maryland health connection

Exchange Implementation Advisory Committee

October 18, 2012

A service of Maryland Health Benefit Exchange

SHOP Discussion

Qualified Plans
Plan Data File Format

Plan Data File Format Options

Option	Pros	Cons
1. SERFF Integration	Streamlined process for carriers.	Timeline for release is unclear.
2. SBC Data File	Existing standardized data file that is already developed by carriers.	Insufficient data elements for plan presentment.
3. Modified SBC Data File	Leverage existing work as the baseline.	Level of development effort is unknown.
4. EHB Data File	Existing standardized data file that is already developed by some carriers.	Insufficient data elements for plan presentment.
5. FFE File Format	Streamline process for carriers.	Timeline for release is unclear.
6. Connecture Custom Files	File templates are already complete for health plans.	Separate process that is unique to Maryland.
Other Options?		

Plan Certification
Board Approved Policies
Part 1

What is Plan Management?

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Plan Management encompasses a broad range of functions that are required for certification of a state-based Exchange.

Carrier & Plan Set Up

- Carrier Agreement
- Plan Certification

Plan Compliance

- Plan Recertification
- Maintain Operational Data
- Rate Increase Justifications
- Plan Decertification

Plan Presentment

- Plan Searches
- Plan Comparisons
- Plan Availability Changes

Plan Management Guiding Principles

The Maryland Health Benefit Exchange (MHBE) will use the following guiding principles to establish its approach to Plan Management:

- **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

Qualified Plan Workflow

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Step 1

Submit Participation Intent Form

October 2012

- Statement of Intent to Participate
- Details to Establish Contact for HIX Login

Step 2

Business Agreement

Q4 2012

- Maryland Market Rules
- Service Area Requirements
- Marketing Standards
- Transparency Standards
- Quality Data Requirements
- Tracking of RELICC Data
- Reporting Requirements

Step 3

MIA Review & Approval

Q1 2013

- **SERFF**
- Licensure
- Solvency
- Benefits, Rates & Forms
- Essential Health Benefits
- Limitations on Cost Sharing
- Actuarial Value/Metal Levels
- Discriminatory Benefit Design

Step 4

Exchange Final Certification

Q2 2013

- **HIX Via SERFF or Direct Upload**
- Accreditation
- Network Adequacy Data
- Essential Community Provider Data
- Transparency Data

Step 5

MHCC Quality & RELICC Data

Timing Varies

- **Annual Custom File**
- HMO/PPO HEDIS Scores
- HMO/PPO CAHPS Scores
- Dental Plan CAHPS Scores
- Vision Plan CAHPS Scores
- RELICC Data (Internal use only)

Plan Certification
Board Approved Policies

Service Area

Federal and/or State Requirements	Options
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. 45CFR §155.1055.	1. Allow carriers to self-define service area as long as at least a county is covered. 2. Require carriers to use the same service area as the commercial market or MCO market 3. Require all carriers to operate statewide.
Key Considerations **Current Market Practice** Medicaid defines service areas for MCOs supporting the Medicaid population. HMO and PPO carriers self-define service areas. **Continuity of Care** The Exchange needs to consider how icarrier service areas support churn as consumers move from Medicaid, to employer sponsored coverage or to plans offered on the Maryland Health Connection. **Business Model of carriers** New market entrants such as Consumer Operated and Oriented Plans (CO-OPs) may not be able to support statewide service areas. Some existing carriers do not operate statewide and could not meet a requirement to do so.	**Board Approved** Existing Carriers – Require carriers to use the same service area as the commercial market or MCO market. For carriers that have both commercial and MCO lines of business, the commercial service area will be used for Maryland Health Connection. If the MCO service area is preferred by the carrier, a request with justification can be filed to MHBE for review and approval. New Entrants – Allow carriers to self-define service areas as long as at least a county is covered.

Licensure & Solvency

Federal and/or State Requirement	Options
A carrier must be licensed and in good standing. Carriers are required to meet state financial and solvency standards. 45 CFR §156.200(b)(4); Insurance Article §31-115(b)(5)(i), Annotated Code of Maryland.	1. Develop MHBE-specific licensure and solvency requirements. 2. Defer to the MIA for licensure and solvency.
Key Considerations **Current Market Practice** The Maryland Insurance Administration (MIA) currently grants certificates of authority to carriers. The MIA has oversight of company solvency to make sure claims can be paid. **Administrative Readiness** Separate licensure and solvency requirements would create a burden on carriers. **Timeline** The short implementation timeline may limit the ability of carriers to meet new licensure and solvency requirements.	**Board Approved** Defer to MIA for licensure and solvency.

Benefit Design Standards

Federal and/or State Requirements	Options
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). 45 CFR §§156.200(b)(1) and 156.225(b)	1. Defer to the MIA for benefit design review. The MIA will ensure all federal and state requirements are included within plans. 2. Develop a new, separate MHBE-specific benefit design review process to meet federal requirements.
Key Considerations **Current Market Practice** By statute, the MIA has authority to review benefit plans to ensure compliance with Maryland laws, the inclusion of mandated benefits and non-discrimination in product design. **Resources** Significant resources and expertise are needed to review benefit plans and ensure compliance with the law. **New Requirements** The Affordable Care Act and Mental Health Parity & Addiction Equity Act (MHPAEA) include new requirements that are not included in today's benefit design review process for small group and individual market.	**Board Approved** Defer to the MIA for benefit design review. The MIA will ensure all federal and state requirements are met with plans.

Rate Changes

Federal and/or State Requirements	Options
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. 45 CFR §§155.1020 and 156.210	1. Defer to the MIA for the review of rate changes. 2. Develop a new, separate MHBE-specific review process for rate changes.
Key Considerations **Current Market Practice** By statute, the MIA is responsible for performing a review for all rate changes. Justification forms will be required and will be posted on the MIA website for consumer comment along with a consumer friendly summary.	**Board Approved** Defer to the MIA for the review of rate changes.

Marketing Standards

Federal and/or State Requirements	Options
Carriers must comply with all applicable State laws governing marketing of insurance plans and cannot discourage enrollment of individuals with significant health needs. Communications must be simple and understandable terms, use Plain Language and language that is accessible to people with Limited English Proficiency. 45 CFR §§155.1040(b) , 156.220(c) and 156.225.	1. File and Approve Policy - Require all marketing materials to be approved by MHBE before use. 2. File and Use Policy - Require all marketing materials to be filed with MHBE before use but no approval is needed. 3. Statewide Marketing Standards - Require standardized language developed by MIA and MHBE for all marketing materials used in the state.
Key Considerations **Current Market Practice** In the commercial market, Medicare Supplemental Plans and Long Term Care plans are the only plans that require prior approval of marketing materials. All other materials are dealt with on a complaint and audit basis. Medicaid MCOs must file and gain approval before use. **Consumer Protection** MHBE and carriers will be marketing to consumers so confusion may arise unless there are mechanisms to ensure appropriate communication to consumers. **Resources** In the initial year, significant marketing will be needed to encourage enrollment. This will lead to a large volume of materials to review. If approval is required, MHBE staffing levels must be appropriate to ensure a timely turnaround.	**Board Approved** Require carriers to meet existing state Marketing requirements. For Marketing communications that are related to market reform enrollment issues, the establishment of the Maryland Health Connection marketplace and/or plans offered on Maryland Health Connection, statewide Marketing standards will be jointly developed by the MHBE and MIA. These standards would require the use of standardized text and would establish protocols for communicating with transitioning enrollees.

Network Adequacy

Federal and/or State Requirements	Options
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. An carrier must make its provider directory, indicating providers not accepting new patients, available to current and prospective enrollees. 45 CFR §§155.1050 and 156.230 The Maryland Insurance Article requires that carriers update online directory data at least every 15 days. Insurance Article § 15-112(j)(3)(ii), Annotated Code of Maryland.	1. Develop standardized network adequacy requirements for all carriers offering plans on Maryland Health Connection. 2. Allow carriers to "self-define" network adequacy requirements and perform audits to ensure requirements are met.
Key Considerations **Current Market Practice** Medicaid provides prescriptive requirements for MCO network adequacy. For PPO and HMO plans, network adequacy is defined by the carriers. **Access to Care** Little data is available on the population's network needs. It is expected that high enrollment volume and pent up demand will require robust networks to be available. **Adverse Selection** Creating a separate (more rigorous) network standard could result in adverse selection for the Maryland Health Connection. **Timeline** The short implementation timeline may limit the ability of carriers to expand networks in time for open enrollment in 2013.	**Board Approved** MHBE will allow carriers to "self-define" network adequacy standards. Each carrier must provide MHBE with an explanation of its year one standard for review and approval as a condition of certification. Carriers will be required to provide MHBE with data on a quarterly basis to demonstrate sufficient access to care. Carriers will be required to submit provider data to the CRISP Provider Information Management system. ***Evaluation & Reassessment:*** For year two, MHBE will determine if standardized network adequacy requirements are appropriate.

Essential Community Providers

Federal and/or State Requirements	Options
Carriers must include a sufficient number and geographic distribution of Essential Community Providers (ECPs) that serve low-income and medically underserved individuals. ECPs are defined in section 340B (a)(4)of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV)of the Social Security Act. 45 CFR §156.235. *Alternate standard:* Carriers that provide a majority of covered services through employed physicians can satisfy the standard by using employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities. 45 CFR §156.235(b).	Definition of ECPs 1. Use the federal definition of ECPs only. 2. Expand the definition of ECPs to include more provider types. Sufficiency Standard 1. Establish standardized requirements including a specific number and geographic distribution of ECPs. 2. Allow carriers to "self-define" standards for inclusion of ECPs.
Key Considerations **Access to Care & Transparency** ECPs will serve as a needed safety net for traditional commercial networks. Consumers will need to know who these providers are to assist in their decision making process. **Continuity of Care** Many uninsured use the federally designated ECPs and other provider types as primary care providers. Expanding the definition of providers will allow for continued services when people churn from Medicaid to the Maryland Health Connection. **Administrative Readiness** Some ECPs may not be prepared for credentialing, eligibility verification, claims billing required to join commercial networks in time for open enrollment in 2013.	**Board Approved** MHBE will use the federal definition of ECPs. Carriers will be required to meet federal requirements to ensure sufficiency. Carriers must provide MHBE with an explanation of its year one standard for review and approval as a condition of certification. Carriers will be required to provide MHBE with data on a quarterly basis to demonstrate sufficient access to care from ECPs and/or alternate standard providers. Carriers will be required to submit provider data to the CRISP Provider Information Management system. ***Evaluation & Reassessment:*** For year two, MHBE will determine if expanded categories and additional sufficiency requirements are needed.

Accreditation

Federal and/or State Requirements	Options
Carriers are required to obtain accreditation within a timeframe specified by the Exchange. HHS has recognized URAC & NCQA as authorized accreditation entities. 45 CFR §§155.1045 and 156.275	Grace Period 1. Allow a grace-period for non-accredited carriers to initially participate with no accreditation. 2. Do not allow a grace period.
Key Considerations	**Board Approved**
Current Market Practice Carriers are not required to obtain accreditation in the commercial or Medicaid markets however some do have accreditation already. **URAC vs. NCQA Accreditation** URAC includes a review of MHPAEA as part of accreditation. NCQA accreditation is more prevalent for Maryland carriers. **New Commercial Market Entrants** New market entrants including Consumer Operated and Oriented Plans (CO-OP) and MCOs that establish commercial lines of business may not have commercial plan accreditation. **Stand-Alone Dental & Vision Plans** No accreditation entities exist for stand-alone dental and vision plans.	For the 2014 plan year, MHBE will accept Medicaid or Commercial accreditation from carriers. For the 2014 plan year only, non-accredited carriers will have a 1-year grace period to become accredited. Carriers must apply for accreditation by July 1, 2013 to be eligible for the 2014 grace period. Stand-alone dental and vision carriers will be exempt from the accreditation requirement. The MIA Certificate of Authority will suffice to meet accreditation requirements for stand-alone dental and vision carriers. ***Evaluation & Reassessment:*** For year two, MHBE will reassess accreditation requirements based on new accreditation standards that become available.

Transparency Data

Federal and/or State Requirements	Options
Carriers must report to the HHS, Exchanges, state departments of insurance, and the public information on key policies, practices and data on cost sharing including: • 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 • 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 45 CFR §156.220(a)	1. Carriers will only be required to provide the transparency data required by federal law. 2. Carriers will be required to provide expanded transparency data reporting specific to Maryland's needs.
Key Considerations	**Board Approved**
Affordability/Quality Transparency data will provide a better basis for consumers to make purchase decisions. More information will also foster competition which could drive down costs and improve quality. **Timeline** Carriers have a short timeline to get systems ready for new data reporting requirements. **Federal Guidance** Additional guidance on reporting requirements is expected from the federal government. The MHBE policy should not conflict with federal requirements.	MHBE will require that carriers provide transparency data required by federal law in year one. ***Evaluation & Reassessment:*** For year two, MHBE will determine if additional Maryland-specific transparency data will be required for issuers.

Quality

Federal and/or State Requirements	Options
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. 45 CFR §155.200(d).	1. Develop MHBE-specific quality performance system for carriers. 2. Require carriers to participate in MHCC's system for quality. MHCC will incorporate stand-alone dental and vision plans into the quality process.
Key Considerations **Current Market Practice** The Maryland Health Care Commission (MHCC) currently has a plan quality and performance evaluation system for medical carriers with a premium volume in Maryland that exceeds $1 Million. The system includes the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) and the AHRQ Consumer Assessment of Health Providers and Systems (CAHPS). **Stand-alone Dental & Vision Plans** MHCC does not currently include stand-alone dental and vision plans in the plan quality and performance processes. HEDIS is not designed for these plans. The standard CAHPS enrollee survey is designed for medical plans.	**Board Approved** MHBE will require that carriers participate in MHCC's system for quality. MHBE will require stand-alone dental and vision plans to report quality data to MHCC. Stand-alone dental and vision carriers will not be included in the quality reporting in the first benefit year. MHBE will collaborate with MHCC to determine the appropriate timing for expanding the system for quality to include stand-alone dental and vision carriers.

RELICC Data Tracking

Federal and/or State Requirements	Options
The Maryland Health Benefit Exchange Bill of 2011 requires annual reporting to the General Assembly including data to identify disparities related to gender, race, ethnicity, geographic location, language, disability, or other attributes of special populations. Insurance Article § 31-119(d)(2)(iii), Annotated Code of Maryland.	1. Develop MHBE-specific process to collect disparity data from carriers. 2. Require carriers to participate in the MHCC Maryland RELICC Assessment process.
Key Considerations **Current Market Practice** The Maryland Health Improvement and Disparities Reduction Act of 2012 expanded the authority of MHCC to establish and implement a system to evaluate and compare the quality and performance of care provided by commercial health benefit plans. The Maryland Health Care Commission (MHCC) has announced a process for health carriers to track and collect race, ethnicity, language, interpreter need and cultural competence (RELICC) data for benefit year 2012. **Maryland Disparities** DHMH Office of Minority Health and Health Disparities has collected data to indicate a wide difference in health outcomes between Whites and other minorities	**Board Approved** MHBE will require that carriers participate in the MHCC Maryland RELICC Assessment process. Stand-alone dental and vision carriers will not be included in the Maryland RELICC Assessment reporting in the first benefit year. MHBE will collaborate with MHCC to determine the appropriate timing for expanding the Maryland RELICC Assessment to include stand-alone dental and vision carriers.

Plan Recertification
Board Approved Policy

Plan Recertification

Federal and/or State Requirements	Options
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. 45 CFR§155.1075	N/A
Key Considerations **Appeals Process** Failure to recertify a plan could significantly limit an carriers ability to be competitive in the State. Because of this, if a plan fails recertification appeals rights should be available for carriers.	**Board Approved** *Annual Reviews* On an annual basis, MHBE 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 • Access to Care • Quality information • Complaints/Grievances In the initial business agreement, carriers will be required to agree to complete corrective action plans based on issues identified in the year one annual review. *Biennial Recertification* On a biennial basis, a formal recertification process will occur that will require MHBE to review all of the original certification data to confirm the plan still meets requirements and can continue to be offered to consumers. MHBE will have the right to modify the recertification frequency after the first biennial recertification period. The MIA benefit design review is not a part of the MHBE Annual Review or Biennial Recertification process. Carriers will have the right to appeal recertification decisions.

Plan Decertification
Board Approved Policy

Plan Decertification

Federal and/or State Requirements	Options
The Exchange has the authority to decertify a 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. 45 CFR§ 155.1080.	Define MHBE-specific decertification plan.
Key Considerations **Appeals Process** Decertification could significantly limit an carriers ability to be competitive in the State. Because of this the decertification strategy should include appeals rights for carriers. **Consumer Impact** Decertification of a plan requires that a special enrollment period be offered to allow consumers enrolled in the decertified plan to select another alternative plan. **Timing** Decertification of plans should coincide with open enrollment wherever possible to minimize disruption/impact to enrollees.	**Board Approved** MHBE may decertify any plan that fails to meet the requirements for recertification or fails to comply with a corrective action plan. Carriers will have the right to appeal decertification decisions.

Plan Choice
Board Approved Policies

Submission Limits

Federal and/or State Requirements	Options
Several states are considering policies that address how much choice consumers should have in the Exchange. TN – A "rule of 12" to provide a maximum of 48 standard plans from which consumers may choose. OR – Limiting plans that can be offered per metal level and per service area. RI – Limiting number of plans per metal level.	1. Allow carriers to offer up to two benefit designs per metal level. 2. Allow carriers to offer up to four benefit designs per metal level. 3. Allow unlimited number of plans to be offered by carriers as long as they meet certification and recertification requirements.
Key Considerations	**Board Approved**
Best Practice Data Medicare Advantage data on how people make choices notes that expanding the number of choices does not lead to making better selections. **Innovation** Allowing more plans encourages carriers to be innovative with product design. **Resource Planning** Limiting the number of benefit designs will improve resource planning for the benefit design reviews and certification processes that will be performed by the MIA and MHBE.	MHBE will allow a maximum of four benefit designs per metal level to be offered by each issuing company. Separate limits apply for the Individual Exchange and the SHOP Exchange. ***Evaluation & Reassessment:*** MHBE will re-evaluate the need for carrier submission limits on an annual basis.

Standardized Plans

Federal and/or State Requirements	Options
N/A	1. MHBE will require carriers to offer a standardized plan at each metal level. 2. MHBE will not require any plan standardization beyond the Essential Health Benefits Benchmark.
Key Considerations **Plan Variation** 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. **Innovation** By requiring a standard plan, this may limit benefit design innovation in the market.	**Board Approved** For year one, MHBE will not require standardization beyond the Essential Health Benefits benchmark. ***Evaluation & Reassessment:*** MHBE will re-evaluate the need for standardized plans on an annual basis based on standards for value-based design.

Updates

Carrier Training & Reference Manual

The first in a series of carrier training sessions will be conducted:
Wednesday 10/24
9:00 – 5:00
Maryland Department of Transportation
7201 Corporate Center Drive
Hanover, MD 21076

RSVP to mmason@mdinsurance.state.md.us

Registration deadline 10/22/12

Carrier Training & Reference Manual

Topics will include:

- Participation requirements
  - Sample Participation Intent Forms
- Benefit design requirements
  - What we know now!
- Rating rules
  - What we know now!
- A demonstration the Carrier Administration Portal of the Maryland Health Connection
- Carrier Reference Manual – Release 1.0

Next Exchange Implementation Advisory Committee Meeting

November 1st

2:00 – 5:00

UMBC Tech Center

Thank you!

For more information on the Maryland Health Connection, please visit us at:
www.MarylandHealthConnection.gov