Title 14 INDEPENDENT AGENCIES

Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE

Chapter 16 Plan Certification Standards

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

.01 Scope.

This chapter describes the standards a qualified plan shall meet in order to be certified as a qualified plan by the Maryland Health Benefit Exchange under § 31-115 of the Insurance Article, Annotated Code of Maryland.

.02 Definitions.

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

B. Terms Defined.

(1) "Commissioner" means the Commission of the Maryland Insurance Administration.

(2) "Essential Community Provider" means:

(a) an essential community provider as defined in 45 C.F.R. § 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 10.09.80.03.B(1) & (B)(3), that is licensed or approved by the State Department of Health & Mental Hygiene as programs or facilities; or

(d) a school-based health center.

(3) "Good faith" means that the carrier offers the same contract terms to an essential community provider that a willing, similarly-situated, non-essential community provider would accept or has accepted from the carrier.

.03 In General.

A. An authorized carrier shall apply for a certificate of authorization for each qualified health plan, dental plan, or SHOP plan the carrier intends to offer in the Individual Exchange or SHOP Exchange.

B. The authorized carrier may no longer offer an authorized plan on the Exchange if:

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

(2) The plan is decertified by the Exchange; or

(3) The carrier withdraws the plan from the market under 45 CFR §156.290.

C. All plans authorized under this chapter for sale in the Exchange shall cap the premium rating for dependents at three dependents under the age of 21.

.04 Plan Certification--Application.

A. Each authorized carrier shall annually submit an application form for each qualified health plan to the Exchange on the form specified by the Exchange.

B. A authorized carrier shall submit a completed application, including all required information and submissions under this regulation, no later than the July 1 prior to the beginning of the Open Enrollment period during which the plan will first be offered.

C. The Exchange shall notify a carrier of the decision to approve or deny the application within 45 days of receipt of a completed application.

D. When necessary, authorized carriers shall provide both an initial and final data submission in connection with their applications as requested by the Exchange.

E. An authorized carrier shall provide the following as part of its application:

(1) A copy of the claims payment policies and practices; and

(2) Information on implementation of enrollee rights under title I of the Affordable Care Act.

F. For each plan application, an authorized carrier shall provide to the Exchange on the forms provided by the Exchange:

(1) A plan and benefits template;

(2) A plan crosswalk template;

(3) A unified rate review;

(4) A prescription drug template;

(5) A network template;

(6) A service area template;

(7) A rate data template;

(8) A rating business rules template;

(9) An actuarial memorandum;

(10) Provider directory data as specified in paragraph E of this regulation;

(11) A partial county service area justification for applicable qualified health plans; and

(12) Summaries of benefits and coverage for each offered qualified health plan variation.

G. In the form provided by the Exchange, a network access plan shall include information, including:

(1) The average wait time for primary care providers in the plan's network;

(2) The average wait time for mental health providers in the plan's network;

(3) The average drive distance to primary care providers in the plan's network;

(4) The average drive time to primary care providers in the plan's network;

(5) The average drive distance to mental health providers in the plan's network;

(6) The average drive time to mental health providers in the plan's network;

(7) The percent of primary care providers in network accepting new patients in the plan's network;

(8) The percent of mental health providers in network accepting new patients in the plan's network;

(9) The plan's Consumer Assessment of Healthcare Providers and Systems most recent scores; and

(10) Any other network metrics the carrier would like to provide to the Exchange.

.05 Additional Requirements for Participation

A. An authorized carrier shall present evidence that it has complied with the rate and form review procedures, including review of compliance with essential health benefits requirements, established by the Commissioner.

B. By submitting data and information to the Exchange, an authorized carrier acknowledges that the data may be provided to the Commissioner as part of the Commissioner's rate and form review process.

C. The authorized carrier shall provide the Exchange the Preliminary Justification Forms I and II filed with the Commissioner for each plan certification application the authorized carrier submits to the Exchange.

D. The authorized carrier shall notify the Exchange of the final disposition of the premium rate increase request by the Commissioner at least 45 calendar days before the effective date of the new premium rate for each certified plan.

.06 Plan Service Areas

A. Size of plan's service areas.

(1) The carrier shall use a service area for qualified plans that it offers for sale that is:

(a) the commercial market service area, where the carrier offers only commercial health benefit plans for sale;

(b) the commercial market service area, where the carrier offers both commercial health benefit plans and managed care organizations, unless a request with justification for using the service area of the managed care organization has been filed and approved by the Exchange; or

(c) the service area of the managed care organization, where only serving a managed care organization.

(2) A plan may serve an area smaller than one county only if the carrier offering the plan demonstrates on its application that the boundaries are not designed to discriminate against individuals excluded from the plan's service area.

B. After the initial data submission under Regulation .04D of this chapter, a change to a plan's service area shall only be made by petition to the Exchange and subject to approval by the Maryland Insurance Administration, including:

(1) The carrier cannot secure enough providers; or

(2) An Exchange request to serve an unmet need.

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

D. An authorized carrier shall submit to the Exchange a description of the boundaries of the service area of each qualified plan the authorized carrier seeks to offer for sale through the SHOP Exchange or Individual Exchange; and

E. An authorized carrier shall submit data on the demographics of areas served by each qualified plan the carrier offers for sale within the SHOP Exchange or Individual Exchange except where the carrier provides a statewide service area, including information of members in the area about:

(1) race;

(2) ethnicity;

(3) language;

(4) population-level health status indicators;

(5) prevalence of medical conditions;

(6) claims experience;

(7) receipt of healthcare;

(8) genetic information;

(9) evidence of insurability; and

(10) disability

.07 Network Information and Provider Directories.

A. For each qualified plan that the authorized carrier seeks to offer for sale through the Individual Exchange or SHOP Exchange, the carrier shall submit:

(1) The carrier's standards for network management information submitted for accreditation to either NCQA or URAC;

(2) Treatment cost information for Exchange-specified treatment examples, including:

(a) Inpatient substance use disorder treatment;

(b) Outpatient substance use disorder treatment;

(c) Inpatient mental health treatment; and

(d) Outpatient mental health treatment.

B. The authorized carrier shall provide provider directory information for the network of each plan that is certified to participate in the Exchange in the form specified by the Exchange.

C. The carrier shall provide directory information directly to the Exchange provider directory system in the format required by the Exchange provider directory system.

(1) Provider directory data shall be current, accurate and complete.

(2) Updated data shall be submitted in the format specified under this section at least once every 15 calendar days.

(3) Provider directory data shall include whether each provider is accepting new patients.

(4) Provider directory data may include:

(a) Program and community health center names;

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

(c) And any other information that may assist consumers search for specific programs or centers by name.

D. The authorized carrier shall provide provider directory information on the carrier's public website without requiring log-in information.

.08 Consumer Transparency Requirements.

A. An authorized carrier shall provide information to the public in plain language.

B. An authorized carrier shall provide quality data and race, ethnicity, language, interpreter need, and cultural competency data to the Maryland Health Care Commission.

C. An authorized carrier shall provide to HHS and the Exchange quality improvement strategy data and enrollee satisfaction data for plans that have been offered through the Exchange for at least two years.

D. A carrier shall provide to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in a timely manner and in a format accessible to individuals with disabilities and individuals with limited English proficiency all critical information needed for obtaining health insurance coverage or access to health care services through the qualified plan.

(1) At minimum, critical information shall include applications, forms required to be submitted to the authorized carrier, and notices.

(2) Critical information shall also include all information required by law or regulation to be provided to a qualified individual, applicant, qualified employer, qualified employee, or enrollee.

(3) Critical information further includes the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider.

(a) Critical information must be provided to an enrollee in a timely manner upon the request of the individual.

(b) Critical information shall be made available to such individual through an Internet Web site and such other means as necessary for individuals without access to the Internet, at minimum.

.09 Essential Community Providers

A. For each qualified plan that the carrier seeks to offer for sale through the SHOP Exchange or the Individual Exchange, the carrier shall contract with at least 30% of available essential community providers in the plan's service area as part of each plan's provider network.

(1) The carrier may list additional essential community providers that are not included in the non-exhaustive list of essential community providers provided by HHS to allow carriers to comply with 45 CFR §156.270 or Exchange-provided list for Regulation .02(1)(b) through (d) of this chapter.

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

(i) 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;

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

(iii) The National Provider Identifier (NPI) number, if the provider has such a number.

(b) The carrier shall provide information under this subparagraph as part of the certification application submitted under regulation .05 of this chapter.

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

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

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

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

(ii) American Indians and Alaska Natives;

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

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

B. Carriers shall offer contracts in good faith to the following provider types:

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

(2) Except for stand-alone dental plans, any willing local health department 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 section 340B(a)(4) of the Public Health Services Act;

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

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

(d) student health center;

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

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

C. A carrier shall submit verification of such offers if the Exchange requests the contracts to verify good-faith compliance.

.10 Network Adequacy.

A. The carrier shall maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services are accessible to all enrollees without unreasonable delay.

B. The qualified plan shall meet the network adequacy standards specified at:

(1) 45 CFR §156.230; and

(2) COMAR 31.10.34.05(C)(2).

.11 Covered Prescription Drugs and Formularies.

A. Covered drugs and formularies within a plan.

(1) Drugs covered under plan's medical benefit shall be identified in the authorized carrier's application for plan certification.

(2) A carrier shall provide the website address for the plan's drug formulary.

(a) The address shall link directly to the plan's list of covered drugs without further navigation.

(b) The plan's list of covered drugs shall include tiering and cost-sharing information.

(c) The plan's list of covered drugs shall be up-to-date, accurate, and complete.

(d) The plan's list of covered drugs must be in the same standard machine readable format as specified by HHS at 45 CFR §156.122(d)(2).

(3) A carrier may classify a covered drug as a preventative drug covered at zero cost and shall identify any drugs so covered in its formulary.

(4) A carrier shall comply with 45 CFR §156.122 and establish a drug exception process for standard situations by which an enrollee can request access to a drug not on the plan's formulary list under subparagraph (F)(1) of this regulation.

(a) A carrier shall notify the enrollee of its coverage decision no more than 72 hours after receipt of the exception.

(b) A carrier shall have an external review process by an independent review organization for denied requests.

(c) The external review organization shall complete its review and provide a decision within 72 hours of receiving the review request.

.12 Waiver Authority.

The Exchange, with the approval of the Exchange Board of Trustees, and for reasons satisfactory to the Exchange, may grant a waiver to a specific provision of this chapter, with or without conditions, under the procedure in COMAR 14.35.15.12.

.13 Denial, Suspension and Revocation of Certification or Pursue Other Remedies.

A. If the Exchange determines that a carrier has failed to comply with this chapter, Title 31 of the Insurance Article, or any other federal or state laws or regulations applicable to carrier offerings in the Exchange, 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. If the Maryland Insurance Administration takes action against the carrier, the Exchange may use the Commissioner's action as a finding to take an action under this regulation.

C. The Exchange may take an action under §A of this regulation based on a finding that the qualified plan does not satisfy requirements or has otherwise violated standards for certification, including requirements and standards related, but not limited, to:

(1) enrollment;

(2) essential community providers;

(3) complaints and grievances involving the 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) complying with fair marketing standards developed jointly by the Exchange and the Commissioner.

D. Instead of, or in addition to denying, suspending, or revoking certification, the Exchange may impose other remedies or take other actions, including:

(1) imposing 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.

E. In determining the amount of a penalty under this §C 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.

.14 Post-Certification Standards

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

B. An authorized carrier may be required to submit a corrective action plan to correct non-compliance of a plan.