Health Services Planning Council, the Planning Council leadership and Comprehensive Planning Committee Co-Chairs wish to submit comments to the Plan Management Advisory Committee of the Maryland Health Benefits Exchange Board.

Should you have questions, please contact InterGroup Services, Inc., the Planning Council Support Office, at (410) 662-7253.

Please see the comments provided below.

To: Plan Management Advisory Committee of the Maryland Health Benefits Exchange Board
Date: July 31, 2012

Thank you for this opportunity to provide comments.

We are writing on behalf of the Ryan White funded services continuum that provides critical HIV-related health care and support services to over 29,000 people with HIV and AIDS in Maryland. The Ryan White service continuum is comprised of medical providers, community-based organizations, community health centers, public health agencies and consumers committed to ensuring access to medical and services for people living with HIV and AIDS.

In 2014, thousands of people living with HIV and AIDS will have access to private insurance – many for the first time. But to be meaningful, insurance coverage must include the comprehensive services that people living with HIV and AIDS need to stay healthy. Services that play a vital role in effective management of HIV disease include comprehensive prescription drug coverage, preventive services such as routine HIV testing, routine access to medical providers and appropriate laboratory testing, chronic disease management services and mental health and substance abuse services. Such services are necessary to ensure that people living with HIV/AIDS are diagnosed early, stay in regular care and treatment and realize the lifesaving benefits of HIV treatment. Further, because we now know effective HIV treatment prevents HIV transmission, comprehensive care for people living with HIV and AIDS is important to our state's public health.

1. Ryan White providers as essential community providers.
We strongly support the explicit recognition that Ryan White Part A, B, C and D providers be considered as “essential community providers” and should be included in plan networks to ensure sufficient HIV medical capacity and continuity of care for the hundreds of HIV patients who will transition to health coverage in 2014.

2. Robust requirements for network adequacy standards.
We strongly support more robust requirements for network adequacy standards that require enrollees have timely access to all services and recommend that the board closely monitor for enrollee access to HIV providers and services. Effective care management requires a hybrid of specialty and primary care—particularly for patients diagnosed late (as are nearly a third of HIV patients) and after damage to the immune system has occurred. The complexity of HIV care is compounded by the high rates of serious co-morbidities among people with HIV infection, including hepatitis C, serious mental illness, substance use disorders, diabetes and heart disease. While HIV medicine does not fall under the purview of any one medical specialty, it is well documented that higher quality and more cost effective care is delivered by clinicians with experience and expertise in treating HIV, regardless of specialty training. Failure to provide access to qualified HIV providers will put HIV-infected patients at higher risk for treatment failure, disease progression and the development of resistance to effective treatment.

3. Providing prospective enrollees with accurate and detailed information to make appropriate decisions.
Exchange plans should provide prospective enrollees with accurate and detailed information to assess total out-of-pocket costs, including premium, deductibles and cost sharing for in- and out-of-network care and treatment. Our clients with HIV rely on regular access to a comprehensive set of services, care and medications. Out-of-pocket expenses are a critical factor in selecting a health plan to ensure reliable and uninterrupted access to medical care and treatment.

4. Ensuring that the EHB include patient protections concerning benefit limitations, medical necessity determinations, and utilization management practices.
It is important to ensure meaningful access to medically necessary health care services, particularly for individuals with higher cost chronic conditions, such as HIV/AIDS. We urge the board to issue regulations and guidance that prohibit insurance companies from limiting access to lifesaving care and treatment through dollar or visit limits on essential services, condition-specific restrictions, and unduly burdensome utilization management and prior authorization practices. Service limits penalize individuals with HIV infection and others with chronic conditions who rely on routine medical visits and laboratory monitoring to stay healthy and prevent disease progression. As the state awaits for separate guidance to be issued specifically on cost sharing, and we encourage the board to ensure that people living with HIV and AIDS and other complex and high cost medical conditions have access to affordable care and treatment.

5. Ensuring that substitution of benefits within plans does not compromise access to services for patients with complex conditions such as HIV and Hepatitis
Because of the unique needs of people living with HIV and AIDS and other complex conditions, we encourage the board to discourage plans that substitute benefits that will result in limits on or elimination of important services as a mechanism for discouraging certain populations from enrollment. We encourage the board to support substitution of benefits within plans if they do not compromise access to medically necessary services for patients with complex conditions such as HIV.

Again, we thank you for the opportunity to comment. As we learn more about the plans being proposed, we may follow up with additional recommendations.

Respectfully submitted,

Carolyn L. Massey, Chair
Jeanne Keruly, CRNP, NP, Vice-chair
Melanie Reese, Nominating Committee Chair

Leonard Sowan, MD, MPH and Carlisle Harvey, Sr., Co-chairs, Comprehensive Planning Committee
Greater Baltimore HIV Health Services Planning Council

The Greater Baltimore HIV Health Services Planning Council

Our mission *is to provide comprehensive, high quality services to people living with HIV/AIDS in the greater Baltimore eligible metropolitan area (EMA) regardless of their ability to pay. The planning council will plan for and ensure access to culturally sensitive, high quality, cost-effective services in collaboration with local authorities, providers and consumers of HIV-prevention and care services. The planning council and its advisors will act in a timely and unbiased manner when setting priorities to allocate resources to people living with HIV and AIDS. For more information about the planning council, please visit:www.baltimorepc.org.*

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Maryland Health Benefit Exchange
Plan Management Public Comments Form

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- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Larry Gross	**Kaiser Permanente**	**larry.a.gross@kp.org**	**301-816-7161**

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	Agree. State licensure is critical for consumer protection.

Solvency	Carriers must meet State financial and solvency standards.	Use MIA current policy The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	Agree. Kaiser Permanente believes that use of the current MIA policy for financial and solvency standards combined with market conduct reviews will ensure that carriers are meeting their obligations.
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	Agree. Kaiser Permanente supports the development of marketing standards by the Exchange. The review criteria for marketing materials, along with the process and timing should be reviewed with carriers. Final standards should clearly be defined and communicated to carriers to support accurate and efficient use of marketing materials. We encourage the Exchange to provide adequate resources for this process to ensure that it goes smoothly and timely.

Benefit Design Standards	Carriers do not employ benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for "qualified" plans.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	Agree. The use of existing processes through the MIA will facilitate approval. We encourage the Exchange and the MIA to provide adequate resources for this process to ensure that it goes smoothly and timely.

Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I& II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	Agree. The Maryland Insurance Administration's existing review requirements are comprehensive and will ensure that benefits and rates comply with current law and that plans are fairly priced for Marylanders. The use of existing processes will facilitate approval.
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	Agree. Kaiser Permanente believes that the use of the existing network adequacy standards will support equal network standards both in and out of the Exchange. The Exchange and interested health plan participants face a significant amount of work to make the Exchange operational in 2014. Deferring the consideration of additional, new requirements until after the Exchange is operational is prudent.

Accreditation	Carriers must receive accreditation within a timeframe specified by the Exchange	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	Kaiser Permanente does not support allowing a grace period for issuers that are not accredited to participate in the Exchange. Allowing non–accredited issuers to participate in the Exchange poses risk to both quality and affordability. HEDIS measures that are part of the accreditation process help ensure quality of care. Issuers that don't adhere to these standards may impact the ability to quickly identify and resolve health issues resulting in poor quality and an increase in overall health care costs. In addition to ensuring quality and controlling costs, requiring accreditation of issuers would facilitate an "apples to apples" quality comparison of health plans. Current accreditation ratings demonstrate where high quality health care is occurring and provide a standard methodology for employers and consumers to compare issuers. We suggest that the Exchange only allow issuers to participate, if they provide quality health care and are accredited.
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	Kaiser Permanente, as a QHP issuer that provides a majority of its covered professional services through a single contracted medical group, is allowed to comply with the alternate standard described in the final 3/12/12 exchange regulations, section 156.235. As such, Kaiser Permanente will provide reasonable and timely access to low-income, medically underserved individuals through the providers of our contracted medical group and hospital facilities in accordance with the Exchange network adequacy standards. We suggest that Maryland's final rules incorporate this standard.
Service Area	Carriers cannot establish service areas that are	Require carriers to use the same service areas as the "outside" commercial	Kaiser Permanente agrees that a key component of promoting non-discriminatory service areas is requiring the

	discriminatory	market.	same service area for both the Exchange and "outside" market. Exchange service areas should be allowed to match existing service areas that have been filed and approved by the Maryland Insurance Agency.
Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	For the most part, Kaiser Permanente agrees that the Exchanges initial data requirements should be aligned with federally required data elements to facilitate Exchange implementation and plan participation. We suggest, however, that in addition to the federal requirements, carriers should be required to report the structure of their commission and bonus program that is used to pay brokers and agents. We believe the details of these programs should be made transparent to small employers both in and out of the Exchange to increase their understanding of the cost of coverage for their employees.
Quality	The Exchange must evaluate carriers quality improvement strategies	Use the existing Maryland Health Care Commission (MHCC) quality and performance processes to provide	Agree. Kaiser Permanente strongly supports the use of quality data/ratings in the health plan decision process for consumers and believes that these ratings should be

	and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	prominently featured as part of the selection criteria. The current MHCC process for quality data is thorough and the data output is relevant to Marylanders. Kaiser Permanente suggests evaluating the possible use of Exchange related quality data for 2015 after the Exchange has confirmed that the sample size is creditable. In the event that the Exchange related quality data does not produce a creditable sample size, we suggest continued use of plan level MHCC data through 2015.
Race, Ethnicity,	The Exchange recognizes that there are significant	Use the MHCC RELICC (eValue8) tool to track and report data so that	Agree. Kaiser Permanente fully supports the collection of patients'/ members' demographic data (race, ethnicity and

Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	language preference) and has begun to plan ways to do so within our system of care. The Exchange should try to maximize the level of granularity possible in the data collection process so the data can be meaningful or sufficiently granular to be actionable. The Exchange should ask health plans to share specific actionable projects/initiatives/work plans and lessons learned that have successfully addressed the reduction of health disparities.
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	Kaiser Permanente recognizes that continuity of care across different issuers and two programs poses a great challenge. Kaiser has successfully reduced redundancy for our members through our industry leading electronic health record. Through the use of our EHR, every Kaiser Permanente physician has access to the test results, office visits, and medical histories of their patients. Kaiser's EHR is a valuable tool to improve quality, safety, and eliminate redundancy for our members. We welcome the opportunity to engage in further dialogue with the Exchange on this important issue.
Broker Commissions and Bonuses		Kaiser Permanente believes that each carrier should be required to pay their brokers and agents the same commissions and bonuses for selling their policies in the Exchange as they pay for selling their policies outside of the Exchange.	To create a level playing field in and out of the Exchange and to eliminate the ability of carriers to steer business to the outside market, Kaiser Permanente believes that a carrier's commissions and bonuses must be identical regardless of whether the policy is sold inside or outside of the Exchange.

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances **Biennial Recertification** On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	The re-certification process will likely be extensive. For this reason, Kaiser suggests that the Exchange consider recertification after three years. Implementing an annual review of QHPs will provide a forum to discuss and identify action plans as appropriate for best practices and opportunities. We suggest clarity around components of the annual review and timeline to allow issuers opportunity to prepare.

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	Agreed. Kaiser Permanente supports the proposed decertification process and encourages the Exchange and MIA to provide reasonable time frames for corrective action to be implemented, if needed, to allow carriers to remain viable options for Maryland consumers.

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	Agree. Limiting benefit designs to three choices per metal level seems appropriate to facilitate the plan comparison process for consumers. The Exchange may want to consider offering guidance on how financial accounts (HRAs and HSAs) or multiple networks (e.g., narrow vs. standard) will be counted within the three options.
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer additional benefit designs.	Kaiser Permanente supports the standardization of plans as an avenue to simplify the plan options offered to Maryland consumers. Standardizing plans will allow consumers to more easily make an “apples to apples” comparison within each tier and allow other important decision factors such as price, quality and delivery system features to drive the selection process. Kaiser Permanente encourages the Exchange to consider increasing the number of standard plans from one to two to decrease the complexity for consumers.

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	We recommend that the Exchange allow carriers the option to embed adult dental/vision benefits with a qualified health plan or offer them as separate benefits. Kaiser Permanente's integrated care delivery model is inclusive of vision services that may be challenging to carve out and offer separately. If the Exchange allows adult dental/vision benefits to be embedded, then consumers should be made aware of this additional coverage so that they can make comparisons to other available plans.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to <u>disclose the price</u> of adult dental/vision benefits to consumers separately?	We recommend against requiring carriers to disclose the premium impact of adult dental/vision if embedded with a qualified health plan. Providing this level of information may cause member confusion and lead to significantly more customer service calls and questions related to premiums. The Exchange and Navigators would need to be trained on how to handle these additional questions. In addition, disclosing pricing only for dental/vision benefits may lead to further requirements to break out pricing for other benefits that would be administratively costly to support.
3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as <u>standalone too</u>?	We recommend that the Exchange allow carriers the option to embed adult dental/vision benefits with a qualified health plan or offer them as separate benefits. The Exchange should not require carriers to offer these benefits on a standalone basis in addition to embedding them with a qualified health plan. Offering embedded and stand alone benefits would create consumer confusion

	and potentially lead to purchasing duplicate coverage if they did not understand that the adult dental/vision benefits were included with their qualified health plan. It would also introduce additional administrative complexity for the Exchange and carriers.
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	We do not recommend requiring medical carriers to disclose pricing for pediatric dental/vision benefits within the Essential Health Benefits package. We believe this would lead to confusion and more customer service calls and complaints. In addition, disclosing pricing only for dental/vision benefits may lead to further requirements to break out pricing for other benefits that would be administratively costly to support.
5) Pediatric Dental/Vision Stand Alone Options Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a standalone basis when a carrier offers them as part of the Essential Health Benefits package?	We believe the Exchange should not require carriers to offer pediatric dental/vision benefits on a standalone basis in addition to embedding them with a qualified health plan. Offering embedded and standalone benefits would create consumer confusion and potentially lead to purchasing duplicate coverage if they did not understand that the pediatric dental/vision benefits were included with their qualified health plan. It would also introduce additional administrative complexity for the Exchange and carriers.

Tequila Terry (DHMH) <tequila.terry@maryland.gov>

Plan Management Advisory Committee's Recommendations

1 message

Judith Gallant <jg708@columbia.edu>
To: tequila.terry@maryland.gov

Tue, Jul 31, 2012 at 1:13 PM

As a concerned Maryland resident and practicing clinical social worker, I believe that Qualified Health Plans (QHPs) must demonstrate compliance with federal Mental Health Parity Law, and that there

must be clear standards for network adequacy. Neither of these important requirements is currently adequately addressed in the Summary document.

1. The Plan Management Advisory Committee Summary Report lists under Plan Certification twelve standards (Licensure & Solvency, Benefit Design, etc) that are each based on Federal Requirements listed in the Accountable Care Act. One important Federal Requirement standard is missing: the ACA requires QHPs to be compliant with the Mental Health Parity and Addiction Equity Act (MHPAEA). This requirement is also included in the Maryland Health Benefit Exchange Act signed by the Governor this year. **A thirteenth standard to the Plan Certification section that requires demonstration of compliance with MHPAEA should be added.**

2. Under Plan Certification, the Network Adequacy standard includes inadequate initial requirements for adequacy of the provider network. If networks appear to be similar in size and geography between two QHPs, but the network listing in one QHP is more accurate than the other, then the consumer will not learn of this imbalance until he or she attempts to access providers in the network. Only then will they learn that there is a much smaller number of actual providers who are actually accepting new patients. This goes against the Transparency standard, while also potentially contributing to adverse selection. **The Network Adequacy standard should include specific requirements that (a) QHPs must maintain accurate network listings and (b) QHPs must maintain current indicators of which network providers are currently accepting new outpatients in a timely manner.** This latter requirement is also a Federal Requirement under the ACA.

3. Under Plan Certification, the Accreditation standard indicates acceptance of either NCQA or URAC accreditation. URAC updated its standards this year to include detailed requirements to plan for and demonstrate compliance with the Mental Health Parity Act (MHPAEA); however, NCQA has not yet done so and it is unclear if or when it will update its standards. QHPs who use either NCQA or URAC accreditation would thus be held to different standards. To maintain equivalence, and to reduce the compliance monitoring load on MIA, **the Accreditation requirement should either use only URAC accreditation, or it should include the detailed standards developed by URAC as a requirement for all QHPs**. This would also reduce adverse selection between plans using differing accreditations.

Thank you for your attention to these important issues which will help ensure Maryland residents have access to mental health care and addiction treatment on parity with other medical care under the new ACA guidelines.

Sincerely,

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Maryland Health Benefit Exchange
Plan Management Public Comments Form

The Maryland Health Benefit Exchange (the Exchange) is seeking comments from the public on the following key Plan Management policies:

- Plan Certification Policy
- Plan Recertification Policy
- Plan Decertification Policy
- Plan Choice Policy
- Dental & Vision Pricing Display Policy

Please provide comments on these areas and return this form via email to tterry@dhmh.state.md.us by 7/31/12.

Submitter's Name	Organization (if applicable)	Email	Phone
Eboni Morris	Hemophilia Federation of America (HFA)	e.morris@hemophiliafed.org	202-603-3240

I. PROPOSED CARRIER & PLAN CERTIFICATION POLICIES

The following elements would be criteria included in the Exchange's certification requirements for carriers and plans. Each certification element has a proposed policy option that could be adopted by the Exchange. Please provide comments on the proposed policies.

Certification Element	Definition	Proposed Exchange Policy	Comments
Licensure	Carriers must be licensed and in good standing in the State in which it intends to offer qualified plans.	Use Maryland Insurance Administration (MIA) current policy. The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	
Solvency	Carriers must meet State financial and solvency	Use MIA current policy	

	standards.	The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans.	The Exchange will develop fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require carriers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange would collaborate with the MIA to identify consumer complaints.	HFA encourages the state of Maryland to provide direct oversight of the marketing materials used by insurance plans that operate in the exchange. We also recommend the exchange board review materials for consumer usability and comprehension level before they are rolled out to the public.
Benefit Design	Carriers do not employ	Use the MIA Rate, Benefit & Form review	

Standards	benefit designs that discourage enrollment by higher need consumers. The plans offered meet requirements for "qualified" plans.	process to ensure compliance with: o Essential Health Benefits o Actuarial Value Requirements (Metal Levels) o Limitations on Cost-Sharing o Discriminatory Benefit Design Note: The Exchange will need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans. The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	The following should be considered when setting up benefit design standards *Cost sharing-* It is vital for patients with rare diseases to choose a health insurance policy that will meet their unique needs. Individuals with bleeding disorders rely on expensive therapies known as biologics, where there are no generics available. Therefore, plans should be required to disclose all information about the deductible, co-payment and co-insurance amounts that are applicable to in-network and out-of-network covered services as well as any limitations on services. In addition, specialty tier pricing for prescription drugs should be prohibited and/or plans should offer protections for these high out-of-pocket costs by providing tiering exceptions. States should provide an oversight mechanism to review plan benefit design, ensuring that cost-sharing does not discriminate or unfairly target any patients or rare disease groups. *Ensuring Patient Access to Medications and Treatments* Utilization management (UM), prior authorization, and step therapy are all mechanisms some insurance companies use to limit patient access to treatments, particularly when the treatment is very costly. States must have specific oversight mechanisms allowing them to review and reject plans that choose these techniques to monitor patient care. Plans should be required to disclose to all prospective and current members if these guidelines are being used. *Access to Specialists and Treatments* For patients with rare and chronic conditions such as bleeding disorders, this access to specialists and treatments should be based on medical literature and treatment guidelines recommended by medical

			and patient organizations. An example of such a standard for individuals with bleeding disorders is MASAC #188 from the Medical and Science Advisory Committee of the National Hemophilia Foundation. Comparatively, the exchange should allow patients access to needed specialists at the appropriate site of care, whether in the hospital, outpatient clinic, office of the physician, hemophilia treatment center (HTC), or the home setting. It is important to note that specialized treatment facilities, such as the federally recognized HTCs, do not fit neatly into specific categories of services. HTCs provide comprehensive, multi-disciplinary services in a single setting, and have been shown through research at the Centers for Disease Control and Prevention (CDC) to improve quality and reduce morbidity and mortality of individuals living with bleeding disorders. *Limits on benefits*- HFA opposes additional limits on specific or total benefits in the package. We recommend prohibiting treatment caps, prior authorization, utilization management or other restrictions by cost or in limits on treatments (in particular those approved by the FDA).
Rate & Benefit Reporting	Carriers must provide information on rates and covered benefits, and submits a justification for any rate increases.	Use MIA current policy. MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification	

		forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	
Network Adequacy	Carriers must maintain provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delays.	Allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.	HFA encourages the state to define network requirements as soon as possible. We would also recommend an immediate standardization of insurer networks. The exchange should allow patients' access to needed specialists and allow the physician to formulate the best treatment regime for patients at the appropriate site of care whether in the hospital, outpatient clinic, office of the physician, hemophilia treatment center, or the home setting. Allowing access to comprehensive care centers ensures that the most appropriate balance of care is provided to the patient by medical professionals. It is also important to note that many patients may travel outside of the state of Maryland to see a specialist to surrounding states including, Virginia, District of Columbia and Delaware based on where they reside. The ability to use plan benefits across state lines for their specialty care is extremely vital.
Accreditation	Carriers must receive accreditation within a	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015.	HFA supports the use of NCQA accreditation and would

	timeframe specified by the Exchange	• Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.	recommend it be required as soon as the exchange is operational.
Essential Community Providers	Carriers must include in the provider network Essential Community Providers that serve low-income and medically underserved populations	Require carriers to contract with Essential Community Providers in Medically Underserved Areas (MUAs) unless they are exempted by criteria established in the final rule.	HFA urges the exchange board to identify ECPs that are ready to contract with commercial plans and that serve patients with rare and chronic diseases. Hemophilia Treatment Centers should also be included as ECPs. There is only one HTC located in the state of Maryland, at Johns Hopkins Hospital in Baltimore MD. As mentioned above, HTCs provide comprehensive, multi-disciplinary services in a single setting and have been shown through research at the Centers for Disease Control (CDC) to improve quality and reduce morbidity and mortality of individuals living with bleeding disorders. We also recommend that the hospital lab be included as an ECP. Lab work is extremely critical to the care of patients with bleeding disorders. Inaccurate lab results can most likely lead to fatal consequences for an individual with a bleeding disorder. Patients have found that lab work done outside of the hospital at independent facilities has not been as reliable as lab work done within the hospital.

Service Area	Carriers cannot establish service areas that are discriminatory	Require carriers to use the same service areas as the "outside" commercial market.	To ensure network adequacy we support requiring carriers to use the same service areas inside the exchange as they do outside the exchange. This can also help to prevent adverse selection by health plans.
Transparency Data	Carriers must report to the U.S. Department of Health & Human Services, Exchanges, state Departments of Insurance, and the public information on key policies, practices and data on cost sharing.	As a condition of certification for 2014, require the following: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage	Patients with bleeding disorders and other rare diseases will definitely be looking to the exchange for coverage. Treatment for a bleeding disorder is expensive, with an average cost of $250,000 per year /per patient. Therefore, Maryland's exchange should require plans to disclose all information about the deductible, co-payment and co-insurance amounts that are applicable to in-network and out-of-network covered services as well as any limitations on services. In addition, the exchange should prohibit specialty tier pricing for prescription drugs, and/or plans should offer protections for these high out-of-pocket costs by providing tiering exceptions. The exchange should also provide a robust oversight mechanism to review plan benefit design, ensuring that cost-sharing does not discriminate or unfairly target any patients or rare disease groups.

Quality	The Exchange must evaluate carriers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Use the existing Maryland Health Care Commision (MHCC) quality and performance processes to provide clinical performance data and enrollee satisfaction ratings • For October 2013 open enrollment, and 2014 use a roll-up of MHCC's HMO/PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data. (May not be available before Nov) • For 2015 and beyond, track and display the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings • Use the AHRQ enrollee satisfaction survey for dental plans • Use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey	

		The existing MHCC quality reports for the commercial health plan market can be found: http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	
Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland. The Exchange could require qualified plan carriers to track and report RELICC data so that disparities can be addressed in future years.	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. • For 2013 and 2014 use MHCC results. • For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.	The exchange should also track data on disability status.
Continuity of Care	Maryland could require qualified carriers to establish policies/protocols to address "churn" as enrollees move from Medicaid to the Exchange and vice versa.	The Exchange Continuity of Care Advisory Committee will examine this element. A separate process will be defined to collect input on this topic.	It is common for low- to middle-income families and adults dealing with a bleeding disorder to experience frequent fluctuations in their incomes due to various factors, including the expense of treatment and the loss of wages because of complications due to the bleeding disorder. This may cause them to move to pubic programs like Medicaid and back again to employer sponsored coverage. The state needs to ensure that changes in coverage have a minimal effect on the ability to access care. These protections must be in place so patients are not required to re-establish treatment protocols with provders.

			The state may want to look at setting the same guidelines for exchange plans and Medicaid, establishing any willing provider rules, which may allow patients to still see the same provider, or making sure a specific course of treatment is covered for the duration recommended, no matter the type of insurance coverage.

II. PROPOSED CARRIER & PLAN RECERTIFICATION POLICY

The following table includes the Exchange's proposed recertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Key areas of focus will include: •Enrollment information •Network adequacy •Quality information •Complaints/Grievances	

Biennial Recertification On a biennial basis, a formal recertification process will occur that requires the Exchange to review all of the original certification data of participating health, dental and vision plan carriers to confirm the plan still meets requirements. • Licensure • Solvency • Actuarial Value of Existing plans • Accreditation status • Network information • Use of Essential Community Providers • Transparency data • Quality information • Complaints/Grievances *Please note that the MIA review is not a part of the Exchange Annual or Biennial Recertification process. An MIA review only occurs when there is a change to rates or benefits.*	

III. PROPOSED CARRIER & PLAN DECERTIFICATION POLICY

The following table includes the Exchange's proposed decertification policy for carriers and plans. Please provide comments on the proposed policy.

Proposed Exchange Policy	Comments
The Exchange has the authority to decertify a qualified plan that is no longer meeting exchange standards. The U.S. Department of Health & Human Services has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification. The following would be criteria for decertification of carriers and/or of specific health, dental or vision plans: *1. Unresolved sanctions* The Exchange and the MIA both have authority to issue sanctions on carriers for various	

reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is issued and those that are unresolved within the timeframe provided by the issuing agency could be grounds for decertification. *2. Recertification failure* If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification. *3. Quality performance issues* The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification. Note: Carriers will have the opportunity to appeal Exchange decertification decisions. For any carriers or qualified plans that are decertified outside of an open enrollment period, a special enrollment period would then be offered to enrollees to select new plans.	

IV. PLAN CHOICE POLICY

The Exchange could implement policies to reduce the number of plans that would be available to consumers. The below table describes policy options that could be adopted. Please provide comments on the proposed policies.

Exchange Policy Questions	Comments
1) Carrier Submission Limits The Exchange could establish a policy to allow carriers (at the holding company level) to submit a maximum of 3 benefit designs (plans) per metal level.	
2) Standardization of Plans The Exchange could define a baseline benefit design that carriers (at the holding company level) would be required to offer at each metal level. Carriers would also be allowed to offer	HFA urges the state to require a baseline benefit design for each metal level to allow patients to compare plans effectively.

additional benefit designs.	

V. DENTAL & VISION PRICING DISPLAY POLICY

The following table includes Exchange policy questions for displaying pricing information for dental and vision plans that will be offered on the Exchange. Please provide comments on

Exchange Policy Questions	Comments
1) Offering Adult Dental/Vision Should the Exchange allow adult dental/vision benefits to be embedded with a qualified health plan? Or should these non-essential benefits always be offered separately?	The exchange should allow adult dental and vision benefits to be embedded with QHP.
2) Adult Dental/Vision Pricing Disclosure If adult dental/vision is allowed to be embedded with a qualified health plan, should the Exchange require carriers to disclose the price of adult dental/vision benefits to consumers separately?	The carriers should be required to disclose the price separately.
3) **Adult Dental/Vision Stand Alone Options** If adult dental/vision is allowed to be embedded with a qualified health plan, should carriers have to offer it as stand alone too?	
4) Pediatric Dental/Vision Pricing Disclosure Should the Exchange require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits?	Yes, the Exchange should require medical carriers who also offer pediatric dental/vision benefits as part of their Essential Health Benefits package to disclose their pricing for dental/vision benefits.
5) Pediatric Dental/Vision Stand Alone Options	

Should the Exchange require medical carriers to also offer pediatric dental/vision benefits on a stand alone basis when a carrier offers them as part of the Essential Health Benefits package?	

National Federation of the Blind
Nonvisual Accessibility Web Certification Program
(NFB NVA Certification)

The first Web application certification specifically for the blind. The uniquely qualified National Federation of the Blind tests sites and applications with current versions of talking screen access technology.

"Accessibility has been a priority since our inception, and we are committed to providing all students and teachers with the same innovative platform. We're honored to be working with the NFB, and are grateful for their pioneering work in accessibility, and their foundational contributions to education."
Cory Reid, Vice President of Instructure

"The Internet has become integrated into every aspect of daily living, from working to shopping to entertainment. The blind population, which stands at 1.3 million and is growing as Americans age, must have access to Web sites and new Web applications if we are to participate fully in modern society and the information economy."

Dr. Marc Maurer

Introduction

Working with members of the technology community, the National Federation of the Blind Jernigan Institute has developed a rigorous procedure whereby Web sites and applications that have made special efforts to be accessible to the blind can be identified and recognized.

Our mission at the National Federation of the Blind (NFB) is to integrate the blind into society on a basis of equality. Ensuring full access to information technology and resources is a vital piece of that mission. The NFB, as the largest member organization by and for the blind, has a better grasp of the consumer point of view of blindness accessibility than any other entity in the United States.

Not only is it in our best interest to maintain the integrity of our standards for certification, but we are also in the best position of any organization to determine usability of applications and Web sites by the blind; the International Braille and Technology Center at the NFB Jernigan Institute in Baltimore provides the most comprehensive resource in Access Technology, and conducts continuous testing of new technology.

Read on to find the answers to your questions about the program…

How do I become certified?

See also http://www.nfb.org/nfb/becoming_certified.asp

Through a WAC

Without going into too much detail, the following is a summary of the procedures:

- The applicant consults with one of NFB's Web Accessibility Consultants (WACs)
- The WAC performs a thorough Accessibility Audit on the Web site or application
- After fixing any problems and determining accessibility, the WAC refers the Web application developer to the NFB
- NFB conducts a task-performance test utilizing at least two talking screen access programs
- If the application or site is found to be as usable by the blind as it is by the sighted, the NFB offers the NFB-NVA Certification
- The NFB-NVA Certification Seal is placed on the accessible site or application

Direct Application

Web application developers who have been working on and are familiar with accessibility issues have the option of applying directly to the NFB for certification testing. In such a case, the procedures are as follows:

- The applicant submits a request for evaluation on the Introduction page for the NFB NVA Certification
- The NFB assesses applicant's site and sends an accessibility report to the applicant
- The applicant performs any necessary remediation
- NFB conducts an in-depth task-performance test and issues a report to applicant of its findings. If successful, the NFB NVA Certification is issued
- Applicant pays the fee

For more information about the initial application form and the accessibility report, please contact the National Federation of the Blind.

The NFB reserves the right to withdraw certification if the site becomes inaccessible during the year of certification and if the owner fails to remedy accessibility issues after being notified by the NFB.

Sounds straightforward. What do I get from certification?

Your **benefits** include:

- A more searchable, indexable, more easily navigable Website
- Opening up the market of consumers with disabilities, including the 25.5 million Americans who suffer some degree of vision loss
- Establishing a reputation as a socially responsible organization
- Strengthening your position when you apply for grants
- A certification seal that you may display on your Web site
- Inclusion on the NFB Web site list of all certified organizations
- Issuance of a joint press release with the NFB announcing the certification
- A letter of commendation from Dr. Marc Maurer, President of the National Federation of the Blind, to your organization's board, Federal Oversight Committee, Section 508 coordinator, or other relevant persons regarding the efficacy of your accessibility initiative
- Inclusion in an article published in the NFB's national magazine, the *Braille Monitor*
- Certified organizations are entitled to three hours of free consultation to ensure the continued accessibility of their site. Additional consultation will be provided at a discount.
- Certified organizations will also be Section 508 compliant, and are certified by the country’s most influential organization of blind people
- New certifications will be mentioned in a newsletter to members and professionals in the blindness field, including optometrists and ophthalmologists

How much does it cost?

Certification cost is based on the size of the company applying and on the level of certification attained as described below.

Certification level	**Organization Type**		
	Small (<100 employees)	Medium (100-500 employees)	Large (>500 employees)
Silver	$1,500	$1,500	$1,500
Gold or E-commerce	$2,000	$3,000	$4,000
Platinum	$4,000	$6,000	$8,000

Definition of Certification Levels

Silver

1. Top 100 URL's are completely accessible - all content is compliant with WCAG 2.0 Level AA or NFB NVA standards.

Gold

1. Top 100 URL's are completely accessible – all content and all Web content controlled by organization are compliant.
2. Twenty (20) most frequently accessed documents (MS Office/PDF) and resources (Flash/Video/Audio) (from analytics report) are compliant.

E-commerce

1. All of the most frequently used transaction paths are completely accessible.

Platinum

1. All Web content, documents, and resources are completely compliant
2. The organization commits to independent audits and continuous monitoring
3. Site owner maintains appropriate control over aggregated content (all content presented on its Web site, even if controlled and contributed by someone outside the organization)

General Notes:

- Site owner must show progress in the year following initial Silver certification towards advancing to the next level.
- Sites that have achieved Platinum status will be promoted and showcased by NFB Jernigan Institute in various forums and functions throughout the year.

Certification lasts for one year, provided that your site or application remains accessible.

How can I be sure I remain accessible and stay certified?

It is your organization's responsibility to maintain accessibility. If you have maintained a nonvisually accessible Web site or application throughout your

certification year, your certification renewal will be automatic upon your payment of the renewal fee.

I have some other questions ...

What if a Web site or application does not pass the task-performance test?
If our testing indicates that a site or application is inaccessible in a material aspect, we will report the results to the testing candidate. The candidate may come back for further testing, free of charge, *twice* after receiving a negative result. (This is based on the "Three Strikes and You're Out" principle.) **Negative results will not be communicated to anyone other than the candidate and the WAC (if there is a WAC).**

Why can't Web application developers go through just any technology consultant before being tested by NFB?
Applicants have the option to use other technology consultants. The NFB's WACs, however, have proven experience in the field of nonvisual accessibility and will be able to fully prepare the applicant for certification. Other consultants are often not prepared for accessibility compliance testing, and as a consequence applicants can end up with a site that is not as accessible as they thought.

Why have a "WAC"? What is the difference between a WAC's audit and the NFB task-performance testing?

While NFB testing incorporates some of the same testing as that used by WACs, our focus and expertise is on usability testing. Our resources are not geared to do in-depth technical consulting and Web design regardless of our capabilities in those areas. Our WACs are in that business.

Incidentally, *usability* here (as throughout) means *equivalent usability* for the blind as for the sighted. A site or application should be as easy or as difficult for a blind person to use as it is for a sighted person to use. If a sighted person finds it nearly impossible to navigate your site, then, by golly, a blind person should find it "as" impossible! Of course, you may want to reconsider your design in that instance.

Does your testing guarantee Section 508 compliance?
Our testing probably cannot succeed without a Web site or application meeting Section 508 requirements, with the exception of paragraph b (synchronization) and paragraph j (flickering).

For more information about procedures, WACs, WCAG, or anything relating to the certification program, go to our Web site <www.nfb.org> or contact the National Federation of the Blind:

Attention: Anne Taylor
<ataylor@nfb.org>

(410) 659-9314, extension 2413
200 East Wells Street
at Jernigan Place
Baltimore, Maryland 21230

Plan Management Advisory Committee

A Summary of Stakeholder Feedback
Report to the Maryland Health Benefit Exchange Board

August 9, 2012

Plan Management Advisory Committee:
Report to the Maryland Health Benefit Exchange Board

Introduction

The Co-Chairs of the Plan Management Advisory Committee (Committee) hereby submit this report of its efforts to the Maryland Health Benefit Exchange Board (Board).

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. This federal law requires all states to participate in health insurance exchanges operated by the state, the federal government, or through a state-federal partnership beginning January 1, 2014. As Maryland works to establish its state-based exchange, the Board has underscored the importance of having stakeholder engagement in the implementation process.

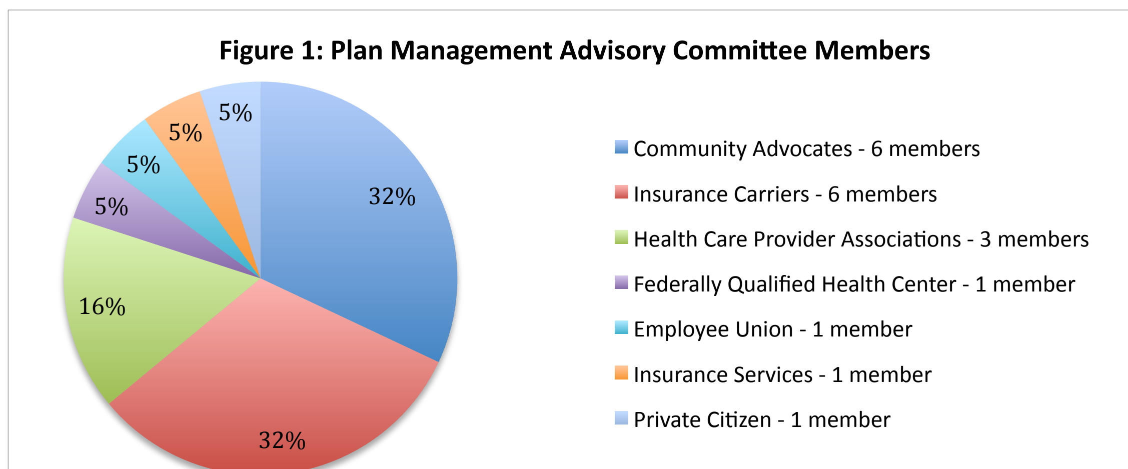
Maryland is home to many resources with expertise in the current health insurance market. Recognizing this, the Board established the Plan Management Advisory Committee to assist in the development of key policies for Maryland's state-based exchange. As the Maryland Health Benefit Exchange (the Exchange) seeks to establish a new health insurance market for individuals and small businesses, the Plan Management Advisory Committee's input will be used to inform the Board as policy and implementation decisions are contemplated. By creating this forum as a means to capture diverse perspectives of stakeholders, the Board can be assured that the Exchange will meet the needs of Marylanders.

Through an open, collaborative process, the Plan Management Advisory Committee was asked to consider proposed Exchange policies for the following five plan management areas and identify pros and cons of each proposal:
Policy Area 1: Plan Certification
Policy Area 2: Plan Recertification
Policy Area 3: Plan Decertification
Policy Area 4: Consumer Plan Choice Architecture
Policy Area 5: Dental & Vision Pricing Display

The Committee held six public meetings (June 11, June 18, June 25, June 27, July 26, July 30), at which presentations were made, discussions were held, and opportunity for public comment was provided regarding the Exchange's plan management policies. To supplement the feedback from the Plan Management Advisory Committee, oral and written comments from the public were also accepted. This report is a compilation of the feedback captured during meetings with the Exchange's Plan Management Advisory Committee. A separate document has been compiled with additional written comments received from the public.

Advisory Committee Membership, Scope & Feedback Process

The Board appointed nineteen members of the public to the Plan Management Advisory Committee. Committee members were selected to represent a broad array of stakeholders.



The Committee members affiliated with community advocacy included representation from health care, mental health, substance abuse/addiction, hemophilia, oral health, and disability organizations. Committee members affiliated with insurance carriers represented medical, stand-alone dental, and stand-alone vision carriers. Committee members affiliated with health care provider associations represented medical, optometry and mental health disciplines. A list of all committee members is included in Appendix A.

The scope of the Committee's work included a review of the following five Exchange policy areas:
Policy Area 1: Plan Certification
What certification rules should the Exchange adopt for carriers and their associated qualified health plans (QHPs), qualified dental plans (QDPs) and qualified vision plans (QVPs)? Additionally, how can certification standards be used to reduce disparities?

Policy Area 2: Plan Recertification
What recertification rules should the Exchange adopt for carriers and their associated QHPs, QDPs and QVPs?

Policy Area 3: Plan Decertification
What decertification rules should the Exchange adopt for carriers and their associated QHPs, QDPs and QVPs?

Policy Area 4: Consumer Plan Choice Architecture
How can plan information be presented to consumers to best assist them with choosing plans based on criteria other than price? Should the Exchange require a standardized plan to be offered at each metal level? Should Maryland limit the number of qualified plans issuers can submit to the Exchange?

Policy Area 5: Dental & Vision Plan Presentment
How should dental and vision plans be presented to consumers to balance the need for transparency and affordability?
The Committee is a non-voting body tasked with vetting proposed plan management policies for the

Exchange. At each advisory committee meeting, information on proposed Exchange policies was presented to committee members. Additionally State agency liaisons representing the Department of Health & Mental Hygiene (DHMH) Medicaid and Office of Oral Health, the Maryland Insurance Administration (MIA), the Maryland Health Care Commission (MHCC), and the Maryland Community Health Resources Commission (MCHRC) were present to provide committee members with insight on current market policies. The assigned Exchange Board liaison also attended all sessions to ensure the group was on task and its work was in line with the expectations of the Board. Finally, support staff and additional subject matter experts were also included in meetings to provide Committee members with clarification on the federal laws and to provide demonstrations of Exchange technology options as needed. A full list of committee resources including State agency liaisons, the Board liaison and support staff is included in Appendix A.

Based on the proposed policy options presented, the committee provided feedback – pros and cons – that has been compiled in this report across the five major policy areas that were considered by the group. Readers of this document should keep the make-up of the committee in mind and not assume that the opinions presented in this report are representative of all stakeholders in Maryland.

Plan Management Overview

A key goal of Maryland's Exchange is to offer a variety of affordable and high quality insurance plans to consumers. In order to achieve this goal, the Exchange will implement policies and procedures to ensure that all carriers and qualified plans meet federal and state requirements. Plan management is the functional area of the Exchange that includes policies, procedures and systems associated with:

- Contracting with carriers
- Certification of qualified plans
- Compliance monitoring of plans
- Recertification of plans
- Maintenance of operational data
- Management of changes in plan availability
- Review of rate increase justifications
- Management of decertification process
- Presentment of qualified plan data to consumers

Of these areas, the Plan Management Advisory Committee was asked to review proposed Exchange policies associated with certification, recertification, decertification and presentment of qualified plan data to consumers. As part of the Committee discussions, members were introduced to the following Exchange plan management guiding principles:

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

The Committee was asked to keep these principles in mind as they contemplated pros/cons of the plan management policies.

Policy Area 1: Plan Certification

Insurance carriers and plans offered in the Exchange must be certified to ensure they meet federal and state requirements. The Plan Management Advisory Committee was presented with the following

proposed criteria and policies for the certification of carriers, QHPs, QDPs and QVPs. The Committee was also given information on the existing policies for Medicaid, the MIA and the MHCC to assist during the discussion of the proposed Exchange policies (Appendix B). Unless specifically noted, the proposed policies would apply to all carriers (health, dental and vision) and the plans they offer.

a. Licensure & Solvency

Federal Requirement: A carrier must be licensed and in good standing in the State in which it intends to offer qualified plans. Additionally, carriers are required to meet state financial and solvency standards.

Proposed Exchange Policy:

The Exchange will use the existing MIA policy for licensing and verifying solvency of carriers.

Pros	Cons
• This approach leverages the existing market process that carriers are familiar with. • The MIA is already managing this area so using the existing process eliminates redundancy between MIA & Exchange.	• N/A

b. Marketing Standards

Federal Requirement: Carriers must comply with all applicable State laws governing marketing of insurance plans and cannot discourage enrollment of individuals with significant health needs.

Proposed Exchange Policy:

The Exchange will develop it's own fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require issuers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange will collaborate with the MIA to identify and resolve consumer complaints.

Pros	Cons
• A robust marketing materials review process will increase enrollment in the Exchange. • Added costs are minimal to require prior approval of marketing materials and the benefit to consumers is great. • Adds a layer of consumer protection, ensuring there is less likelihood of discouraging enrollment or steering individuals with high needs into a specific plan.	• The policy needs to clarify whether the materials submission process will be one of "file and deemed approved", or whether the Exchange will require approval before use. • For an approval process, turnaround time and staffing needed by the Exchange could be an issue. • Not sufficiently stringent. Need to ensure all marketing materials are reviewed and approved before release to the public to ensure consumers are protected. • A prior approval process will add costs to products sold on the Exchange. • General commercial health plan marketing standards that have been historically used in Maryland should be adequate for Exchange

	oversight of QHP marketing activities. The Exchange can play an important role by ensuring the Exchange participants are required to follow existing standards and support the available anti-steering mechanisms.

c. Benefit Design Standards

Federal Requirement: Carriers must not employ benefit designs that discourage enrollment by higher need consumers. Plans offered by carriers must meet the requirements for "qualified" plans (e.g., Essential Health Benefits, actuarial value, limitations on cost-sharing, non-discriminatory benefit design).

Proposed Exchange Policy:

The Exchange will use the MIA Rate, Benefit & Form review process to ensure compliance with new federal requirements for essential health benefits, actuarial value requirements (metal levels), limitations on cost-sharing, and ensuring a non-discriminatory benefit design.

(Note: Additional federal guidance is expected for actuarial value requirements for stand-alone dental plans. No federal guidance is expected for stand-alone vision plans. The expectation is that the same actuarial value requirements established for dental plans may be applicable to vision plans.)

Pros	Cons
• Leverages existing market processes.	• Demonstration of compliance with the Mental Health Parity law is not specifically mentioned here, yet both the federal and state law on HBE's specifically state that compliance is mandatory. Given the higher health care needs of this population and the challenges so far in demonstrating compliance, this should be explicitly stated in the Benefit Design Standards.

d. Rate & Benefit Reporting

Federal Requirement: Carriers must provide justification for any rate increase prior to implementing increases. Exchanges must consider that justification in determining whether to certify or recertify a qualified plan.

Proposed Exchange Policy:

The Exchange will use MIA current policy to require rate changes be reviewed and approved before release to consumers. Rate change justifications would be publicly accessible on the MIA and Exchange websites.

Pros	Cons
• Public visibility of rate changes is good for consumers.	• N/A

e. Network Adequacy

Federal Requirement: Carriers are required to maintain provider networks that are sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delays. A carrier must make its provider directory, indicating providers not accepting new patients, available to current and prospective enrollees.

Proposed Exchange Policy:
The Exchange will use the MIA current policy to allow carriers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet carrier-specific requirements. In 2015 and beyond, the Exchange will determine if Exchange specific standardized network requirements are appropriate.

Pros	Cons
• Will result in more participation by carriers since policy would allow flexibility in defining networks. • Will encourage more competition between carriers. Networks will differentiate plans. Consumers will "force" carriers to build stronger networks without the need to prescribe standard requirements. • By keeping the network adequacy standard consistent with the outside commercial market, the Exchange is less likely to experience adverse selection. • The Exchange and interested health plan participants face a significant amount of work to make the Exchange operational in 2014. Deferring the consideration of additional, new requirements until after the Exchange is operational is prudent.	• Not prescriptive enough to ensure all specialties needed by consumers will be represented in the network. Need to further defined standards (e.g., number of doctors, patient to active provider ratios, emergency room services, wait times, non-covered services, out-of-network services, percentage of providers not accepting new patients). • May result in lower levels of provider participation for Bronze, Silver and Gold levels if no provider requirements are in place (e.g., requirement for providers to participate in all metal levels of plans which may conflict with the "anti-cram down" legislation). • Doesn't allow for a standardized network policy and patient/provider protections that would be applicable to all plans in the Exchange, which may result in adverse selection for plans with greater transparency. • Lack of transparency for consumers without prescribed network adequacy standards -- consumers and carriers have different understanding of network adequacy. • Need to define the types of network variations that carriers will be allowed to have (e.g., HMO, PPO, thin networks, value-based networks etc.) and consider that different standards should apply to each network type. • Does not provide a standard for the frequency of updating the network to ensure consumers have accurate information. Maryland law currently requires internet listings of participating providers be updated every 15 days. (Insurance Article 15-112(j)) • Does not address HHS requirement that all names of providers and whether they are accepting new patients be provided to all

	current and prospective enrollees. • Does not address whether carriers will be able to file a network on a more limited geographic basis (which allows for better price point for consumers). • Proposed plan does not hold carriers sufficiently accountable for maintaining an available and adequate network. The policy does not contain any penalties for QHP issuers that provide weak networks, inaccurate listings, or lists of providers who are not accepting new patients. • Proposed plan does not discuss how patients will be treated in emergency situations or in situations when an individual cannot access in-network care in a reasonable time so an out-of-network provider is necessary. • Mental Health Parity law identifies inadequate networks as a non-quantitative treatment limitation. Same network standards must apply to behavioral health networks as to physical health networks. • Policy is short term – the timeline for compliance with network adequacy standards are not defined beyond 2014. • Current MIA standards do not ensure that individuals have access to adequate numbers of specialty providers, especially mental health and addiction providers and with possible pent-up demand with current uninsured population. • The Plan Management guiding principles includes (1) Ensure access to quality care, (2) Facilitate informed choice of health plans and providers, and (3) Reduce health disparities. This requires accurate, transparent network directories that indicate who is accepting new patients. • To ensure accuracy of directory information, the policy should specify that providers can update their own contact information, including whether they are accepting new

	patients, to maximize timely accuracy.

f. Accreditation

Federal Requirement: Carriers are required to obtain accreditation within a timeframe specified by the Exchange.

Proposed Exchange Policy:

The Exchange will accept NCQA or URAC commercial or Medicaid accreditation for 2014 and 2015. Non-accredited carriers will have a 1-year grace period to become accredited (for 2014 only). For 2016 and beyond, Exchange-specific accreditation could be required.

Dental & Vision carriers would be exempt from this requirement since no accreditation program exists for these types of plans. Instead these plans would be required to have the MIA Certificate of Authority.

Pros	Cons
• Recognizes and supports a policy of dental and vision being different. • Encourages new market entrants (e.g., smaller carriers, co-ops, Managed Care Organizations) to participate on the Exchange while working to meet the requirements. • Reduces the impact of cost, process, and resources that could have been an issue with no grace period.	• There are differences in the NCQA versus URAC standards (e.g., for patient safety, mental health services, requirements for demonstration of compliance with Mental Health Parity provisions). By accepting both, there could be differences in quality offered by the plans. • Would allow non-accredited entities to offer plans on the Exchange during the grace period. Allowing non–accredited issuers to participate in the Exchange poses potential risk to both quality and affordability. HEDIS measures that are part of the accreditation process help ensure quality of care. Issuers that don't adhere to these standards may impact the ability to quickly identify and resolve health issues resulting in poor quality and an increase in overall health care costs. In addition to ensuring quality and controlling costs, requiring accreditation of issuers would facilitate an "apples to apples" quality comparison of health plans. Current accreditation ratings demonstrate where high quality health care is occurring and provide a standard methodology for employers and consumers to compare issuers. • Should require that QHP issuers must have at least applied for accreditation by the beginning of Year 1 – this provides enough flexibility while increasing QHP quality.

g. Essential Community Providers

Federal Requirement: Carriers must include a sufficient number and geographic distribution of Essential Community Providers (ECPs) that serve low-income and Medically Underserved Populations (MUPs). (See Appendix C for the federal definition of ECPs.)

<table>
<tr><td colspan="2">Proposed Exchange Policy:
The Exchange will require that carriers contract with ECPs in Medically Underserved Areas (MUAs) unless the carriers are exempt pursuant to criteria established in the Exchange final rule.</td></tr>
<tr><th>Pros</th><th>Cons</th></tr>
<tr><td>• ECPs will supplement the networks and be a safety net to ensure networks are adequate.

• ECPs should be included in networks however the proposed policy should also address the following:
o Need to further define who the ECPs are beyond the federal definition.
o Need to ensure dental and chronic care providers are included.
o Need to address ECPs that serve Maryland residents but are outside of the State (e.g., District of Columbia).
o Need to expand contracting requirements to also require ECPs in MUPs and Health Professional Shortage Areas (HPSAs).</td><td>• Mandatory contracting with ECPs could be an issue if these providers are not ready to contract with commercial carriers. ECPs will need to establish certain minimum administrative capabilities (e.g., claims administration, electronic billing, insurance eligibility verification, credentialing requirements, and quality reporting requirements).

• Carriers cannot required essential community providers to contract with them and providers may not be willing to accept reimbursement rates from carriers.</td></tr>
</table>

h. Service Area

Federal Requirement: Carriers must have service areas that cover a minimum geographical area that is at least a county. Carriers must establish service areas in a non-discriminatory manner without regard to race, ethnicity, language or health status of the individuals in the service area.

<table>
<tr><td colspan="2">Proposed Exchange Policy:
The Exchange will require carriers to use the same service area as the outside commercial market.</td></tr>
<tr><th>Pros</th><th>Cons</th></tr>
<tr><td>• By using the same service area as the commercial market, carrier participation is encouraged.

• Allows carriers to operate in a manner consistent with the business model that works best for them.

• Supports continuity of care as people move from employer sponsored coverage to the Exchange.</td><td>• Does not address the “non-discriminatory” service area requirement of the ACA. The Exchange should provide clarification on how this will be determined.

• Allow the possibility for plans to be offered/ restricted to certain geographic areas.</td></tr>
</table>

i. Transparency Data

Federal Requirement: Carriers must report to the HHS, Exchanges, state departments of insurance, and the public information on key policies, practices and data on cost sharing.

<table>
<tr><td colspan="2">Proposed Exchange Policy:
As a condition of certification for 2014, the Exchange will require carriers to provide the following transparency data:
• Claims payment policies and practices
• Financial disclosures
• Information on enrollee rights
• Upon request of an individual, information on cost-sharing with respect to a specific item/service

For 2015 and beyond, require the following:
• Data on enrollment/disenrollment
• Data on number of claims that are denied
• Data on rating practices
• Information on cost-sharing and payments with respect to out-of-network coverage

Note: The Exchange expects additional federal guidance on transparency reporting requirements. Based on this, the Exchange will modify its policy.</td></tr>
<tr><th>Pros</th><th>Cons</th></tr>
<tr><td>• N/A</td><td>• Does not go far enough in providing consumers with transparency information. The Exchange should also consider collecting information on medical management policies and reasons for denials.

• Need medical management policies to demonstrate compliance with the Mental Health Parity Act.

• Carriers have concerns with disclosing proprietary information and rating data.

• The policy does not address the need for data on consumer satisfaction and network adequacy.

• The Exchange should also require information on carriers' business practices for disenrolling members for non-payment of premiums.

• Does not go far enough in providing transparent information to small group employers. Carriers should be required to report the structure of their commission and bonus programs that are used to pay brokers and agents (both in and out of the Exchange) to help employers increase their understanding of the cost of coverage for their employees.</td></tr>
</table>

	• Policy does not specify what information must be available to consumers.

j. Quality

Federal Requirement: The Exchange must evaluate plan issuers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.

Proposed Exchange Policy: The Exchange will use the existing MHCC quality and performance processes to provide clinical performance data and enrollee satisfaction ratings. For October 2013 open enrollment and 2014 benefit plan year, the Exchange will use a roll-up of MHCC's HMO and PPO quality and performance data and enrollee satisfaction ratings based 2012 calendar year data (most current data). For benefit plan year 2015 and beyond, the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings will be tracked and displayed. The Exchange will use the AHRQ enrollee satisfaction survey for dental plans. The Exchange will use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey.	
Pros	**Cons**
• Leverages strength of existing state health plan quality program for carriers that will participate on the Exchange.	• Need to have sufficient experience with the Exchange population to understand how it is similar or different to the non-Exchange population. • Need to ensure there is a minimum sample size of Exchange enrollees to achieve reliability with measures.

k. "RELICC" Data Tracking

Proposed State Requirement: In an effort to reduce disparities in health care and health outcomes among racial and ethnic groups in Maryland, carriers must track and report race, ethnicity, language, interpreter use and cultural competence (RELICC) data for Exchange population enrollees.

Proposed Exchange Policy: The Exchange will require that carriers use the "eValue8" tool to track and report RELICC data so that disparities can be analyzed and addressed in future years.	
Pros	**Cons**
• N/A	• Captured data is taken from member enrollment forms and will only be as accurate as the information members choose to report. • No data is collected on Lesbian, Gay, Bi-sexual and Transgender (LGBT) population, individuals with disabilities, or behavioral health issues that will allow the Exchange to identify and address all health equity issues

	as required by the ACA. • Does not address gender-based disparities.

Additional Committee Comments
The Committee also provided comments on the following areas that should be considered as the Exchange develops final recommendations for its plan certification policy:

- Compliance with Mental Health Parity & Addiction Equity Act – Demonstration of compliance with Mental Health Parity is required both in the ACA and in the state Health Benefit Exchange law. Some members noted that a 13th requirement for Parity Compliance is necessary to address QHP certification rules and also address the well-known disparities among those with behavioral health conditions.

- Broker compensation – A committee member noted that the Exchange should ensure carriers will offer the same compensation to brokers for plans sold inside/outside the Exchange. This will ensure that all plans that are available to consumers are presented.

- Provider Reimbursement – A committee member noted that the Exchange should consider how the provider fee schedule utilized by carriers will impact network participation.

Oral Public Comments
After the Committee discussions on plan certification, the public was also able to provide oral comments. The following comments were noted regarding the proposed Exchange plan certification policies:

- Network Adequacy – Members of the public noted that Maryland has different network adequacy rules for HMO plans (regulated by DHMH) and PPO plans (regulated by the MIA) and existing state laws should be used for the Exchange. Additionally, comments were made about the possibility of adverse selection if the network requirements inside the Exchange are richer than outside of the Exchange. A member of the public also noted that carrier defined network adequacy may not yield adequate access to providers for consumers. Finally,I was noted that the Exchange should establish separate standards for dental network adequacy.

- ECPs - Members of the public encouraged the Exchange to adopt a broader definition of ECPs to include categories of providers beyond the federally defined ECP list of 340B and 1927(c) providers to support the large volume of newly insured that is expected in 2014.

Policy Area 2: Plan Recertification

Plans offered in the Exchange must be periodically recertified to ensure that they continue to meet federal and state requirements. The recertification process must include a review of the criteria outlined in certification. The Plan Management Advisory Committee was presented with the following proposed policy for recertification of qualified plans.

Federal Requirement: The Exchange must complete the recertification process to ensure that carriers and consumers are fully informed of the qualified plan choices well in advance of open enrollment.

Proposed Exchange Policy: Annual Reviews On an annual basis, the Exchange will review the performance of participating health, dental and vision carriers and make recommendations on areas of improvement. Performance review areas will include: • Enrollment data by plan • Network adequacy

• Quality information
• Complaints/Grievances

<u>Biennial Recertification</u>
On a biennial basis, a formal recertification process will occur that will require the Exchange to review all of the original certification data to confirm the plan still meets requirements and can continue to be offered to consumers.

Note: The MIA benefit design review is not a part of the Exchange Annual Review or Biennial Recertification process.

Pros	Cons
	• Proposal does not address the due process rights for carriers including the right to judicial review and regulations needed. • The proposal does not include an opportunity for provider input. • The annual review does not provide information on the status of the plan regarding accreditation status. • The annual review does not provide information on plan compliance with the transparency policy. • Policy assumes that the "any willing issuer" model will continue indefinitely - timeframe for recertification conflicts with a possible Exchange contracting model change. • Annual review and biennial recertification do not include examining best practices, such as dental quality measures. • The recertification process will likely be extensive. The Exchange may want to consider recertification after three years. • Recertification should also consider whether carriers have been compliant with the Mental Health Parity and Addiction Equity Act

Policy Area 3: Plan Decertification

HHS notes that decertification is an action taken by the Exchange in response to the most severe infractions of a carrier or plan. Decertification can also occur if a determination is made not to recertify a plan. The Exchange has the authority to decertify a carrier or qualified plan that is no longer meeting the required certification standards. HHS has further clarified that exchanges will have the ability to impose

intermediate sanctions for noncompliance that fall short of full decertification. The Plan Management Advisory Committee was presented with the following proposed policy for decertification of carriers or qualified plans that no long meet Exchange requirements.

<table>
<tr><td colspan="2">Proposed Exchange Policy:
The Exchange would use the following criteria for decertification of carriers and/or of specific QHPs, QDPs and QVPs:

1. Unresolved Sanctions - The Exchange and the MIA both have authority to issue sanctions on carriers for various reasons. The agencies will work together to ensure that carriers are in good standing in order to offer qualified plans on the Exchange. Each agency will notify the other if a sanction is imposed and sanctions that are unresolved (where sanction required action by carrier and carrier failed to take requisite action) within the timeframe provided by the issuing agency could be grounds for decertification.

2. Recertification Failure - If a carrier or its qualified plans do not meet requirements for recertification at the biennial recertification review, the Exchange could opt to decertify the issuer or some of its qualified plans. The Exchange could also opt to require corrective action as an alternative to decertification.

3. Quality Performance Issues - The Exchange may opt to develop additional decertification criteria based on consumer feedback (via CAHPS and the complaints/grievances process) and quality performance results. Poor performing plans could be decertified or the Exchange could require corrective action as an alternative to decertification.</td></tr>
<tr><th>Pros</th><th>Cons</th></tr>
<tr><td></td><td>• Proposal does not address due process rights for carriers including the right to judicial review. Regulations should be developed to address this. While a plan is exercising its due process rights, it should not be decertified.

• The policy does not address whether or not, a plan will be able to participate in the Exchange while it is asserting appeal rights.

• Judicial review can be a timely process, so consumers will receive care under a substandard plan while the judicial process is completed.

• Process and regulations for the corrective action plan needs to be defined.</td></tr>
</table>

Policy Area 4: Consumer Plan Choice Architecture

Effective 2014, all health benefit plans offered must provide coverage for all Essential Health Benefits and meet the actuarial value requirements for the Platinum, Gold, Silver, or Bronze metal tiers. While these requirements ensure minimum coverage and a level of standardization, they allow for a wide range of potential variation in plan designs. The cost sharing components, such as annual deductibles, copayments,

coinsurance, and out-of-pocket cost limits are expected to serve as the predominant determinants of actuarial value, which is the measure that will be used to categorize benefit plans to be offered to consumers. These components, along with premiums, allow consumers to compare how much various benefit plans will cost them under expected and adverse health event scenarios.

With no limitations on the number of plans that carriers can offer, the volume of plans that could be available on the Exchange is expected to grow very quickly. The Exchange recognizes that offering too many choices to consumers could result in confusion and frustration. The manner in which the consumer portal is designed and the policies the Exchange adopts for plan choice will determine the order and number of plans presented to consumers. Standardizing and/or reducing the number of plans that are available could make the shopping process made easier for consumers. The Plan Management Advisory Committee was asked to consider two policy proposals designed to limit the number of plan choices consumers would have available.

a. Standardization of Plans

Proposed Exchange Policy:
The Exchange will define a baseline benefit design that carriers would be required to offer at each metal level and also allow carriers to offer additional benefit designs of their own.

Pros	Cons
• Assists consumers with making plan selections based on meaningful differences between plans. • Quality would be a key differentiator between plans. • Reduces the possibility of adverse selection, which may occur with too many choices.	• Limits flexibility and creative plan options. • Does not allow market to dictate consumer needs. • Complicated for a consumer to understand standard vs. non-standard plans.

b. Carrier Submission Limits

Proposed Exchange Policy:
Allow carriers to offer a maximum of three benefit designs per metal level.

Pros	Cons
• Good for competition – carriers will ensure only their most competitive plans are offered on the Exchange. • Ensures carriers are offering plans to fit consumers – plans will be designed specifically to attract Exchange population enrollees. • Facilitates fewer, simplified plan choices for consumers. • Consistent with current employer sponsored insurance system. In the employer-sponsored market, there are typically only a few plans	• Each consumer has different health needs that the limited benefit designs may not cover. • This sets artificial limits, and doesn't allow carriers to respond to the market. • Could make it more difficult for individuals who have had employer-sponsored-insurance (ESI) to find Exchange insurance that is similar to what they had as ESI.

offered. • Helps stabilize the Exchange market. • Requires that carriers design plans with meaningful differences, enabling informed decision by purchaser and decreasing potential for consumer confusion.	

c. Consumer Portal Plan Presentment

As part of the discussion on plan choice architecture, the Plan Management Advisory Committee viewed a demonstration of the commercial off-the-shelf (COTS) version of the consumer portal. The Exchange's web portal vendor, Connecture, walked the group though a series of "filtering" and "preference" questions that would control the number and order of plans presented to consumers. Committee members were asked to offer input on the criteria that consumers use when shopping for insurance plans. The committee noted affordability as a key factor in consumer plan selection and as such emphasized the importance of showing the monthly premium cost minus any available subsidies. The group also emphasized the need for a plan shopping design that also allows for the searching based on:

- Specific carriers
- Quality rating of plans
- Coverage of specific services (e.g., mental health services, prescription drugs, treatments for chronic conditions)
- Specific providers (including an indication of which providers are available to accept new patients as dictated by the ACA and community providers such as Federally Qualified Health Plans)
- Consumer geographic information (e.g., zip code, service area)

Given the wide variety of data elements that were suggested by committee members, the group agreed that it would be important for the Exchange to recognize that too much information could become overwhelming for the average consumer. The group noted that "assisters" (e.g., navigators, brokers) and multiple enrollment options (e.g., in person and paper) would be critical to ensuring that consumers make informed choices. The group also encouraged the inclusion of consumers in the portal testing process.

Oral Public Comments

During the Committee discussions on plan choice architecture, the public was also able to provide oral comments. The following comments were noted regarding the proposed Exchange plan choice policies:

- Portal Design & Testing - Suggestions were made on how the portal could be made more user-friendly (e.g., providing an interactive map, providing a consumer assistance chat feature, and using native speakers for the consumer assistance functions.) Members of the Committee and the public expressed and interest in being involved in Exchange portal testing to ensure the design is appropriate for the target audience.

- Standardized Plans/ Carrier Submission Limits – A member of the public noted Maryland's previous history with standardized plans in the small group market and indicated the low enrollment in these plans due to the limited benefit offering. Additionally it was noted that requiring standardized plans in conjunction with a carrier submission limit would severely limit the number of plans carriers could offer on the Exchange. Furthermore, questions were raised about how dental and vision benefits would be affected by the submission limit.

Dental & Vision Plan Presentment

In Maryland's current commercial insurance market, dental and vision benefits are offered to consumers in a variety of ways:

- *Embedded* - Dental and vision coverage is sold in conjunction with or as an endorsement to the medical plan.
- *Stand-alone* - Dental and vision coverage is sold separately from the medical plan.

The 2012 Maryland Health Benefit Exchange Act gives the Exchange Board the authority to determine the manner in which dental and vision benefits will be offered to consumers who will purchase these benefits on the Exchange. After viewing web portal "wireframes" designed to depict possible design options for displaying embedded and stand-alone plans, the Plan Management Advisory Committee was asked to provide input on the policy that should be used to determine how dental and vision benefits should be presented to consumers both for pediatric coverage (essential benefits) and for adult overage (non-essential benefits).

As the Committee considered the pricing display policy questions, the State agency staff noted that Maryland is expecting additional federal guidance on key dental/vision benefit questions that will likely impact the State's policy decisions in this area. Several open federal questions still exist regarding dental and vision benefits (e.g., a formal definition of pediatric, clarification of which consumer protections will apply to dental and vision plans, whether or not pediatric coverage is required for childless adults, and a formal definition of adequate coverage for dental and vision plans etc). Maryland continues to collaborate with the federal government to identify answers to these questions.

a. Offering Embedded and/or Stand-Alone Benefits

Exchange Policy Questions:
Should the Exchange allow adult dental and vision benefits to be embedded with the Qualified Health Plan? Should carriers that offer embedded dental/vision plans, also be required to offer these as stand alone plans?

Reasons to Offer Embedded	Reasons to Offer Stand Alone

• Today's market currently allows adult and pediatric dental to be embedded with medical so the Exchange should continue to allow this to minimize disruption.
• Carriers should not be forced to offer stand alone if that is not their model today.
• Carriers will incur the following additional administrative costs if they are required to split out plans that are today offered as embedded.
    o IT system revisions will have to occur to split the dental/vision out by benefit category and administrative processes would need to be revised.
    o Separate product and rate filings would be required to the MIA by benefit category increasing the workload for the MIA and potentially the Exchange.
	• 98%*of the current market offers dental benefits as stand-alone today so the Exchange should do what is most prevalent in the current market. (*Based on data from the National Association of Dental Plans.)
	• By separating dental benefits, consumers can more easily understand what they are purchasing vs. paying for something in an embedded plan that they don't need.
	• Adult benefits are not required benefits so by separating them, consumers more clearly see what their out-of-pocket costs are.
	• Subsidies cannot be used for adult dental/vision benefits so carriers will need to separate this out for the purpose of subsidy calculation.

○ Consumer enrollment paperwork would be duplicated for each carrier. ○ Eligibility determinations would need to be performed by benefit category. ○ Separate appeals procedures would have to be implemented and the consumer may be subjected to three potential appeals processes. ○ Separate billing and collection procedures would have to be designed (assuming carriers will maintain this function) and implemented, and the consumer may be subjected to three potential bills/collections per month. ○ Cost sharing coordination between medical, dental and vision would have to be managed separately making it difficult to determine when consumers have met their out-of-pocket maximums. • By allowing embedded plans, this reduces the volume of plans to be reviewed by the MIA and Exchange. • Embedding plans reduces the number of choices for consumers – splitting these benefits out would create too many scenarios of options for consumers. Embedding allows for a "one stop shopping" experience. • Vision plans work better in an embedded model in the Individual Exchange market – the costs for services are more than the premiums collected unless the vision is embedded with medical. • Cost comparisons are easily performed with an embedded model; the embedded model cost is X and the stand-alone medical plus dental plus vision equals Y. • Non-essential benefits may easily be identified on the web portal as such so the consumer knows what is essential and what benefits are options. • Consumers receive all ACA consumer protections under the embedded plans: this is not necessarily true under the stand-alone plans as they are "excepted benefit" and thereby exempt from certain ACA requirements.	• Consumers need stand-alone to make fair comparisons of all their choices. Without the ability to compare, they can't make informed decisions. • For vision services, there is increased likelihood of utilization when plans are separately offered. Stand-alone would result in more preventive care occurring due to the singular focus on vision health. • Embedding the offer or payment of dental into major medical would not improve coverage or the delivery of care. Delivery of dental care is separate from medical (different provider networks) and there are different claims systems.

• Allowing embedded plans will provide consistency and a more seamless experience for family coverage. Families will have one customer service phone number for questions and concerns, one website to track health care spending and paperwork, and a more seamless experience related to the global annual and lifetime limits for all EHB benefits. • Allowing embedded plans will create administrative efficiencies for carriers that will be passed onto the consumer as savings in premium costs.	

b. Pricing Disclosure

Exchange Policy Question:
Should the Exchange require carriers that embed medical, dental and vision benefits together to disclose the price of the dental and vision benefits separately?

Do Not Require Price Disclosure	Disclose Price
• Medical, dental, vision products are filed jointly not with separate pricing today. Requiring separate pricing would create an administrative burden for carriers. • Providing this level of information may cause member confusion and lead to significantly more customer service calls and questions related to premiums. The Exchange and Navigators would need to be trained on how to handle these additional questions. In addition, disclosing pricing only for dental/vision benefits may lead to further requirements to break out pricing for other benefits that would be administratively costly to support. • Cost comparisons are easily performed with an embedded model; the embedded model cost is X and the stand-alone medical plus dental plus vision equals Y.	• Because most carriers are offering separate dental and vision offerings today in the individual market, there should be no issue with disclosing the price. • Disclosing price is a consumer protection - consumers must have clear understanding of the price of each type of benefit (medical, dental, vision) they are purchasing. • If the Exchange determines it is in the interest of consumers to separately offer and price oral services, then the Exchange should establish it as a standard for QHP certification.

Oral Public Comments

After the Committee discussion on dental and vision plan policies, the public was also able to provide oral comments. The following comments were noted regarding the presentation of dental and vision plans:

- Stand-alone vision plans work well for adult population but consideration needs to be made for the close link that exists between medical conditions and vision conditions. By keeping vision and medical combined, children
- Stand-alone offerings will allow consumers to determine which bills they can afford to pay from month-to-month. By separately offering medical, dental and vision coverage, individuals and

families that have limited income may be able to retain at least partial coverage during times when they can not afford premiums for all the benefits.

Conclusion

The Co-Chairs of the Plan Management Advisory Committee wish to thank its members for their dedication to the advisory committee process. They would also like to thank everyone who brought forth perspectives for their invaluable contributions, including members of the public, Committee members, state agency liaisons, advisory committee staff, and the teams at Connecture. The Co-Chairs hope the Board can utilize the perspectives presented in this document as Maryland constructs an Exchange that best serves the needs of Marylanders.

Appendix A. Plan Management Advisory Committee Membership & Resources

Co-Chairs
Mary-Jo Braid-Forbes, MD Citizen's Health Initiative
Andrea Greene-Horace, Private Citizen

Committee Members
Penny Anderson, Maryland Dental Action Coalition
Colleen Cohan, UnitedHealthcare
Steven Daviss, M.D., Maryland Psychiatric Society
James Eickhoff, O.D., Maryland Optometric Association
Adrienne Ellis, Mental Health Association of MD
Jeffrey Endick, Slevin & Hart, P.C.
David Engwall, Man Alive
Robert Gregory, Trinity Financial Services
Larry Gross, Kaiser Permanente
Thomas Grote, Aetna
Mark Haraway, DentaQuest
Eileen Rivera Ley, Ley & Associates
Christine Libertino, Hemophilia Foundation of Maryland
Vonsetta Manns, Chase Brexton Health Services
Gary Pushkin, M.D., MedChi – The Maryland State Medical Society
Michael Reamer, Avesis
Kurtis Shook, United Concordia Dental

Board Liaison
Ken Apfel, University of Maryland School of Public Policy

State Agency Liaisons
Amy Gentile, DHMH Medicaid
Diane Herr, DHMH Medicaid
Molly McIntyre, DHMH Medicaid
Nadine Smith, DHMH Medicaid
Dr. Carlessia Hussein, DHMH, Office of Minority Health and Health Disparities
Dr. David Mann, DHMH, Office of Minority Health and Health Disparities
Dr. Harry Goodman, DHMH Office of Oral Health
Jon Kromm, Governor's Office on Health Reform
Carolyn Quattrocki, Governor's Office on Health Reform
Megan Mason, Maryland Insurance Administration
Bruce Kozlowski, Maryland Health Care Commission
Scharmaine Robinson, Maryland Health Care Commission
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Christopher Yeiser, The Hilltop Institute
Jocelyn Guyer, Health Reform Policy Advisor
Justin Stokes, Health Reform Project Management Office
Inash Pokharel, Health Reform Project Management Office
Nadia Zahangir, Health Reform Project Management Office
Tim Fisher, Connecture
Dana Leopold, Connecture

Appendix B. Comparison of Proposed Plan Certification Criteria to Current Medicaid & Commercial Market Requirements

Certification Element	Definition	ACA Required	Medicaid Current Policy (Where applicable)	MIA/MHCC Current Policy (Where applicable)	Proposed Exchange Policy
Licensure	A carrier must be licensed and in good standing in the State in which it intends to offer qualified plans.	Yes	N/A	The MIA grants certificates of authority to carriers to provide plans within the state and maintains records of all licensed carriers. Insurance Title 4, Subtitle 1 for insurers. Insurance Title 14, Subtitle 1 for Non-Profit Health Service Plans. Health General Title 19, Subtitle 7 for HMOs.	Use MIA current policy.
Solvency	Carriers are required to meet state financial and solvency standards.	Yes	N/A	The MIA has oversight over company solvency to make sure that claims can be paid. Insurance Title 4, Subtitles 1 & 3, and Title 5. The MIA also performs market conduct reviews to make sure carriers are meeting obligations. Insurance §§ 2-205 through 2-209.	Use MIA current policy.
Marketing Standards	Carriers must comply with all applicable State laws governing marketing of insurance plans and cannot discourage enrollment of individuals with significant health needs.	Yes	Subject to prior approval by the Department, an MCO may engage in marketing activities designed to make recipients aware of their availability, as well as any special services they offer. COMAR 10.09.65.23	The MIA's Market Conduct unit currently conducts market conduct examinations to determine if carriers are complying with Maryland laws. Insurance Title 27, Subtitle 2	The Exchange will develop it's own fair marketing standards for carriers. Carriers would then be required to contract/self-attest to using the standards. The Exchange will require issuers to submit all Exchange specific marketing materials for review 30 days in advance of usage. The Exchange will collaborate with the MIA to identify and resolve consumer complaints.

Benefit Design Standards	Carriers must not employ benefit designs that discourage enrollment by higher need consumers. Plans offered by carriers must meet the requirements for "qualified" plans (e.g., Essential Health Benefits, actuarial value, limitations on cost-sharing, non-discriminatory benefit design).	Yes	Required benefits package as identified in COMAR 10.09.67, 10.09.70	The MIA currently has a form review process in place that reviews for approval every health insurance and HMO contract used in Maryland for compliance with Maryland laws, including mandated benefits and discrimination in product design. Insurance §§12-203, 12-205; §14-126, and Health-General §19-713.	Use the MIA Rate, Benefit & Form review process to ensure compliance with: ○ Essential Health Benefits ○ Actuarial Value Requirements (Metal Levels) ○ Limitations on Cost-Sharing ○ Discriminatory Benefit Design Note: Need federal guidance on Actuarial Value requirements for dental plans. No federal guidance is expected for vision plans. The expectation is that the same Actuarial Value requirements established for dental plans may be applicable to vision plans.
Rate & Benefit Reporting	Carriers must provide justification for any rate increase prior to implementing increases. Exchanges must consider that justification in determining whether to certify or recertify a qualified plan.	Yes	N/A	MIA currently does a review for all rates, both new, and rate changes for Insurers, Nonprofit Health Service Plans, Association Plans and Health Maintenance Organizations. Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Insurance §§ 12-203 & 12-205 for	The Exchange will use MIA current policy to require rate changes be reviewed and approved before release to consumers. Rate change justifications would be publicly accessible on the MIA and Exchange websites.

				insurers. Insurance § 14-126 for Nonprofit Health Service Plans. Health General § 19-713 for HMOs. Chapter 513 and 514 Acts of 2012 for Association Plans.	
Network Adequacy	Carriers are required to maintain provider networks that are sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delays. A carrier must make its provider directory, indicating providers not accepting new patients, available to current and prospective enrollees.	Yes	Primary Care: (i) For physicians, with respect to adult enrollees, 2,000:1; (ii) For physicians, with respect to enrollees who are younger than 21 years old, 1,500:1; and (iii) For advanced practice nursing specialties enumerated in §A(5)(f) and (g) of this regulation, 1,000:1. Specialty Networks also have specific requirements based on the region the MCO is operating in. Reasonable travel times /miles for urban & rural areas are also required. COMAR 10.09.66	See COMAR 31.10.34. It requires the carriers to establish their own standards of network sufficiency. Prominent carriers (those with at least $90,000,000 in written premium for medical benefits in Maryland) are required to make annual reports to the MIA indicating how they met their own standards.	Use MIA current policy to allow issuers to define network requirements for 2014. The Exchange will monitor networks to ensure networks meet issuer-specific requirements. In 2015 and beyond, the Exchange will determine if standardized network requirements are appropriate.

Accreditation	Carriers are required to obtain accreditation within a timeframe specified by the Exchange.	Yes	New language is being added in upcoming revisions. COMAR 10.09.64.08	N/A	Accept NCQA or URAC commercial or Medicaid accreditation for 2014 & 2015. • Non-accredited issuers will have a 1-year grace period to become accredited (for 2014 only) • For 2016 and beyond, Exchange specific accreditation could be required • Dental & Vision plans would be exempt from this requirement and instead would be required to have the MIA Certificate of Authority.
Essential Community Providers	Carriers must include a sufficient number and geographic distribution of Essential Community Providers (ECPs) that serve low-income and Medically Underserved Populations (MUPs).	Yes	Medicaid relies upon Essential Community Providers to support enrollees.	N/A	The Exchange will require that carriers contract with ECPs in Medically Underserved Areas (MUAs) unless the carriers are exempt pursuant to criteria established in the Exchange final rule.
Service Area	Carriers must have service areas that cover a minimum geographical area that is at least a county. Carriers must establish service areas in a non-discriminatory manner without regard to race, ethnicity, language or health status of the individuals in the service area.	Yes	Service areas must include a minimum of two regions COMAR 10.09.64.05	Typically, a PPO policy does not define a service area. They define the "network" as being the providers under contract with the insurer. COMAR 31.10.34, the provider panel regulation, addresses network adequacy and does not mention service area.	The Exchange will require carriers to use the same service area as the outside commercial market.

Transparency Data	Carriers must report to the HHS, Exchanges, state departments of insurance, and the public information on key policies, practices and data on cost sharing.	Yes	N/A	Preliminary Justification forms I & II will be required for the individual market on July 1, 2012 and for the small group market on January 1, 2013. These will be posted online for consumer comment along with a consumer friendly summary. Other yearly reports are posted online, such as the Covered Lives Report which gives general market information.	As a condition of certification for 2014, the Exchange will require carriers to provide the following transparency data: • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service For 2015 and beyond, require the following: • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage Note: The Exchange expects additional federal guidance on transparency reporting requirements. Based on this, the Exchange will modify its policy.
Quality	The Exchange must evaluate plan issuers quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.	Yes	Clinical quality and enrollee quality reporting is utilized. http://mmcp.dhmh.maryland.gov/healthchoice/SitePages/CY%202010.aspx	Quality and health plan performance is measured and reported by the Maryland Health Care Commission. http://mhcc.dhmh.maryland.gov/healthplan/Pages/healthplanquality/default.aspx	The Exchange will use the existing MHCC quality and performance processes to provide clinical performance data and enrollee satisfaction ratings. For October 2013 open enrollment and 2014 benefit plan year, the Exchange will use a roll-up of MHCC's HMO and PPO quality and performance data and enrollee

					satisfaction ratings based 2012 calendar year data (most current data). For benefit plan year 2015 and beyond, the previous 12 months of Exchange specific quality and performance data and enrollee satisfaction ratings will be tracked and displayed. The Exchange will use the AHRQ enrollee satisfaction survey for dental plans. The Exchange will use a modified version of the AHRQ dental plan survey as the basis for a new vision plan survey.
Race, Ethnicity, Language, Interpreter Use, Cultural Competence (RELICC) Data Tracking	In an effort to reduce disparities in health care and health outcomes among racial and ethnic groups in Maryland, carriers must track and report race, ethnicity, language, interpreter use and cultural competence (RELICC) data for Exchange population enrollees.	No	N/A	The MIA currently requires carriers to provide appeals and grievances notices in a culturally and linguistically appropriate manner as described in the ACA. Insurance §§ 15-10A-10 and 15-10D-05 See State Government § 10-1101	Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. For 2013 and 2014 use MHCC results. For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.

Appendix C. Definition of Essential Community Providers

Definition of Essential Community Providers
“Essential Community Providers" (ECPs) are provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care. These patient populations include the low income and uninsured, residents in medically underserved rural and urban areas, and often those with special care needs, such as children with serious illness, those with mental health and substance abuse disorders, the chronically ill, or target communities such as the homeless, persons with HIV/AIDS, and migrant workers. [1]

Section 156.235 of the Affordable Care Act establishes requirements related to essential community providers.

- *(a)General requirement.* (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers…to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals…”

- *(b) Alternate standard.* A QHP issuer …must have a sufficient number … of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities…”

- *(c)Definition.* Essential community providers are providers that serve predominately low-income, medically underserved individuals, including…providers defined in section 340B(a)(4)of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV)of the Social Security Act…”

While this section describes some aspects of Essential Community Providers, it does not specify what standard the Exchange should use to determine that there are a "sufficient" number of these providers in qualified plan networks. Additionally, it should be noted that the ECP requirement applies only to plans inside the Exchange.

Examples of Federally Defined Categories of ECPs
(A) Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act). This category includes:

- FQHC Look-alikes
- Community Health Centers (Sec.330(e) Public Health Service Act)
- Migrant Health Centers (Sec.330 (g) Public Health Service Act)
- Health Care for the Homeless (Sec.330(h) Public Health Service Act)
- Health Centers for Residents of Public Housing (Sec. 330(i) Public Health Service Act)
- Office of Tribal Programs or urban Indian organizations (P.L. 93-638 and 25 USCS §1651)

(B) A family planning project receiving a grant or contract under Sec. 1001 PHSA (42 USCS§300)

(C) An entity receiving a grant under subpart II of part C of Title XXVI of the Public Health Service Act (relating to categorical grants for outpatient early intervention services for HIV disease) - Early HIV Intervention Services Categorical Grants (Title III of the RWCA)

[1] California Health Benefit Exchange: Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability, Discussion Draft – Options and Recommendations (July 16, 2012).

(D) A State-operated AIDS Drug Assistance Program (ADAP) receiving financial assistance under Title XXVI of the Public Health Service Act

(E) A black lung clinic receiving funds under Section 427(a) of the Black Lung Benefits Act (30 USCS§901)

(F) A comprehensive hemophilia diagnostic treatment center receiving a grant under section 501(a)(2) of the SSA

(G) A Native Hawaiian Health Center receiving funds under the Native Hawaiian Health Care Act of 1988 (42 USCS§11701)

(H) An urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 USCS§1601)

(I) Any entity receiving assistance under title XXVI of the Public Health Service Act (other than a State or unit of local government or an entity described in subparagraph (D)), but only if the entity is certified by the Secretary

(J) An entity receiving funds under section 318 (42 USCS §247c) (relating to treatment of sexually transmitted diseases) or section 317(j)(2) (42 USCS§247b(j)(2)) (relating to treatment of tuberculosis) through a State or unit of local government, but only if the entity is certified by the Secretary

(K) A disproportionate share hospital (as defined in section 1886(d)(1)(B)) of the SSA -

(L) A children's hospital (as defined in section 1886(d)(1)(B)(iii) of the SSA –

(M) A critical access hospital as defined in Section 1820(c)(2) of the SSA –

(N) A free standing cancer hospital as defined in as defined in Section 1820(c)(2) of the SSA –

(O) Rural Referral Center as defined in as defined in Section 1886(d)(5)(c)(i) of SSA

(P) Sole Community Hospital as defined in as defined in Section 1886(d)(5)(c)(iii) of SSA