Title 14
INDEPENDENT AGENCIES
Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE
14.35.16 Plan Certification Standards

Authority: Insurance Article, §§31-108, 31-115, and 31-116, Annotated Code of Maryland

Notice of Proposed Action

[18-305-P]

The Maryland Health Benefit Exchange proposes to adopt new Regulations **.01— .12** under a new chapter, **COMAR 14.35.16 Plan Certification Standards**.

Statement of Purpose

The purpose of this action is to set forth the standards a qualified health plan shall meet in order to be certified as a QHP by the Maryland Health Benefit Exchange under Insurance Article, §31-115, Annotated Code of Maryland. This chapter addresses standards for QHP certification for the Individual and SHOP Exchanges. Standards for carrier certification for the Individual and SHOP Exchanges are addressed in COMAR 14.35.15.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Jessica Grau, Health Policy Analyst, Maryland Health Benefit Exchange, 750 East Pratt Street, Baltimore, MD 21202, or call 410-547-6888, or email to mhbe.publiccomments@maryland.go, or fax to 410-547-7373. Comments will be accepted through December 10, 2018. A public hearing has not been scheduled.

.01 Scope.

This chapter describes the standards a qualified health plan shall meet in order to be certified as a QHP by the Maryland Health Benefit Exchange under Insurance Article, §31-115, Annotated Code of Maryland. This chapter addresses standards for QHP certification for both the Individual and SHOP Exchanges, unless otherwise noted. Standards for carrier certification for the Exchange are addressed in COMAR 14.35.15. This chapter does not address plan certification standards for QDPs or QVPs.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) Annual Letter to Issuers.

(a) "Annual Letter to Issuers" means a written communication, issued by the Exchange, which should be interpreted in the same manner as the Annual Letter to Issuers that is distributed by the federally facilitated Exchange.

(b) "Annual Letter to Issuers" includes instruction on how issuers shall meet compliance with QHP certification standards, establishes timelines on implementation, details Exchange expectations of issuer compliance with such certification standards, and alerts issuers of policy developments.

(2) "Essential community provider" means:

(a) An essential community provider as defined in 45 CFR §156.235(c);

(b) A local health department;

(c) An outpatient mental health center, as described in COMAR 10.21.20, or a substance use disorder treatment provider, as described in COMAR 10.09.80.03B(1) and (3), that is licensed or approved by the State Department of Health and Mental Hygiene as a program or facility; or

(d) A school-based health center.

(3) "Similarly situated" means alike in all relevant ways.

.03 Qualified Health Plan Certification—In General.

A. An authorized carrier shall apply for a certificate of authorization for each health benefit plan the carrier intends to offer on the Exchange.

B. The authorized carrier shall no longer offer a QHP on the Exchange, if:

(1) The plan's certification of authorization expires;

(2) The plan is decertified by the Exchange;

(3) The carrier elects to withdraw from the market with the Exchange, under 45 CFR §156.290; or

(4) The carrier elects not to offer or renew the QHP on the Exchange in accordance with Insurance Article, Annotated Code of Maryland.

C. With respect to per-member premium rating for family coverage offered through a QHP on the Exchange, a carrier shall cap the premium rating for non-spousal dependents at three non-spousal dependents under the age of 21 for all plans authorized for sale under this chapter.

.04 Qualified Health Plan Certification—Application.

A. Each authorized carrier shall annually submit an application, in a form specified by the Annual Letter to Issuers, for each health benefit plan intended to be certified as a QHP to be offered on the Exchange.

B. A carrier shall submit a completed application, including all required information and submissions under this regulation, to the Exchange.

C. The Exchange shall notify a carrier of the application status within 45 days of receipt of a completed application.

D. If an application is determined incomplete, the Exchange shall notify a carrier of the application status within 45 days of the initial submission.

E. Information Submission.

(1) An authorized carrier shall submit an initial submission containing the information required under §§E and F of this regulation and Regulations .04 — .10 of this chapter as part of the application under §B of this regulation and detailed through the Annual Letter to Issuers.

(2) If requested by the Exchange, an authorized carrier shall submit a supplement to its initial submission under §E(1) of this regulation.

F. In accordance with Insurance Article, §31-115(g)(2), Annotated Code of Maryland, upon request, an authorized carrier shall provide in its application a description of the health benefit plan, in plain language and in a form specified by the Annual Letter to Issuer, that includes:

(1) Claims payment policies and practices;

(2) Data on enrollment, disenrollment, number of claims denied (including in whole and in part), and rating practices, if applicable;

(3) Information on cost sharing and payments with respect to any out-of-network coverage; and

(4) Any other information as determined appropriate by the Exchange.

G. An authorized carrier shall provide in its application, in a form specified in the Annual Letter to Issuers, the following information about the health benefit plan:

(1) Plan, benefit, and cost sharing;

(2) Plan information for the renewal of QHP enrollment;

(3) Unified rate review template;

(4) Prescription drug cost sharing and formulary;

(5) Provider network;

(6) Service area, including justifications for partial county service areas;

(7) Rate and premiums;

(8) Actuarial information required to be submitted to the Exchange under 45 CFR §155.1030(b);

(9) Provider directory data as specified in Regulation .07 of this chapter;

(10) Summaries of benefits and coverage, under 45 CFR §147.200, for each cost-sharing reduction variation;

(11) Essential community providers contracted to participate within the health benefit plan's provider network; and

(12) Any other information the carrier would like to provide to the Exchange to supplement the application.

H. An authorized carrier shall comply with the rate and form review procedures, including review of compliance with essential health benefits requirements, established by the Commissioner.

I. Data and information submitted to the Exchange may be provided to the Commissioner, if requested, for consideration in the Commissioner's annual QHP rate and form review process.

J. The authorized carrier shall provide to the Exchange the rate justification forms filed with the Commissioner for each QHP certification application the authorized carrier submits to the Exchange.

.05 Qualified Health Plan Certification—Plan Service Areas.

A. As part of a QHP certification application, an authorized carrier shall submit:

(1) A description of the boundaries of the service area of any health benefit plan that is smaller than the State of Maryland; and

(2) For any service area smaller than the State of Maryland, an explanation of the reason for the smaller service area, including a justification that the boundaries are not designed to discriminate against individuals excluded from the health benefit plan's service area.

B. Carriers submitting a justification under §A(2) of this regulation are not required to submit a justification in subsequent years, after the initial justification submission, if there has been no change in the carrier's health benefit plan service areas.

C. After the initial data submission under Regulation .04E of this chapter, a change to a health benefit plan's service area shall be made only by petition to the Exchange and:

(1) Because the carrier cannot secure enough providers; or

(2) Because of an Exchange request to serve an unmet need.

D. After the final data submission under Regulation .04E of this chapter, a change to the health benefit plan's service area shall be permitted only if the change is an expansion of the health benefit plan's service area.

.06 Qualified Health Plan Certification—Provider Directories Specific to Individual Exchange.

A. An authorized carrier shall submit to the Individual Exchange the health benefit plan's provider directory information for each QHP's network.

B. Provider directory data shall include the requirements specified in Insurance Article, §15-112(n)(3), Annotated Code of Maryland, as well as be current, accurate, and complete.

C. Provider directory data may include:

(1) Program and community health center names;

(2) Providers' affiliations with certain facilities, programs, and centers; and

(3) Any other information that may assist consumers in searching for specific programs or centers by name.

D. Updated provider directory data requested in §B of this regulation shall be submitted in the format required by the Individual Exchange at least once every 15 calendar days.

.07 Qualified Health Plan Certification—Essential Community Providers.

A. For each health benefit plan that a carrier seeks to offer through the Exchange, the carrier shall make all good faith efforts to contract with at least 30 percent of available essential community providers in the plan's service area as part of each plan's provider network, except as specified in §C of this regulation.

B. Additional Essential Community Providers.

(1) Included with its application for certification and in the form provided by the Exchange, the carrier may write in additional essential community providers that are not included in the definition for essential community provider under Regulation .02B of this chapter.

(2) If available, the carrier shall include the following information when writing in additional essential community health providers:

(a) The provider's zip code reflecting a provider location within a low-income zip code or Health Professional Shortage Areas included on the "Low-Income and Health Professional Shortage Area Zip Code Listing" from CMS;

(b) The provider's service street address, which may not be a Post Office Box number; and

(c) The National Provider Identifier (NPI) number, if the provider has such a number, or an alternate identification, such as a Tax Identification Number, if the provider does not have such a number.

(3) The authorized carrier shall provide information under this section as part of the application submitted under Regulation .04 of this chapter.

C. Carriers Who Are Unable to Meet Contracting Requirements.

(1) If the authorized carrier cannot meet the standard under this section, the authorized carrier may satisfy this requirement under the alternative standard.

(2) To meet the alternative standard, the authorized carrier shall provide a narrative explanation of the authorized carrier's justification that the carrier includes access to sufficient essential community providers within the health benefit plan's network.

(3) The narrative explanation shall describe the extent to which the authorized carrier's provider sites are accessible to, and have services that meet the needs of, specific underserved populations, including:

(a) Individuals with HIV/AIDS, including those with co-morbid behavioral health conditions;

(b) American Indians and Alaska Natives;

(c) Low-income and underserved individuals seeking women's health and reproductive health services; and

(d) Other specific populations served by essential community providers in the plan's service area.

(4) The narrative explanation shall demonstrate that low-income members receive appropriate access to care and satisfactory service, including performance on provider quality and patient satisfaction metrics, as specified in the Annual Letter to Issuers.

D. For each health benefit plan that a carrier seeks to offer through the Exchange, the carrier shall make all good faith efforts to contract with at least one available essential community provider of each essential community provider type, under §E of this regulation, in each county, or partial county, of the plan's service area as part of each plan's provider network.

E. Authorized carriers shall offer the same provider contract terms in good faith to the following essential community providers that a willing, similarly situated, non-essential community provider would accept or has accepted from the authorized carrier to the following provider types:

(1) All available Indian Health Care Providers in the plan's service area;

(2) Willing local health departments under Insurance Article, §15-112(b)(3)(iii), Annotated Code of Maryland, in the plan's service area; and

(3) For each county in the plan's service area, at least one provider from the following provider types, if such a provider is available and provides the medical or dental services, as applicable to plan type:

(a) A health care provider defined in §340B(a)(4) of the Public Health Services Act;

(b) An outpatient mental health center as described in COMAR 10.21.20;

(c) A substance use disorder treatment provider as described at COMAR 10.09.80.03B(1) and (3);

(d) A school based-health center;

(e) A health care provider described in §1927(c)(1)(D)(i)(IV) of the Social Security Act; and

(f) A State-owned, government-owned, or not-for-profit family planning services site that does not receive federal funding.

F. An authorized carrier shall submit verification of essential community provider contract offers to the Exchange upon request.

.08 Qualified Health Plan Certification—Network Adequacy.

A. Each health benefit plan shall meet the network adequacy standards stated in 45 CFR §156.230, Insurance Article, §15-112, Annotated Code of Maryland, and COMAR 31.10.44.

B. Each health benefit plan shall meet the provider panel sufficiency requirements under COMAR 31.10.34.04A.

.09 Qualified Health Plan Certification—Covered Prescription Drugs and Formularies.

A. An authorized carrier's application under Regulation .04A of this chapter shall identify drugs covered under the health benefit plan's medical benefit.

B. Drug Formulary List Location.

(1) An authorized carrier shall provide the Internet address for the drug formulary for each health plan with the application submitted for the health benefit plan to the Exchange under Regulation .04A of this chapter.

(2) The Internet address required under §B(1) of this regulation shall link directly to the health benefit plan's list of covered drugs without further navigation.

(3) The health benefit plan's list of covered drugs shall:

(a) Include plain language drug category information for each drug category;

(b) Include information on utilization management tools such as prior authorization, step therapy, quantity limitations, and generic substitutions; and

(c) Be up to date, accurate, and complete.

C. An authorized carrier may classify a covered drug as a preventative drug covered at zero cost and shall identify any drugs so covered in its formulary.

D. Drug Exception Process.

(1) An authorized carrier shall establish a drug exception process by which an enrollee can request access to a drug not on the plan's formulary list in standard situations, as required by Insurance Article, §15-831(c), Annotated Code of Maryland, and 45 CFR §156.122(c).

(2) A carrier shall notify the enrollee of its coverage decision no later than 72 hours after receipt of the request for exception.

E. A carrier shall follow the external review process established by the Administration for advice from an independent review organization for denied requests as described in COMAR 31.10.19.

F. A carrier shall establish a process for the emergency review of denials that is compliant with State and federal statute and regulation.

.10 Qualified Health Plan Certification—Waiver Authority.

The Exchange, with the approval of the Board, may grant a waiver to a specific provision of this chapter, with or without conditions, under the procedure in COMAR 14.35.15.10.

.11 Qualified Health Plan Denial, Suspension, and Revocation of Certification and Other Remedies.

A. If the Exchange determines that a carrier has failed to comply with this chapter, Insurance Article, Title 31, Annotated Code of Maryland, or any other federal or State laws or regulations applicable to carrier offerings in the Exchange that are not otherwise specified in Insurance Article, §31-115(k), Annotated Code of Maryland, the Exchange may initiate one or more of the following actions against the carrier:

(1) Deny certification for participation in the Exchange;

(2) Suspend the carrier's certification for participation in the Exchange;

(3) Revoke the carrier's certification for participation in the Exchange; or

(4) Another remedy defined under §D of this regulation.

B. Subject to the contested case hearing provisions of State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland, and the limitations stated in Insurance Article, §31-115(k), Annotated Code of Maryland, the Exchange may deny certification to a health benefit plan, or suspend or revoke the certification of a qualified health plan, based on a finding that the health benefit plan or qualified health plan does not satisfy requirements or has otherwise violated standards for certification that are established under this regulation and interim policies adopted by the Exchange, and not otherwise under the regulatory and enforcement authority of the Commissioner, including requirements and standards related, but not limited, to:

(1) Enrollment;

(2) Essential community providers;

(3) Complaints and grievances involving the Individual Exchange;

(4) Network adequacy;

(5) Quality;

(6) Transparency;

(7) Race, ethnicity, language, interpreter need, and cultural competency (RELICC);

(8) Plan service area, including demographics;

(9) Accreditation;

(10) Authorization of the plan's sponsoring carrier; and

(11) Fair marketing standards developed jointly by the Individual Exchange and the Commissioner.

C. Instead of or in addition to denying, suspending, or revoking plan certification, the Exchange may impose other remedies or take other actions, and to the extent not otherwise under the regulatory and enforcement authority of the Commissioner, including:

(1) Requiring a corrective action to remedy a violation of or failure to comply with standards for certification; and

(2) Imposing a penalty not exceeding $5,000 for each violation of or failure to comply with standards for certification.

D. In determining the amount of a penalty under §C of this regulation, the Exchange shall consider:

(1) The type, severity, and duration of the violation;

(2) Whether the plan or carrier knew or should have known of the violation;

(3) The extent to which the plan or carrier has a history of violations; and

(4) Whether the plan or carrier corrected the violation as soon as they knew or should have known of the violation.

E. The penalties available to the Exchange under this regulation shall be in addition to any criminal or civil penalties imposed for fraud or other violation under any other State or federal law.

.12 Qualified Health Plan Certification—On-going Compliance with Qualified Health Plan Certification Standards.

A. The Exchange may conduct compliance reviews of a QHP during the plan benefit year.

B. The Exchange may require an authorized carrier to develop, submit for approval, and follow, as amended by the Exchange, a corrective action plan for compliance issues noted by the Exchange during its compliance review of a QHP.

MICHELE S. EBERLE
Executive Director