maryland health connection

State Reinsurance Program Regulations

Summary of Public Hearing Comments and Proposed Regulations

September 17, 2018

A service of Maryland Health Benefit Exchange

Public Hearings Process

- The Maryland Health Benefit Exchange held four public hearings to discuss the State Reinsurance Program ("SRP") regulations and receive the public's questions and testimony

- The public hearings were held in two locations to receive as much feedback as possible from the public on the following dates:
  - Hearing #1: July 26, 2018 (Office of the Maryland Health Benefit Exchange)
  - Hearing #2: August 2, 2018 (Office of the Maryland Health Benefit Exchange)
  - Hearing #3: August 9, 2018 (Maryland Department of Transportation)
  - Hearing #4: August 16, 2018 (Office of the Maryland Health Benefit Exchange)

- MHBE designated topics to be discussed at each hearing in order to organize and facilitate discussion (available at marylandhbe.com)

- In total, approximately 30 members of the public attended these hearings, many of whom also provided testimony and 8 respondents submitted written testimony regarding the SRP regulations

- The public comment period drew responses from a diverse group of people, including carriers, professional organizations, advocacy organizations, and consumers

Testimony - Incorporated in Chapter 17

- Administration
  - Kaiser Permanente and CareFirst both request that MHBE leverage the EDGE server for the SRP
  - Kaiser Permanente and CareFirst also both agree that the All-Payer Claims Database is not a feasible option because it would have to be customized for the purpose of the SRP

- Interaction of reinsurance and risk adjustment – **Board Resolution 08/24/18**
  - Kaiser Permanente supports the Wakely method as the best way to reduce premium for the most members without disrupting the competitive landscape for carriers
  - Kaiser Permanente thinks it is important to remove the entire interaction between RI and RA, to do otherwise would be to subsidize PPO plans
  - Carefirst does not support accounting for interaction between the RI/RA but, if the State was to adopt an approach, CareFirst supports the MIA method and believes it will remove the RI/RA interaction.
  - Carefirst does not support trying to equalize medical loss ratios (MLRs) across claims tiers or between carriers
  - Consumer Health First supports the Wakely method

- Existing incentives
  - CareFirst has the Patient Centered Medical Home (PCMH) program which provides care coordination for high-risk, high-claim members
    - The program applies to all members across all markets and products
    - Physicians are given financial incentives to participate in the program and receive a portion of the costs savings
    - The PCMH program has been successful in reducing costs and hospitalizations

Testimony (cont'd)

- Continued stakeholder engagement
  - Inclusion of incentives in reinsurance program
  - Chronic Disease and Population Health
- Not incorporated at this time
  - Value-based benefit design
  - Using state reinsurance dollars to fund incentive programs
- Complete summary of public testimony is available at marylandhbe.com on the State Reinsurance Program page.

Draft Proposed State Reinsurance Program Regulations

Chapter 17 – State Reinsurance Program

- **.01 Scope**.
  - Provides information on the purpose of Chapter 17 to set forth the structure, implementation, and eligibility standard for the State Reinsurance Program (SRP).

- **.02 Definitions.**
  - Adds definitions for terms utilized throughout the regulation including – *attachment point, coinsurance rate, dampening factor, medical loss ratio, reinsurance cap, RA/RI program interaction, risk adjustment covered plan, and reinsurance-eligible plan, etc.*

- **.03 Eligibility for Receipt of Reinsurance Payments.**
  - Establishes eligibility standards for payment under the SRP.
    - QHPs must be offered by carriers that are authorized to offer individual non-Medigap health benefit plans in Maryland, are compliant with the reinsurance assessment under § 6-102.1 of the Insurance Article, and meet obligation under the Carrier Business Agreement with MHBE.
  - Indicates the health benefit plans that are not eligible to receive payments under the SRP.
    - Ineligible plans include – grandfathered health benefit plans under § 1251 of the ACA, health benefit plans that are not required to comply with the reinsurance assessment under § 6-102.1 of the Insurance Article, group health benefit plans under § 15-1202 of the Insurance Article, short-term limited duration plans identified by § 15-1301, and association health plans identified by§ 15-1301.

Chapter 17 – State Reinsurance Program

.03 Eligibility for Receipt of Reinsurance Payments (cont'd).

- Details the Carrier State Reinsurance Program Accountability Report.
  - Purpose of the report is to detail carrier action to manage the costs and utilization of enrollees whose claims are reimbursable under the SRP.
  - Date of submission for the report will be detailed in the Annual Letter to Issuers.
  - Provides information on the requirements of the report:
    - Identify, and provide a narrative summary on, the initiatives and programs the carrier administers to manage cost and utilization of enrollees whose claims are reimbursable under the SRP.
    - Identify the total population of enrollees with SRP-eligible claims.
    - Indicate the allocation of the SRP-eligible population across the identified initiatives and programs.
    - Indicate the SRP-eligible population that is not participating in any of the identified initiatives and programs.
    - Indicate the effectiveness of the identified initiatives and programs as measured by the estimated reduction of claims and utilization by the SRP-eligible population.
    - Indicate the estimated savings to the SRP.
    - Indicate the estimate impact of the identified initiatives and programs on rates.
    - Detail the methodology utilized to determine the estimated impact of the identified initiatives and programs.
    - Detail population health initiatives and outcomes for MHBE enrollment.

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- **.04 Calculation of Reinsurance Payments under the State Reinsurance Program.**
  - Details the payment parameters for the SRP:
    - An attachment point
    - A coinsurance rate
    - A reinsurance cap
    - A carrier-specific dampening factor provided by the Commissioner.
  - Details the methodology for determining reinsurance payments under the SRP.
  - Provides information on payment adjustments in instances where reinsurance claims are greater than the program funding allocation.

- **.05 Data Collection and Maintenance for Reinsurance Payments.**
  - Details that MHBE will collect data required to determine reinsurance payments.
  - Data submission requirements will be specified through the Annual Letter to Issuers.
  - Details document and record retention standards.
  - Limits the collected data to information that is reasonably necessary for administration of the SRP.
  - Maintenance of security standards for the collected data.

- **.06 Disbursement of Reinsurance Payments.**
  - Provides a date by which carriers will receive notice of payment that will be remitted under the SRP.

Chapter 17 – State Reinsurance Program

- **.07 Request for Reinsurance Payment.**
  - Details the process for filing claims under the SRP.

- **.08 Document Retention and Audits**
  - Details carrier document retention standards under the SRP.
  - Details MHBE audit and corrective action rights to assess carrier compliance with Chapter 17.

- **.09 State Reinsurance Program Surplus.**
  - For benefit year 2019 and after, MHBE will reserve any surplus for claims in future years of the State Reinsurance Program.

Chapter 17 – State Reinsurance Program

Next steps

Tuesday, September 18, 2018

- Submit the approved regulations to the Joint Committee on Administrative, Executive, and Legislative Review ("AELR Committee"). Submit regulation to HGO and Senate Finance Committees.

- All proposed regulations must be submitted to the AELR Committee at least 15 days before they are submitted for publication in the Maryland Register.

- All proposed regulations must be submitted to the House HGO and the Senate Finance at least 30 days before they are submitted for publication in the Maryland Register.

Friday, October 19, 2018

- Submit the Notice of proposed regulation for publication in the Maryland Register.

- The comment period must be open for at least 30 days, and MHBE must provide a way for the public to offer comments.

Chapter 17 – State Reinsurance Program

- **Next steps (cont'd)**

  Process Dates:

  - Initial Issue Date: November 9, 2018
  - 30-Day Comment Period Ends: December 10, 2018
  - Earliest Adoption Date: December 26, 2018
  - Final Issue Date: January 4, 2019

Chapter Regulations

Summary of Proposed Regulations

September 17, 2018

A service of Maryland Health Benefit Exchange

Chapter Regulations Process

- The Maryland Health Benefit Exchange held a public comment period on Draft Proposed Chapter Regulations from June 20, 2019 to July 19, 2019.

- MHBE received written comment from stakeholders including:
  - The Maryland Insurance Administration
  - The Health Education and Advisory Unit
  - Consumer Health First
  - Kaiser Permanente
  - CareFirst

- Each of the stakeholder's comments have been organized in a matrix that has been posted on marylandhbe.com with Staff responses.

- The summarized regulations in this presentation incorporate stakeholder feedback.

Chapter Regulations Summary

- Chapter 1. Definitions
  - Updated chapter incorporates stakeholder feedback to ensure clarity in the definitions utilized by MHBE and alignment with parallel federal regulations.

- Chapter 7. Eligibility Standards for Enrollment in a Qualified Health Plan, Eligibility Standards for APTC and CSR, and Eligibility Standards for Enrollment in a Catastrophic Qualified Health Plan in the Individual Exchange.
  - Updated chapter incorporates stakeholder feedback to ensure clarity in the regulations.
  - Incorporates stakeholder feedback from 2016 and 2018 issuance of draft proposed regulations.
  - High level rules include:
    - Incorporates administration of the Hardship Exemption to enroll in Catastrophic Qualified Health Plans by MHBE
    - Establishes the Open Enrollment Period (OEP) as November 1 through December 15 for 2019 and future plan years.
    - Reserves the right to modify or extend the annual OEP with approval of the Board of Trustees.
    - Establishes the due date as no earlier than the coverage effective date for payment of the first month's premium.
    - Establishes rules for Special Enrollment Period (SEP) Eligibility for Loss of Minimum Essential Coverage; Change in Family Status; Error, Misrepresentation, or Inaction; Misconduct; Violation of Material Provision; Exceptional Circumstances; Permanent Move; and Other SEPs.
    - Establishes verification requirement for Loss of Minimum Essential Coverage SEP.

Chapter Regulations Summary

- Chapter 14. Termination, Cancellation and Rescission of Qualified Health Plan
  - Updated chapter incorporates stakeholder feedback to ensure clarity in the regulations.
  - Incorporates stakeholder feedback from 2016 and 2018 issuance of draft proposed regulations.
  - High level rules include:
    - Enrollee initiated terminations to end household coverage at the carrier and at the Exchange.
  - Items to be included in future regulation after additional stakeholder feedback:
    - Special termination reasons resulting in the termination of a QHP contract holder's enrollment due to enrollment in Medicare, enrollment in group coverage, ineligibility for QHP coverage due to citizenship/immigration status inconsistency under 45 CFR 155.315, and death.

- Chapter 15. Carrier Certification Standards
  - Updated chapter incorporates stakeholder feedback to ensure clarity in the regulations.
  - Incorporates stakeholder feedback from 2016 and 2018 issuance of draft proposed regulations.
  - High level rules include:
    - Conditions for participation and certification on the Exchange.
    - Timeline for submission of an application to the Exchange for Authorization.
    - Rules for enrollee premium payment on the Individual Exchange, e.g. acceptance of payment from Third Party Payers (Ryan White Programs), alignment with premium payment procedures and deadlines under in COMAR.
    - Carrier notice requirements for new enrollees, arrearage, and terminations.
    - QHP offering requirements.
    - Alignment with COMAR 31.10.44 and COMAR 31.19.45 for network adequacy requirements.
    - Board of Trustees waiver authority.

Chapter Regulations Summary

- Chapter 16. Plan Certification Standards
  - Updated chapter incorporates stakeholder feedback to ensure clarity in the regulations.
  - Incorporates stakeholder feedback from 2016 and 2018 issuance of draft proposed regulations.
  - High level rules include:
    - Definition of Essential Community Providers to align with Plan Certification Standards in place from 2016.
    - Definition of Annual Letter to Issuers as tool notify carriers of changes in Plan Certification Policy and Process for each benefit year.
    - QHP Certification application process and timeline.
    - Service Area requirements for participation on the Exchange.
    - Provider directory requirements.
    - Essential Community Providers network inclusion standards to align with Plan Certification Standards in place from 2016.
    - Establishes standards for carrier formulary access and usability.
    - Board of Trustees waiver authority.
    - QHP certification denial, suspension, and revocation and other remedies.
    - Requirement for on-going compliance with QHP certification standards.
  - Items to be included in future regulation after additional stakeholder feedback:
    - Continuity of contributions to the deductible and out-of-pocket maximum when the QHP contract holder is terminated due to a special termination reason.

Chapter Regulations Timeline

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