MARYLAND HEALTH BENEFIT EXCHANGE RESPONSES TO PUBLIC COMMENTS ON 2017 DRAFT LETTER TO ISSUERS

The following chart summarizes public comments submitted to Maryland Health Benefit Exchange (MHBE) regarding the 2017 Draft Letter to Issuers and MHBE's response to each comment. Comments are organized by chapter and topic, and the commenting organization is listed in parentheses after the comment in the second column (please refer to Commenter Key below for abbreviations guidance). Accepted comments are incorporated into the 2017 Final Letter to Issuers. MHBE will provide additional information and guidance to the public for any comments that MHBE has chosen not to incorporate into the Letter at this time but proposes to further review with stakeholders.

Commenter Key

AHIP = America's Health Insurance Plans	CF = CareFirst BlueCross BlueShield	CLINIC = Drug Policy and Public Health Strategies Clinic Coalition[1]	DELTA = Delta Dental
EG = Evergreen Health Cooperative	HEAU = Office of Attorney General, Health Education and Advocacy Unit	KP = Kaiser Permanente	LCPC = Licensed Clinical Professional Counselors of Maryland
LEAGUE = League of Life and Health Insurers of Maryland	MACHO = Maryland Association of County Health Officers	MASBHC = Maryland Assembly on School-Based Health Care	MDAC = Maryland Dental Action Coalition
MIA = Maryland Insurance Administration	MNA = Maryland Nurses Association	MOTA = Maryland Occupational Therapy Association	MWC = Maryland Women's Coalition for Health Care Reform[2]
PPM = Planned Parenthood of Maryland	UHC = UnitedHealthcare		

Summary of Comments by Topic

Draft Letter Proposal	Public Comment to Proposal	MHBE Response to Proposal	MHBE Reason for Response
Chapter 1: CARRIER ANNUAL CERTIFICATION PROCESS AND STANDARDS			
1. NON-EXCHANGE ENTITY AGREEMENT Carriers must have annual NEEA on file	Provide carriers with draft for review prior to signature (CF); Provide 60 days prior to effective date (UHC, LEAGUE)	Accepted as proposed	MHBE will provide any new version of NEEA for the upcoming year to carriers 60 days prior to the effective date.

[1] *Drug Policy and Public Health Strategies Clinic Coalition's comments represent the joint comments of the following individual organizations: the University of Maryland Carey School of Law Drug Policy and Public Health Strategies Clinic; Community Behavioral Health Association of Maryland; Mental Health Association of Maryland; and National Council on Alcoholism and Drug Dependence-Maryland.*

[2] *Maryland Women's Coalition for Health Care Reform's comments represent the joint comments of the following individual organizations: Advocates for Children & Youth; Greater Baltimore HIV Health Services Planning Council; Maryland Citizens' Health Initiative; Maryland Nonprofits; Mental Health Association of Maryland; NCADD-Maryland; Primary Care Coalition of Maryland; and Public Justice Center.*

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2. CARRIER BUSINESS AGREEMENT Carriers must have an active CBA on file	Provide carriers with draft 60 days prior to effective date (UHC, LEAGUE)	Accepted as proposed	MHBE will provide any new version of the CBA to carriers 60 days prior to the effective date.
3. ISSUER CERTIFICATION Issuer must meet certain standards to be certified to offer plans through MHBE	a. Engage carriers further before implementing standards (UHC)	Already incorporated in part; will review further with stakeholders	MHBE will continue to use stakeholder groups such as the SAC and EIAC to propose and discuss issuer certification standards. MHBE originally presented many of the new 2017 proposed standards to stakeholders prior to inclusion in the Draft Issuer Letter and incorporated feedback into its proposal.
	b. Remove "Issuers will be considered accredited if the issuer has an accreditation status level deemed acceptable by MIA" because MIA does not evaluate carrier's accreditation status or deem accreditation status level (MIA)	Accepted with amendments to proposal	MHBE will replace the MIA condition with this language: "MHBE will consider an issuer accredited if it has an accreditation status deemed acceptable under the federal accreditation standard described in CMS' 2017 Letter to Issuers in the FFM".
4. NETWORK ACCESS PLANS Carriers must annually submit a Network Access Plan in MHBE-template; for 2017, MHBE will collect three new templates: quantitative standards network adequacy reporting, provider accessibility standards, and member services standards	a. Clarify difference between quantitative standards NA reporting/provider accessibility standards templates and NA templates HMOs submit to DHMH for network certification (EG)	Accepted as proposed	The templates are different in substance and purpose than what is submitted to DHMH. The Quantitative NA Standards/Provider Accessibility Standards describe an issuer's internal metrics for evaluating their own NA, Provider Accessibility, and Member Services.
	b. Clarify certification compliance evaluation of "Reference Annual Review process" (CF)	Accepted with clarification	To clarify, in order to meet compliance for this standard issuers are expected to provide a review of the manuals upon each annual release of the manuals by MHBE. This requirement is intended to be for issuer benefit.
	c. Engage stakeholders to build NA templates if used to assess NA (KP)	Accepted with amendment	This template will not be used to assess NA; this template will be used to provide

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			to MHBE an issuer's internal network adequacy standards.
	d. Release templates ASAP and align with final CMS templates (UHC)	Accepted with amendments	MHBE will release the templates by end of January. The CMS templates are different in design and purpose. The three new templates are meant to provide additional information to MHBE.
	e. Clarify purpose and content of additional templates (KP)	Accepted with amendments	MHBE will release the templates by the end of January. The CMS templates are different in design and purpose. The three new templates are meant to provide additional information to MHBE.
	f. Adopt NAIC Model Act standards and make carrier access plans publicly available, unless showing that information is proprietary (CLINIC; MWC)	Not accepted at this time; will review further with stakeholders	MHBE will review this comment further with stakeholders.
	g. Require carriers public disclosure of selection/tiering standards for participating providers to ensure compliance with Parity Act (CLINIC; MWC)	Not accepted at this time; will review further with stakeholders	MHBE will review this comment further with stakeholders.
5. CARRIER CERTIFICATION APPLICATION REVIEW MHBE must review application submitted by an issuer within 45 days of receipt	Revise language to indicate certification is deemed approved unless denied (UHC)	Not accepted at this time	MHBE will provide an approval or denial notice to the carrier.
6. WAIVER OF CERTIFICATION STANDARDS To request waiver of certification standards, issuer should inquire with MHBE Account Manager	Clarify who the MHBE Account Manager is (UHC)	Accepted as proposed	MHBE Account Manager is the MHBE Point of Contact for all Plan Management/Operational initiatives. All issuers participating in Maryland Health Connection currently work with the MHBE Account Manager.

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7. DENIAL, SUSPENSION AND REVOCATION AUTHORITY MHBE may deny, suspend, revoke or seek other remedies against issuers	Clarify that review findings and corrective action plans are subject to appropriate remedies under state and federal laws/regulations (UHC)	Accepted as proposed	MHBE will add this language to the subsection.
8. BUSINESS PROCESS REVIEW SURVEY Tool allowing stakeholders to provide feedback; carriers must respond, EIAC may respond; will develop survey through EIAC and public comment	Generally supports proposal (KP)	Accepted as proposed	MHBE will implement business process review survey after stakeholder engagement.
Chapter 2: QUALIFIED HEALTH PLAN/STAND-ALONE DENTAL PLAN CERTIFICATION PROCESS			
9. SHOP PLAN MANAGEMENT REQUIREMENTS Per Feb 9, 2015 SHOP Plan Management II memo, issuers and administrators: (i) must use Standardized Quoting Scenario; (ii) must notify PM of rate changes different from quarterly rates in Rate Data Template; and (iii) can request exemption from SERFF Template Rule	Remove requirements on SHOP plan management, including the role of multiple TPAs, because future and shape of SHOP remains under discussion (CF)	Will review further with stakeholders	The role of SHOP TPAs will be addressed through a separate process. MHBE will consider removing requirements should the program change in the future.
10. DATA RECONCILIATION PROCESS On 9/12, PM will provide CCIIO templates to SHOP Administrators to begin	Given short time frame for reconciliation process, implement streamlined approach where initial and final templates are submitted in SERFF Binder for SHOP Plan Certification only, and where SHOP Administrators and carriers communicate	Accepted as proposed	MHBE accepts this operational suggestion. This change will be updated in the Final Letter to Issuers for 2017 plan certification.

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Plan Data Reconciliation Process, which ends 10/15	directly and only provide MHBE with notice of new iterations of plan templates that will include identification of changes – will reduce dependency on MHBE as facilitator to distribute new iterations of plan templates and decrease length of approval process while allowing MHBE to remain up to date on new iterations (EG)		
11. PLAN DISPLAY TESTING Issuer plan display testing in MHC User Acceptance Testing Environment will occur from 9/1 – 9/9/16. Final templates due 9/2 for SHOP or 9/12 for individual	a. Provide at least 2 weeks for plan display testing after 9/1 + additional time for carriers (CF); require final templates only after plan display testing (CF); allow 3 weeks to submit full suite of docs from date MIA releases them with due date subject to change pending MIA form and rate approval (CF; LEAGUE)	Not accepted at this time	Projected eligibility functionality conflicts with the commenter's proposed timeline. Final rates must be in the HBX platform in order to create correct projected eligibility determinations.
	b. Release Network Access Templates to carriers ASAP for data gathering and testing (LEAGUE)	Accepted as proposed	MHBE will release these new templates to issuers by the end of January. MHBE does not expect the new template to be operationally burdensome to issuer partners.
	c. Clarify that no carrier penalty if template delay because MIA hasn't timely approved forms/ rates (UHC)	Accepted as proposed	The timelines outline by MHBE in the Issuer Letter are subject to MIA rate release schedule.
12. OPTIONAL PLAN SHOPPING TILE AND PLAN COMPARE TEMPLATE Issuers may submit Plan Shopping Tile and Plan Compare Template for plans and plan variants; first round submission 7/15/16	Clarify rationale for request and keep requirement optional, otherwise it would be extremely burdensome on carriers (CF)	Accepted as proposed	The requirement will continue to be optional. Issuers that used the Plan Shopping Tile and Plan Compare Template for 2016 resubmitted templates in fewer iterations and had more correct plan display at the beginning of open enrollment than issuers that did not. This template allows the issuers to identify the data discrepancies from the

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			screenshots provided to them by MHBE, and then provide to MHBE Plan Management the expected output. MHBE Plan Management then uses the information to provide issuers orderly feedback to that correct the discrepancies. This results in fewer template resubmissions in general, and fewer template resubmissions post OE.
13. DEDUCTIBLE AND HSA IN SILVER PLAN MARKETING NAMES MHC will continue to display deductible/HSA eligibility in plan marketing name but recommends removing “deductible”/ “HSA” in silver level plan names	a. Clarify and adopt uniform approach on use of deductibles/HSA in silver plan names (EG)	Will review further with stakeholders	MHBE will continue to recommend that issuers remove variable plan attributes from plan marketing names. MHBE will continue to evaluate marketing name suggestion with stakeholders as we believe this issue affects on- and off-Exchange plans. MHBE will use stakeholder feedback to inform an MHBE proposal on plan marketing names for 2018 plan certification.
	b. Do not remove "deductible"/ "HSA" from silver plan names: informal focus groups with brokers indicate deductible amount/HSA designation are ideal to present and quote business; keep on/off exchange and states consistent: changing name leads to duplications between plan offerings (UHC)	Will review further with stakeholders	MHBE will continue to recommend that issuers remove variable plan attributes from plan marketing names. MHBE will continue to evaluate marketing name suggestion with stakeholders as we believe this issue affects on- and off-Exchange plans. MHBE will use stakeholder feedback to inform an MHBE proposal on plan marketing names for 2018 plan certification.
14. DETERMINATION OF PLAN CERTIFICATION MHBE must review applications within 45 days; will send Approval or Denial Notice; MHBE may deny,	Clarify that any denial, suspension or revocation of certification and compliance review findings and corrective action plans are subject to appropriate remedies under state and federal laws and regulations (UHC)	Accepted as proposed	MHBE accepts this comment as proposed.

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suspend, revoke or seek other remedies against QHP/SADP issuer and conduct compliance reviews of cert. standards			
15. SHOP: GENERALLY 2017 Draft Issuer Letter did not include specific provisions about structure of SHOP, but includes certain requirements for SHOP plans related to timing	Consider letter submitted 12/18/2015 about importance of a single-TPA or MHBE-led SHOP model to ensure more accurate and efficient testing environment; implement and maintain uniform and transparent compensation and finance structure, advocacy for employee choice and SHOP enhancements (KP)	Will review further with stakeholders	MHBE will take all stakeholder comments into consideration regarding the future of the SHOP.
Chapter 4: QUALIFIED PLAN CERTIFICATION STANDARDS			
16. SBC FORMS Carrier must provide MH/SUD treatment cost examples in SBC	a. Eliminate requirement of additional cost examples in SBC forms: federal SBC regulations regarding content and/or length of SBC forms prohibit alteration of SBC forms (AHIP, CF, KP, LEAGUE, MIA, UHC)	Accepted; Will review further with stakeholders	MHBE agrees that the SBC is not the appropriate venue for additional state-specific cost examples. MHBE believes that these examples would be valuable to consumers. MHBE will engage stakeholders to determine appropriate medical condition examples, a uniform template for determining treatment cost, and an appropriate location to share the information in the future.
	b. Provide cost calculator/guidance to fill in additional info like HHS (EG)	Will review further with stakeholders	
	c. Keep additional examples but incorporate further stakeholders and/or SAC input because EIAC only has 1 consumer rep (MWC)	Will review further with stakeholders	
	d. Keep additional examples but identify one SUD/MH disorder and standard type of care for which all carriers must provide typical cost of care (CLINIC)	Will review further with stakeholders	
	e. Regulate SBCs as plan documents rather than marketing materials, or make clear on SBCs that they are marketing materials and	Not accepted at this time	SBC content is governed by federal law and regulation. As a certifying agency, MHBE has authority to address

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	should not be relied upon for specific cost info (CLINIC)		inconsistencies or non-compliance with requirements.
17. ADDITIONAL INFO WITHIN SBC LINK Carriers must include direct URL link to each QHPs complete benefits or terms through a policy contract or SBC	a. Generally supports proposal to include URL on SBC form (EG; MWC; CLINIC; HEAU); with uniform requirements across carriers (EG)	Accepted as proposed	MHBE accepts this comment as proposed. Carriers should adhere to SBC parameters as governed by federal law and regulation.
	b. Implement FFM approach where issuers submit dynamic URLs instead of static PDFs (KP)	For future consideration	MHBE, will accept the commenter's request for future consideration. The MD HBX Platform was built to hold issuer PDFs in plan shopping. Such a request will require development, but will be considered for future enhancements.
	c. MHBE should review language on carrier websites to ensure info is clear and concise (MWC)	Not accepted at this time	SBC content is governed by federal law and regulation. As a certifying agency, MHBE has authority to address inconsistencies or non-compliance with requirements.
	d. Remove requirement, follow FFM standards which only requires URL that allows consumers to access policies and group certificates; 1-click access to specific benefits/terms impossible since final group certificate is unique to each customer; clarify if MHBE plans to go beyond FFM standard (UHC)	Accepted as proposed	Carriers should adhere to SBC parameters as governed by federal law and regulation. MHBE will clarify that MHBE does not intend to include requirements beyond the FFM standard.
	e. Require carriers to include benefit descriptions of all utilization management requirements for specific benefits, including pre-service notification, authorization (prior, concurrent, retroactive) so consumers have notice of access requirements; ensure all relevant info about benefits covered through subcontractor, such as behavioral health or prescription drug management entities,	Will review further with stakeholders	Carriers should adhere to SBC parameters as governed by federal law and regulation. MHBE will further discuss the sharing of additional information in material outside of the SBC with stakeholders.

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	be available to consumers in same manner as other med/surgical benefits (CLINIC)		
18. PROVIDER DIRECTORIES Carriers must make provider directory information available on website in accordance with FFM accessibility standards matching information on CRISP within a reasonable degree of variance to be determined by MHBE	a. Generally supports requirement for issuers to keep directories updated (AHIP; CF; DELTA; MNA; MASBHC; MDAC; HEAU; KP; PPM; MACHO; MWC; CLINIC), especially supports collection of info on "accepting new patients" (CF; MDAC; MWC)	Accepted as proposed	MHBE will require carriers to update provider directories to match provider information in CRISP at least once every fifteen days and will require carriers to accurately report whether providers are currently accepting new patients.
	b. Require providers to notify carriers when directory info changes or otherwise keep info up to date (AHIP; CF; DELTA)	Not accepted at this time	MHBE does not have authority to regulate providers.
	c. Align requirements with forthcoming MIA legislation (CF; EG)	Accepted as proposed	MHBE will work with MIA to update current proposed provider directory requirements to align with MIA proposed legislation if enacted and necessary.
	d. Apply requirement to on/off exchange plans for consistency and to avoid adverse selection (CF)	Will review further with stakeholders	MHBE believes that most carriers have the same provider networks for on- and off-Exchange plans, and therefore the application of this standard to only Exchange plans would have minimal adverse impact on consistency and plan selection. However, MHBE will work with MIA to discuss aligning provider directory requirements to ensure consistency between on- and off-Exchange plans.
	e. Remove requirement of prior MHBE approval of directories (CF)	Accepted with clarification	MHBE intends to require prior approval for location of directories on carrier websites and ensure location consistent with 45 CFR 156.230, but will not approve the directories themselves.
	f. Implement NA/ECP Workgroup recommendations that CRISP directory include program and community health	Accepted as carrier option for 2017; Will review	MHBE will allow carriers to include additional information for 2017 plan year. MHBE will review resources

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	center names so consumers can search for programs or centers by name (MASBHC; PPM)	requirement for 2018 further with stakeholders	required to share this information and a requirement to include this information will be considered for 2018 plan year.
	g. Require issuers to update CRISP data at least 1X/15 days (HEAU)	Accepted as proposed	Current update requirement is twice a month, MHBE will amend requirement to be at least once per 15 days to clarify the required timeline.
	h. Place link next to provider in directories to allow consumers to directly and in real time report inaccuracies (HEAU)	Will review further with stakeholders	MHBE agrees that a process allowing easy, real-time access to provide feedback on directories would be useful to consumers. MHBE is implementing a process to accept consumer feedback on inaccuracies. MHBE will further explore avenues to report this information, such as an embedded link, to ensure directory accuracy based on available resources.
	i. Require hold harmless provision so consumers who detrimentally rely on inaccurate directory info pay in-network rates or receive some form of restitution (HEAU)	Will review further with stakeholders	MHBE will further explore this option with stakeholders
	j. Implement penalties, like FFM/Medicare Adv., including restitution or fines: new regulations allow CMS to fine insurers $25K per beneficiary for errors in MA plan directories and up to $100 per beneficiary for errors in plans sold on FFM (HEAU; MWC)	Will review further with stakeholders	MHBE currently has the authority to impose penalties for failure to comply with standards of certification (Md. Insur. Article §31-115(k)(3)). MHBE will further explore this option with stakeholders.
	k. Use existing billing data to better update carriers' panels (MACHO)	Accepted with amendment	MHBE agrees that issuers could use billing data as one method, among others, to improve the accuracy of their provider directories. MHBE will review issuers' self-selected methods used to establish their benchmark accuracy rate in 2016/2017 with stakeholders, as

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			proposed, in order to present a standard assessment method to Board for approval and use with 2018 certification.
	l. Require carriers to submit accuracy assessment methods to MHBE for approval and SAC for consideration (MWC)	Not accepted at this time in part; Already incorporated in part	MHBE will require updates to directories to conform with CRISP directory information at least once every 15 days. Location on carrier websites and consumer accessibility will be subject to MHBE approval. MHBE will set an assessment method for future years as proposed.
	m. Change last sentence in Section G to read "The issuer will be <u>required</u> to meet the baseline target set by the board." (MWC)	Accepted as proposed	MHBE intended to make baseline targets mandatory and will update language to reflect this.
	n. Clarify and/or allow further comment from carriers regarding requirement that info meet CRISP directory "within a reasonable degree of variance to be determined by MHBE" (UHC)	Accepted request for clarification; request for further comment not accepted at this time	MHBE will clarify that a "reasonable degree of variance" means carrier provider directories should match the CRISP information within 15 days of changes reported to the CRISP directory.
	o. Require carriers to perform quarterly audit of directories as proposed in the new CMS Medicare Advantage rules (MWC)	Will review further with stakeholders	In the proposed standard, carriers may provide information about the steps they take to ensure their directory is accurate. In reviewing a baseline target and uniform method of carrier self-assessment, MHBE will review the approaches taken by MA and the FFM.
19. NETWORK ADEQUACY METRICS Issuers must publicly report certain quantitative provider network metrics through SBC forms: (a) average wait time for PCP and MH providers; (b)	a. Under federal SBC regulations regarding content and/or length of SBC forms, MHBE cannot require additional cost examples in SBC or otherwise alter SBC forms (AHIP, CF, KP, LEAGUE, MIA, UHC)	Accepted as proposed; will review further with stakeholders	MHBE agrees that the SBC is not the appropriate venue for collecting expanded network adequacy metrics, but believes that this data is valuable to consumers. MHBE will further engage stakeholders to determine the appropriate form and content of additional cost examples, an appropriate

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average drive distance to PCP and MH providers; (c) percent of PCPs and MH providers in network accepting new patients; (d) CAHPS scores; and (e) OPTIONAL: additional metrics for any other specialist categories of the issuer's choosing			method for collecting the required NA information and an appropriate location for sharing the information and cost examples.
	b. Do not require potentially prescriptive time and distance metrics that are outdated, work against integrated care, and fail to incorporate key elements; instead, include metrics such as quality of providers and innovative health care delivery approaches (AHIP; KP); average wait time is nearly impossible to calculate due to variations doctor to doctor day to day (MIA)	Not accepted at this time; will review further with stakeholders	MHBE intends to collect this data for the 2017 plan year to determine if quantitative network adequacy standards are necessary, and will engage stakeholders further to discuss utility of certain metrics such as driving time and distance.
	c. Generally supports collection and public release of NA metrics as proposed (MNA; LCPC; MOTA; MDAC)	Accepted as proposed	MHBE will collect and publicly release these network adequacy metrics for the 2017 plan year as proposed.
	d. Collection of metrics does not go far enough, MHBE should adopt and enforce quantitative NA standards; adopt quantitative NA standards in federal 2017 Proposed Payment Rule/NAIC Model Act (MWC; CLINIC; HEAU)	Not accepted at this time; will review further with stakeholders	MHBE intends to collect this data for the 2017 plan year to determine if quantitative network adequacy standards are necessary, and will engage stakeholders further and consider federal standards and the NAIC model act to determine the utility of certain metrics.
	e. Clarify PCPs includes physicians and APRNs (MNA), OB/GYNs (CLINIC)	Accepted as proposed	MHBE will provide a template that carriers should use to provide the requested information to MHBE. The template will break down the categories of PCPs, and MH/behavioral health providers in the template and provide additional guidance to complete the template. Carries may supplement the
	f. Clarify MH providers include all licensed MH providers, including nurse psychotherapists (MNA); licensed clinical professional counselors who provide MH services (LCPC); and occupational therapists who provide MH services (MOTA)		

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	g. Clarify if carriers will be required to account for and provide data for all MH provider designations individually (i.e. LSW, LCP, psychologist, psychiatrist) (CLINIC)	Accepted	template with additional information, at their choosing.
	h. Implement similar requirements for embedded and SADPs so consumers have access to same info for dental coverage and basis for development of future quantitative standards for dental plans (MADC)	Not accepted at this time; will review further with stakeholders	MHBE will clarify that it intends to only collect NA metrics for QHPs as SADPs are not required to meet the same standards. MHBE will engage stakeholders to determine if quantitative standards/metrics will benefit consumers enrolled in SADPs, and if so, what the appropriate standards/metrics would be.
	i. Require similar data collection for SUD providers (CLINIC)	Accepted with amendment	MHBE encourages carriers to provide metrics for SUD providers as well. If the carrier does not provide this information, MHBE requests that the carrier explain to MHBE why it intends not to share this information to assist MHBE in evaluating this metric for future years.
	j. Monitor carrier networks for specialized MH/SUD providers, identify discrete number of providers needed to ensure networks satisfy federal standards, and in event of network inadequacy, allow enrollees to access out of network providers at in-network rates (CLINIC)	Will review further with stakeholders	MHBE will further explore this option with stakeholders.
	k. Clarify if carriers will be required to report average driving distance based on geographical setting (i.e. urban, suburban, rural) (CLINIC)	Accepted as proposed	MHBE will provide a template by end of January. Carriers will be required to report average driving distance/times based upon geographical setting/population density. Carriers must also clearly reference their definitions for

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			the indicators/measures presented, i.e. issuer definition of urban, etc. MHBE will provide further guidance on calculation of driving distance/times and definition of geographical settings.
	l. Clarify if carriers will be required to report network info for a specific plan and/or product (i.e. EPO, MHO or PPO) (CLINIC)	Accepted as proposed	Carriers are expected to report network information specific to the network attributed to a given health plan, i.e. each Issuer must report network information on the provider network associated with a given HIOS ID. For Example: 1. Issuer 1 HMO - Network Information 1 - HIOS ID 1 2. Issuer 1 Narrow HMO - Network Information 2 - HIOS ID 2 3. Issuer 1 POS - Network Information 3 - HIOS ID 3
	m. Clarify how often carriers are required to update metrics. Average wait time and % of PCPs and MH providers in network accepting new patients may vary throughout the year; CAHPS scores may confuse customers; may be useful to only provide average driving distance to PCPs and MH providers. If MHBE includes average wait time, provide guidelines for how to calculate. For all metrics, provide sample language and guidance on how to present metrics on SBCs (EG)	Accepted in part with clarification	MHBE will provide a template and additional future guidance for how to calculate NA metrics. MHBE will clarify that carriers must provide by the certification application date with 2017 plan certification materials but may provide updated information to MHBE on quarterly basis.
	n. Adopt NAIC standards 2017, do not wait until 2018: (a) in 2016 assessment, carrier must implement automated verification	Not accepted at this time; will review further with stakeholders	MHBE will further explore this option with stakeholders of placing financial burden on carriers.

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	process that contacts providers without claim submissions in last 3-6 months to determine if still in network, accepting new patients; (b) place financial burden on carriers for network inadequacy (i.e. access to OON providers at in-network rates; reimbursement; restitution) (CLINIC; HEAU)		MHBE intends to collect NA metric data for the 2017 plan year to determine if quantitative network adequacy standards are necessary, and will engage stakeholders further and consider federal standards and the NAIC model act to determine the utility of certain metrics.
	o. Clarify if carriers required to report type of appointment (i.e. well, sick, new patient, established patient) and if wait time is for each PCP or network average (MIA)	Accepted with clarification	Carriers will be required to report on two broad categories of appointments for wait times: 1. Well Appointment (specifically, appointments billed under zero-cost sharing for preventive services) 2. Sick Appointments (specifically, appointments billed under cost sharing for Primary Care Visit for Illness or Sickness) PCP wait time is to be averaged at the network level. This information will be included in template.
	p. Employ independent dispute resolution among carriers, facilities, and providers to resolve network inadequacy conflicts (HEAU)	Not accepted at this time	MHBE does not have authority to require this proposal at this time.
20. EXPANDED ECP DEFINITION ECP defined as provider that is an ECP under 45 CFR 156.235(c), a LHD, an OP	a. Generally supports expansion to include LHDs, school-based health centers and behavioral health programs (MNA; LCPC; MASBHC; MOTA; MDAC; PPM; MACHO; MWC; CLINIC)	Accepted as proposed	MHBE will expand definition of ECP as proposed and previously discussed with stakeholders.

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MH or SUD treatment providers, as described in COMAR 10.09.80.03(B)(1) & (3), a licensed DHMH program or facility, or a school-based health center; during 2017, MHBE will assess whether the issuer credentialing standard requirement for ECPs is necessary for the providers included in the MHBE-expanded definition. Additionally, MHBE will work with DHMH to provide a list of the MHBE ECPs at least three to four months prior to the June 1, 2016 due date for the Plan Amendments and Supplements submission	b. Do not expand past federal definition (AHIP; CF); do not expand to behavioral health providers (CF)	Not accepted at this time	
	c. MHBE should provide list of ECPs by Jan. 15 or remove standard for 2017; 3-4 months prior to 6/1 too short for deadline (CF; LEAGUE)	Accepted with amendment	In collaboration with DHMH, MHBE will be able to provide list of state-ECP expansion group by the end of January 2016.
	d. Clarify that all SBHCs are ECPs, including those sponsored by LHDs and hospitals that may not be 340(b) eligible (MASBHC)	Accepted as proposed	MHBE intends to expand the ECP definition to all SBHCs.
	e. Expand definition to all programs regulated under COMAR 10.47.02.04 - 10.47.02.11, including community-based residential treatment centers for individuals requiring non-ambulatory withdrawal management services (i.e. detoxification) and more intensive levels of care (CLINIC)	Not accepted at this time; will review further with stakeholders	MHBE intends to expand the ECP definition to the SUD providers proposed in the draft standards.
	f. Do not implement issuer credentialing standard requirement in ECP definition as most ECPs already participate in MCO networks with credentialing requirement (MASBHC)	Will review further with stakeholders	MHBE will work with stakeholders to determine if an issuer credentialing requirement remains necessary for ECPs for future years.
	g. Implement credentialing certification standards but ensure standards are objective, transparent, and incompliance with Parity Act: carriers must demonstrate credentialing standards are in parity, as written and applied, with credentialing standards for medical/surgical services (CLINIC)	Will review further with stakeholders	MHBE will work with stakeholders to determine if additional requirements for an issuer credentialing requirement is necessary for ECPs and to ensure compliance with the Parity Act. MHBE encourages carriers to use objective, transparent and Parity Act-compliant standards.
	h. Develop process to monitor impact of expansion on consumers' access to care	Will review further with stakeholders	MHBE will further discuss with stakeholders to determine MHBE's

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	and impact on health disparities/outcomes (MWC)		access to the required data and resources to assess such data as suggested.
	i. Ensure carriers do not impose contract standards that effectively exclude LHDs from inclusion: LHDs cannot meet two related requirement - malpractice liability insurance coverage and indemnification provisions - that appear in some contract because of statutory cap on state tort liability; some carriers don't enforce provision, some do exclusively on MH/SUD providers; carriers should apply comparable network contracting standards for LHDs (CLINIC)	Not accepted at this time	MHBE encourages carriers to ensure that credentialing requirements do not effectively exclude a type of ECP. However, MHBE will work further with stakeholders to reconsider this requirement if future experience shows that credentialing requirements do exclude a type of ECP.
21. CALCULATION METHODOLOGY FOR ECP NETWORK INCLUSION MHBE will adopt FFM standards with some changes. Carriers must contract with at least 30% of available ECPs in each plan's service area as part of each plan's provider network and must offer contracts in good faith to all available Indian Health Care Providers in service area, any willing LHD in service area, and at least one ECP in each ECP category in each county in service area where available; During	a. Generally supports 30% standard in line with FFM as proposed (MDAC; MOTA; MASBHC; LCPC; MNA; PPM)	Accepted with amendment	MHBE will implement the 30% standard as proposed with certain amendments.
	b. Clarify whether issuers may continue using CMS template for 30%; if not, release tool or standard by which carriers can measure compliance (UHC)	Accepted as proposed	Due to the expanded list of ECPs and change in ECP counting method for ECPs at one location, issuers will not be able to entirely rely on CMS template. MHBE will provide the tool and additional guidance in February.
	c. Clarify whether 30% standard applies to ALL carrier plans and network? If so, suggests alternative that min. number or percentage of plans offered by carrier to meet standard: due to network designs, may be difficult for all of a carrier's plans to meet the standard (EG)	Not accepted at this time	The 30% inclusion standard applies to all QHP plans and carrier networks. If needed, carriers can rely on the alternative standard.
	d. Disaggregate providers in "other ECP provider" category and require carriers to	Not accepted at this time	MHBE will proceed with the standard as proposed and review whether

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2017, MHBE will assess whether a separate threshold standard is needed for specialties, such as mental health or substance use disorder providers, for future plan certification standards.	make good faith effort to contract with each ECP in that category, including separately MH and SUD providers: 30% standards imposes no requirement for diversification of ECP service providers so carriers can satisfy standard by contracting with LHD or other providers without including MH/SUD provider (CLINIC)		amendments are needed for future years.
	e. Adopt 2017 separate 30% requirement for MH and SUD providers (CLINIC)	Not accepted at this time	
	f. Eliminate proposal to count each individual provider located in one physical location as an ECP for purposes of satisfying the 30% requirement: would undermine the purpose of the percentage threshold by allowing carriers to contract with one large entity that employs multiple providers rather than ensuring inclusion of an array of ECP specialties across the service are; no SUD program would be added to a carrier's network under the standard as carriers would contract with full-range provider as opposed to specialty care (CLINIC)	Not accepted at this time	
	g. Provide guidance on how to calculate numerator in addition to denominator (CLINIC)	Accepted as proposed	MHBE will provide clarification on the calculation of both numerator and denominator of 30% standard in forthcoming guidance in February.
22. ALTERNATIVE ECP NETWORK INCLUSION STANDARDS	a. Generally supports flexible alternative inclusion standard (write-in option and/or narrative justification) (AHIP; KP)	Accepted as proposed	MHBE will implement the write-in option and alternative inclusion standard with narrative justification as proposed.

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Issuers that qualify for alternative standards (ex. provide majority of covered professional services through physicians employed by the issuer or single contracted medical group) must demonstrate in narrative that low-income and underserved members receive appropriate access to care and satisfactory service and submit provider validated quality and patient satisfaction metrics. MHBE seeks comment on these specific quality and patient satisfaction metrics: CAHPS, HEDIS, and other metrics reported to accrediting organizations.	b. Require all selected metrics be validated and NQF-endorsed for reliability and comparability (KP)	Accepted with amendment	Selected metrics will be either NQF-endorsed or submitted for endorsement by NQF. This approach to metric selection falls in line with the methodology for metrics inclusion used by the FFM for the Quality Rating System.
23. SADP ECP STANDARDS Follow FFM approach for SADPs; will be compliant with standard if meet 30% ECP standard and offer contract in good faith to all available Indian health care providers in plan's service area. MHBE considers the ECP category per county service area requirement not applicable to SADPs.	Supports inclusion standard generally, but strongly recommends requiring SADPs to offer good faith contract to any willing LHD and at least one FQHC (MDAC)	Accepted in part; Will work with stakeholders	MHBE will strongly encourage SADP issuers to contract with at least 1 FQHC and willing LHDs. MHBE will work with stakeholders to determine if a requirement should be imposed in future years. In addition, MHBE clarifies that SAPDs should offer contracts in good faith to at least 30% of available ECPs in plan's service area.
24. THIRD PARTY PAYMENTS	a. Remove requirement as it contravenes federal and state law on grace periods and	Accepted with clarification	MHBE did not intend to contravene federal law and will clarify that carriers should accept payments from TPPs and

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Issuers must accept premium and cost sharing payments from Ryan White HIV/AIDS Program, Indian tribes, tribal organizations or urban Indian organization, and State/ Federal Gov't programs. Enrollees must be prevented from termination where issuer billing and TP entity disbursement cycles are misaligned	IRS rules prohibiting extension of enrollment in cases of non-payment (CF; EG; KP)		may work with MHBE if operational issues arise under this standard.
	b. Retain requirement and clarify that federal funding under the Substance Abuse Treatment and Prevention block grant and state grant funds qualify as a "State and Federal Government program" third-party entity (CLINIC)	Accepted in part with clarification	MHBE did not intend to exceed the FFM definition and will clarify as such.
25. PROHIBITION ON ENDING PLAN CONTRACT WHEN PRIMARY INSURED TERMINATES COVERAGE When primary subscriber is terminated from plan contract, any other family members enrolled through contract must be allowed to remain on the initial subscriber's contract; issuer shall apply any amounts contributed to deductible and OOP costs under contract, including from initial primary subscriber, on behalf of remaining enrolled household members; if termination of primary results in invalid enrollment group, eligible members will receive 60	a. Generally supports proposal (HEAU)	Accepted with amendment, clarification	MHBE will require seamless continuation of coverage and application of household out of pocket accumulators, regardless of which household member accumulated the costs, when the primary insured is terminated for outstanding citizenship/immigration status terminations only, which follows the FFM approach. MHBE will work with stakeholders to consider for future applications for certain voluntary terminations, such as new Medicare eligibility.
	b. Do not implement proposal as it violates MD law providing policyholder is person to whom the carrier's contract is issued and that much of contract obligation is to policyholder (CF; EG); requirement is much broader than federal standard allowing continuation when policyholder has data matching issue not resolved within 90-95 days; if MHBE wants to pursue standard, and MD insurance law allows, limit application to fed standard (CF)	Not accepted at this time in part; Amended with clarification	
	c. Supports proposal and urges same standard to apply regardless of whether the remaining enrollees are required to select a new plan based on the enrollment group rules of the original plan or choose to do so based on more advantageous coverage for the remaining enrollees (CLINIC)	Accepted as proposed	MHBE will require application of payments made toward group plan to new plans, whether they are individual plans or a continued group plan.

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day SEP and may select prior QHP, a self-only plan, or any combination thereof	d. Clarify if protection for the family members even if the contract is being terminated for non-payment of premium, fraud or material misrepresentation on the part of the terminating member (MIA)	Accepted as proposed	Protection applies only for MHBE-initiated redetermination due to an outstanding citizenship or immigration verification under 45 CFR 155.315(f)(5). It does not apply when the primary member is being terminated for non-payment of premium, fraud or material misrepresentation. MHBE will explore whether policy should be extended to certain circumstances of voluntary terminations, such as new eligibility for Medicare.
	e. Clarify how carryover of contributions to deductible and OOPMs would apply in general, and particularly in scenario where only one remaining family member who continues to be covered after primary subscriber's coverage terminates, and, thus, continued coverage is "self-only" coverage, rather than family coverage (MIA)	Accepted as proposed	Carriers should move over all accumulators to new plan - regardless of who in the household accumulated the costs and whether continued coverage is a family plan or self-only coverage. MHBE will provide additional operational details and work with carriers to implement standard.
	f. Supports "no wrong door" policy if there is robust transaction process in place with enough time for issuers to operationalize; currently next oldest subscriber would become primary if primary is terminated; requests clarification of mechanics - plans to submit comments to proposed functional requirements on Jan 15 Does not agree that, when primary is terminated and remaining group is not valid enrollment group, they can select same QHP or individual policies with SEP; KP's only option is individuals enroll in	Partially accepted, partially not accepted at this time with clarification	

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	corresponding individual plans; urges MHBE to work with stakeholders to align proposal with current processes regarding plan selection and SEPs; supports application of previously paid deductible and OOP limits to new plans, but notes this would be a manual process, and urges MHBE to work with stakeholders to create an efficient and clear process (KP)		
26. PRESCRIPTION DRUG CERTIFICATION STANDARDS Standards will remain consistent with prior year's requirements. Additionally, plans must meet new standards to improve consumer usability of issuer formulary directories, determine necessity of an MHBE continuity of care standard, and determine issuer compliance; specifically: (i) tier category must be clear for each drug; (ii) MHBE will develop timeline to evaluate efficacy of MD Health Progress Act's continuity of care policies and develop, if necessary, a continuity of care proposal; and (iii) issuers will keep account of and report on member drug exceptions processed during the plan	a. Generally supports proposal for formulary directories requiring issuers to include cost-sharing information for prescription drugs (PPM; KP; CLINIC); supports allowing carriers to identify a drug as a preventative drug covered at no cost (CLINIC)	Accepted as proposed	MHBE will implement proposal for formulary directories requiring tier category and allowing carriers to identify drugs as preventative.
	b. Provide timely guidance regarding standard requiring issuers to "keep account of and report on member drug exceptions processed and provide summary metrics to MHBE during plan year" (CF)	Accepted with amendment	Carriers have already been required to keep records in past years' certification standards. MHBE clarifies that carriers should continue to keep these records and, if there comes a time when MHBE seeks the records, carriers should provide them to MHBE as requested.
	c. Allow tiers to change during plan year as drugs move from brand to generic (CF)	Accepted as proposed	MHBE clarifies that drugs may move from brand to generic tiers.
	d. Require cost-sharing info indicated by the tier system to be included in the formulary (PPM)	Not accepted at this time	Multiple plans may use same formulary for tier but have different cost-sharing across plan. Carriers must include tier information, but may include a legend to allow the consumer to match the tier to the drug category as proposed.
	e. Remove language stating that drugs covered under the plan's medical benefit must be identified in plan's MIA filings	Accepted with clarification	MHBE clarifies that this standard applies to prescription drug coverage. This

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year and provide summary metrics to MHBE during the plan year to determine compliance. MHBE will provide guidance to meet this requirement.	because MIA does not require that lists of drugs be filed (MIA); only requirement is signed certification of compliance with 45 CFR 156.122(a)(1) (EG)		standard does not remove obligations for certificate of compliance.
	f. Remove requirement that formulary drug link include info on cost-sharing because SBCs and plan documents contain cost-sharing info for various tiers within formulary, but formulary itself does not contain cost-sharing info as it is plan specific; requiring link to cost-sharing info is not operationally feasible for carriers (EG)	Accepted as proposed	Multiple plans may use same formulary for tier but have different cost-sharing across plans. Carriers must include tier information, but may include a legend to allow the consumer to match the tier to the drug category as proposed.
	g. Clarify how MHBE continuity of care policies would be different than those in current law (EG)	Accepted; will further evaluate	MHBE will separately undertake review of continuity of care requirements. MHBE believes the question raised is broader than the specific topic of prescription drugs. MHBE will further explore its continuity of care policies with stakeholders.
	h. Clarify if drug exceptions reporting is for Individual Exchange and SHOP issuers only. Suggests obtaining information from MIA rather than requiring carriers to report (EG)	Accepted	MHBE will amend to obtain information from MIA but will maintain standard in part to publish information if it determines the need to do so in the future.
	i. Adopt non-duplicative reporting for drug exceptions, issuers already provide this info for NCQA accreditation (KP)	Accepted	MHBE will not require carriers to report drug exceptions for the 2017 plan year, but will continue requiring the information to be collected by carriers.
	Identify Naloxone as preventive drug for all carrier formularies (CLINIC)	Not accepted at this time	MHBE defers to the requirements under the Health-General Article, Section 13-3103-09.

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	j. Require carriers to also identify the authorization standards they employ for selecting formulary medications (CLINIC)	Will review further with stakeholders	MHBE believes authorization standards used to select formulary medications would be useful information for consumers. MHBE will work with stakeholders to further discuss this recommendation.
	k. Clarify if standard is meant to exceed federal standard: proposal may cause carrier to have to establish and maintain a separate drug formulary link for every plan offered (MIA)	Accepted as proposed	MHBE did not intend to exceed the federal standard. Multiple plans may use same formulary for tier but have different cost-sharing across plans. Carriers must include tier information, but may include a legend to allow the consumer to match the tier to the drug category as proposed.
	l. Clarify intentions of having, or eliminate, requirement that carriers have an external review process by an independent review organization for denied drug exceptions: carriers already have internal review processes for any type of adverse decision, and an external review process is provided by MIA under Title 15, Subtitle 10A of the Insurance Article (MIA)	Accepted as proposed	MHBE will clarify that the MIA process and carrier internal and IRO processes satisfies this requirement.
27. MEANINGFUL DIFFERENCE MHBE will adopt FFM meaningful difference standard as described in 45 CFR §156.298 for non-cost-sharing variations of all QHPs offered in the Marketplace and will utilize the meaningful difference tools provided by CCIIO to	a. Supports application of meaningful difference standard to QHPs (KP; MWC); subject to recommendations below on plan offering limitations (KP)	Accepted as proposed	MHBE will adopt meaningful difference standard as proposed. Plan offering limitations is discussed below.
	b. Do not adopt standard in sub-regulatory guidance: standard is a rule with general applicability and future effect and should therefore be proposed through the regulatory process; change in carrier benefit design will have to be duplicated to carrier's off-exchange plans to comply with	Accepted with amendment	MHBE is in the process of promulgating regulations that will incorporate final 2017 plan certification standards as appropriate.

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ensure plans are compliant with the federal standard. During 2017, MHBE will consider whether it may be appropriate to expand the meaningful difference standards to apply to other cost-sharing variations and across metal levels for the 2018 plan year.	federal law, thus regulations should be proposed by MIA to ensure market-wide standards (CF)		
	c. Conduct further analysis to see if FFM standard is sufficient (MWC)	Will review further with stakeholders	MHBE will review additional options, such as FFM standards, for future years with stakeholders.
28. STANDARDS OF NETWORK MANAGEMENT QHP issuers must make public, and provide to MHBE for public release, their Standards for Network Management information reported for 2016 NCQA Accreditation. This information should be provided as an addendum to their current Network Access Plan	a. Generally supports collection and public release of Network Management Standards (MNA; MDAC; KP; MWC; CLINIC)	Accepted as proposed	MHBE will require carriers to publicly share information as proposed with amendments discussed below.
	b. Work with stakeholders to find better quality measures for carriers to report, 2016 NCQA accreditation standards are not helpful to consumers (KP)	Will review further with stakeholders	MHBE will continue to review what information is best to share with consumers to understand plan options.
	c. Ensure reported carrier standards are accessible and understandable to consumers (MWC; CLINIC), specifically on carriers' websites and in paper copy upon request (CLINIC)	Accepted with amendment	MHBE will publish information on MHBE website.
	d. Clarify what info would be publicly disclosed from NCQA accreditation forms as they are not currently available for public review (CLINIC)	Accepted as proposed	MHBE will clarify what information carriers should share with MHBE to publish on its website.
	e. Clarify that URAQ accreditation is acceptable and what documents and information URAQ accredited carriers must submit (MIA)	Accepted as proposed	MHBE will clarify that URAQ accreditation is acceptable and provide additional guidance on acceptable documents/information to be provided.
	f. Agreeable to providing high level accreditation scores, but clarify that	Accepted in part as proposed	Carriers may share/publish information after 2016 renewal surveys are conducted.

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	issuers can wait until after 2016 renewal surveys before providing NCQA info (UHC)		
28. PRIMARY CARE ABOVE-EHB BENEFITS To determine whether MHBE should include any above-essential health benefits in plan certification standards for the 2018 plan year, MHBE will seek input from the SAC and stakeholder groups and, if deemed appropriate, develop recommendations to present to the Board.	a. Eliminate proposal, MHBE has no authority to increase benefits required for QHP for certification without statutory change; requirement contravenes established state and federal law; benchmark selection by MIA in consultation with MHBE must be open, transparent and inclusive and may only be supplemented if the plan is missing an EHB; and proposal would create an unfunded state mandate (CF; EG; LEAGUE)	Accepted with clarification	MHBE will clarify that it does not intend to supersede federal requirements for EHBs. MHBE will amend the title for this section. MHBE will review, in consultation with MIA, whether it can address the number of primary care visits required without cost per year, and if so, whether the number should be increased.
	b. Inclusion of any benefits for 2018 should go through review process (UHC)	Accepted with clarification	
	c. Identify any benefit changes by December 31, 2016 to allow necessary time for carriers to incorporate benefits into plan designs (LEAGUE; UHC)	Accepted with clarification	
29. PLAN OFFERING LIMITATION STANDARDS For the 2017 plan year for QHPs, MHBE will require that issuers continue to meet the four-benefit designs maximum per metal level requirement. MHBE will continue to revisit the limitation standard yearly to determine if the standard continues to meet expectations for promoting consumer choice. For the 2017 plan year for SADPs,	a. Retain 4 benefit designs max per level (CLINIC)	Accepted as proposed	MHBE will retain 4 benefit designs max per level.
	b. Require issuers per HHS proposed rule to offer standardized plan designs at each metal level and limit total number of unique plans offered by issuers to simplify consumer experience, enable consumers to make better comparisons across issuers and select coverage based on quality, providers and cost, and prevent issuers from designing benefits to avoid high risk enrollees (KP; CLINIC)	Will review further with stakeholders	MHBE will further review with stakeholders, in particular the SAC.
	c. Clarify proposed limitation on number of SADPs: the term “product type” does not	Accepted with clarification	MHBE will clarify for SAPDs that the standard is 1 per tier, 1 per level of

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MHBE will require that issuers continue to meet the single benefit design per coverage type per tier per product type requirement.	generally apply to dental plans; is the intent to limit to a certain number of plans per coverage level (i.e. high or low)? (MIA)		coverage, 1 per product type - or 8 plans total allowed.
30. BROKER AND SHOP ADMINISTRATOR PAYMENTS Issuers must pay the same broker compensation for plans offered through the Marketplace that the issuer pays for similar plans offered in the State outside the Marketplace	a. MHBE should pay TPAs since they are carrying out a function of MHBE; if MHBE requires carriers to pay, require all carriers pay all SHOP Administrator's same compensation for SHOP business (EG)	Not accepted at this time; Amended with clarification	MHBE clarifies that the standards do not apply to payments made to TPAs who are functioning as SHOP administrators and this issue will be dealt with separately through the SHOP RFP.
	b. Retain parity for broker compensation on and off Exchange (KP)	Accepted as proposed	MHBE will move forward with the proposed standard.
	c. Clarify what "similar plans" mean in context of compensating brokers for similar plans on and off exchange; if it means same HIOS plan ID, UHC supports; if something else, this is ambiguous and contrary to ACR regulations which allow for different distribution models between plans as reflected in plan adjustment index rate factors (UHC)	Accepted with clarification	MHBE will clarify that “similar” means a plan with the same HIOS ID.
	d. Read and incorporate comments about retention bonuses in SHOP comment letter from 12/18/15 (KP)	Not accepted at this time	MHBE clarifies that the standards do not apply to payments made to TPAs who are functioning as SHOP Administrators and this issue will be dealt with separately through the SHOP RFP.
31. SADP DEPENDENT RATING CAPS All issuers, including SADPs, participating in the Marketplace must cap dependent premium rating at three dependents under 21. The premiums for no	Remove requirement for SADPs: federal medical rate caps do not apply to SADPs and are not used in DC or VA; dental rates off-exchange are not capped, which could lead to discriminatory rates based on distributional channel; and failure to allow carriers to collect full rates could "impact a	Not accepted at this time; Will review further with stakeholders	This standard reflects MHBE's current operational process and IT system capabilities that were accepted by carriers in 2016 plan templates and testing. MHBE will assess the time and resources necessary to alter its system and processes to allow for SADP rating without the cap in future years.

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more than the three oldest covered children must be taken into account in determining the total family premium, in accordance with 45 CFR §147.102(c)(1).	carrier's adequacy and violate state rating laws" (CF)		
32. MARKETING AND BENEFIT DESIGN OF QHPs Plans must attest that the issuer 1) complies with any applicable laws and regulations regarding marketing by health insurance issuers; and, 2) does not employ marketing practices or benefit designs have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. During 2017, MHBE will employ a new standard conducting a detailed analysis of plan benefits to determine if specific plan certification standards are needed to address discriminatory benefit design in future years.	a. Does not support proposal - eliminate new standard, review is unnecessary, MIA already has authority and responsibility ensure non-discrimination (CF)	Not accepted at this time	MHBE has authority (ACA § 1557; 45 C.F.R. § 156.200) to review QHP benefit plans for discriminatory effect as part of certification. Additionally, under State law, fair marketing standards are developed jointly by the Exchange and the MIA Commissioner. See Ins. § 31-115(k)(2)(x). MHBE plans to further review new federal proposed requirements and will clarify that its analysis for discriminatory effect will be conducted following the FFM approach.
	b. Supports proposal - retain new standard for analysis for discriminatory benefit design (KP; MWC; HEAU)	Accepted with clarification	
	c. Undertake additional review similar to those in CMS FFM Draft 2017 Issuer Letter (HEAU)	Accepted with clarification	
33. QUALITY REPORTING QHP issuers must comply with standards and requirements related to	a. Clarify whether issuers must submit QIS in April 2016 to comply with federal minimum reporting requirements or whether QIS is due in 2017 (EG)	Accepted	MHBE will clarify that carriers should follow the QIS federal process and any questions should be directed to CMS.

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quality reporting through the implementation of the Quality Rating System (QRS) and the Enrollee Satisfaction Survey (ESS). Issuers are also required to continue to provide quality data and RELICC data to MHCC. MHBE will determine a final approach for the issuer quality reporting system.	b. Follow QRS Technical Guidance of minimum enrollment requirement of 500 members on 7/1 of the previous year (UHC)		
34. OPTIONAL EMBEDDED PEDIATRIC DENTAL Starting in 2017, a QHP may or may not include embedded pediatric dental benefits; any QHP intending to offer plans without must inform MHBE and identify affected plan	a. Collect info on impact of proposal on take-up rates for dental coverage for adults and families, and impact on cost to the insured in terms of premiums and cost-sharing (deductible and OOPMs) in order to make future decision regarding whether medical plans should have the option of not offering embedded dental plans (MDAC)	Will review further with stakeholders	MHBE is open to reviewing whether MHBE has access to the data needed to conduct this review and, if so, the resources available to conduct this review.
	b. Do not support allowing issuers to opt out, require issuers to offer embedded pediatric dental benefits and ensure benefits across all plans and issuers are consistent (KP)	Not accepted at this time	MHBE does not accept this suggestion at this time because the Board previously considered and voted on this issue when both dental options were available in the IT system and allowed insurers to not embed pediatric dental. Further, legislation has been passed since the Board considered the issue that sets up a process for non-embedded benefits off-Exchange. Pediatric benefits were embedded due to system constraints in 2015.
	c. Retain option for SADP issuers to embed pediatric essential dental health benefits in	Accepted as proposed	MHBE accepts this comment.

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	their plans: giving consumers choice of QHPs without embedded dental will avoid duplicative benefits and allow purchase of a QHP in conjunction with a SADP that has low or zero deductible for highly utilized diagnostic and preventative services (DELTA)		
	d. MDAC is currently concluding a study of expanding adult dental coverage in the Medicaid program. MDAC would like to partner with the MHBE to examine coverage issues in the private market (MADC)	Accepted with clarification	MHBE is open to reviewing stakeholder requests and reviewing resources available to conduct such a review.
35. MEMBER LEVEL REPORTING Starting in 2017, participating issuers must provide an MLR to MHBE at least once per month. With two weeks' notice MHBE may request additional MLRs in a month. Annually, and with reasonable advance notice for field requirements, MHBE will review issuer MLRs to determine if they continue to meet the needs, as supplemental information, for MHBE to adjudicate the appropriate corrective actions for consumer enrollment/eligibility errors.	a. Supports proposal, retain MLR with understanding that proposed process is same as one currently in place (KP - offers to provide additional MLRs upon request with 2 weeks' notice)	Accepted as proposed	MHBE accepts this comment.
	b. Clarify rationale for requirement: this info was necessary previously due to discrepancies between carrier and MHBE enrollment data, but these reports now duplicate the enrollment reconciliation that occurs between issuers and MHBE (CF)	Will review further with stakeholders	MHBE may reconsider requirement if efforts prove to be duplicative.

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36. GENERAL COMMENTS	a. Do not pursue policies that undermine a competitive exchange marketplace model and consumer choice (AHIP)	Will review further with stakeholders	MHBE strives to ensure that Maryland Health Connection is a competitive marketplace offering consumers choices while balancing regulatory requirements and stakeholder input. MHBE sought stakeholder input through a variety of avenues, include the SAC and EIAC, prior to presenting many of the new standards proposed for 2017. MHBE will continue to seek this input during this year and future years. MHBE will continue to monitor approaches taken in the FFM and other states.
	b. Continue to work with plans to address concerns and meet certification requirements rather than denying certification (AHIP)		
	c. Stay consistent with, and don't go beyond, standards being considered by federal regulators or NAIC (AHIP)		
	d. Vet all standards through staff, EIAC, MIA and Exchange Board before final letter is adopted because a number of standards and procedures were not previously released and discussed in full and some standards add burdensome requirements and/or conflict with state and/or federal law, overstep the bounds of MHBE authority, and/ or lack clarity (CF; LEAGUE)		
	e. Generally supports proposals and appreciates that the letter clearly outlines which provisions are applicable to SADPs (DELTA)		
	f. Meet all federal standards and NAIC recommendations and offer protections available through FFM (HEAU; MWC); MD lags behind other states due to incremental approach to implementing quantitative and transparency standards for NA; if NPRM for 2017 Benefit and Payment Parameters is adopted, FFM states would have metrics for time and distance standards and minimum provider-		

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	covered person ratios for specialties with highest utilization in the state (MWC)		
	g. Transparency about network inadequacy does not address the problem, it only increases the amount of complicated information provided to consumers and risks legitimizing network in adequacy in contrast to NAIC and federal government efforts (HEAU)		
	h. **HEAU PROPOSAL FOR THE PROTECTION OF CONSUMERS** *(see p. 5 of HEAU comments)* Per Nov. 17 2015 letter to Board, consider addressing proof of loss requirements imposed by CF on insureds. CF strictly enforces 90 day time limit for consumers but allows 180 days for providers to submit claim for reimbursement; requests 12 month window from date of service to submit claims (HEAU)		
	i. Concerned some requirements position MHBE as an additional regulator of health insurance beyond already significant requirements; duplicative regulation would serve as a significant disincentive for insurance carriers to participate on the Exchange (LEAGUE)		
	j. MWC fully supports all of CLINIC's comments (MWC)		
	k. Concerned that proposed standards don't ensure EHB based plans provide adequate coverage of and access to mental health and substance use disorder		

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	services under the ACA and Parity Act (CLINIC)		
	l. State should proactively address deficiencies identified by MIA in carrier networks for MH/SUD services through remedial standards for 2017 and future plans rather than rely on retrospective review based on market surveys and consumer complaints (CLINIC)		
	m. MHBE could do far more to ensure carrier standards advance goal of expanding access to SUD providers through QHPs by creating synergy between standards and recommendations of the Lt. Governor's Heroin and Opioid Emergency Task Force (CLINIC)		