Consumer Health First

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Maryland Health Benefit Exchange: Plan Certification Standards
Submitted: December 29, 2016

Consumer Health First, along with the undersigned 20 organizations, very much appreciates the opportunity to comment on both the 2018 Plan Certification Standards and the Issuer Letter. In doing so we wish to acknowledge the steps that the Board of the Maryland Health Benefit Exchange has taken from the outset to respond to the needs of consumers in the design of Maryland Health Connection and the plans offered there.

Before providing specific comments, however, we believe it is important to respond to a question that was raised at the December Standing Advisory Committee meeting - whether there was any point in making changes during what is clearly a period of some uncertainty as to the future of the Patient Protection and Affordable Care Act (ACA). We purposely use the law's full name to emphasize the value for consumers in the patient protections, and increased transparency, that Maryland has put in place in its implementation. This process has created a marketplace that many in Maryland have come to rely upon as they make one of the most important and often challenging decisions for themselves and their families - health insurance. Both individuals and the state as a whole have benefited from these investments and they must continue. Now is not the time to stall the progress that has been made. Rather it is imperative that we continue to make progress toward the long-term goal of access to high-quality, affordable and comprehensive health care for all Marylanders.

With the following we provide comments on the certification standards with reference to specific sections of the Issuer Letter:

1. Network access plan (p. 9) -- We support the requirement to gather information on telehealth data. However, we suggest that a report be prepared that protects the confidentiality of plan specific information while providing public access to information on the current use of telehealth in Maryland today.

2. Standardized plans (pp. 24-25) -- In our comments on the 2017 certification standards we noted that a "standard plan" would be in the best interests of consumers. We wrote, "While consumer choice is important, if plans offered by carriers at each metal are not meaningfully different, consumers are being presented with a false choice, thereby adding confusion

and unnecessary complexity to an already complex process of choosing a plan that best meets their needs." We know from the experiences of in-person assisters that consumers are challenged to make a decision on the right plan for them when faced with a plethora of choices. A standardized benefit plan addresses that by providing an anchor, one benefit plan consumers may use to make "apples to apples" comparisons on benefits, price, access to care, and customer service across carriers. Moreover, by requiring greater transparency, carriers are more likely to compete on price, access to care and customer service, all to consumers' benefit.

Some state exchanges have established standardized benefit plans and the take-up rate for these plans makes a compelling case for doing so in Maryland. Examples for 2016 include:

- Connecticut = 72% of the individual exchange enrollment[1]
- Massachusetts = 77% of gold plan enrollment and 49% of silver plan enrollment[2]
- District of Columbia = 41% of individual exchange

Therefore, we strongly endorse the establishment of standardized benefit plans with the following recommendations:

- **Establish a workgroup to finalize the design of standardized plans with work to be completed no later than September 30, 2017.** We appreciate that the MHBE proposed specific designs for a standardized plan. However, we believe that the proposed plan should serve as a starting point from which the plan standards can be finalized. To achieve this, we recommend the establishment of a workgroup specifically charged with developing these standards. This recommendation is based upon the experience in other states and DC and we believe it will be helpful to draw upon their work to finalize Maryland's plans. The workgroup should be tasked with evaluating the proposed plan developed by the MHBE staff, the standardized benefit plans adopted by other states, consumer health needs, and affordability.

[1] Connecticut: http://agency.accesshealthct.com/wp-content/uploads/2016/10/Advisory-Comm-Health-Benefit-Quals-Feb-17-2016-Presentation.pdf

[2] Massachusetts: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2016/2016-12-08/Summary-Report-November2016.pdf

The workgroup should make a recommendation to the MHBE Board no later than September 1, 2017.

- **Include Bronze level plans.** Because 2017 enrollment data to date indicates that bronze plans are becoming more popular, likely due to rising premiums, we recommend that this level be included in the standardized plan options.
- **Reject recommendations to phase in standardized plans.** We do not believe that a phased-in approach is in the best interest of consumers. This would obviate the benefit of a true "apples to apples" comparison and undercut the assurance of meaningful first dollar access to medical services. For this reason, we believe it is prudent to take the time to develop consensus around the standardized benefit plans and require all carriers to offer these plans beginning January 1, 2019.
- **Require a standardized naming convention across all carriers.** A standardized naming convention should be in effect at implementation to maximize the benefits to consumers. Although no state has required this to date, it is understood that such an approach would provide a real benefit to consumers as they make a determination on the optimal plan for themselves and their families. In addition, it will be important to display standardized plans in a way that maximizes transparency and responds to multiple literacy levels. We are uncertain, however, whether the words “Maryland Choice” should be part of the standardized name, as this may lead consumers to believe these plans are “recommended.” We would suggest that MHBE convene a focus group to help choose an appropriate naming convention or, if this is not possible, to simply use “Standard <metal_level>” in the name.

3. Committee to design outpatient/inpatient substance use treatment and outpatient/inpatient mental health treatment cost estimators (pp. 25-26) -- We strongly support this approach as a vehicle to provide consumers with meaningful information about the cost of such care under different plans. We support MHBE’s proposed approach to develop a uniform template and criteria for determining and reporting treatment costs so that consumers receive accurate and sufficiently detailed information. Substance use disorder and mental health treatment encompass a wide range of services and the cost of care will differ across the continuum.

4. Network breadth indicator (p. 26) -- We strongly support the proposed methodology, which is based upon the FFM approach to assign Broad, Standard, Basic or Integrated Delivery System (IDS) to the plans' network.

This will help consumers to assess plans based on cost, benefits, and access to care. Note that this should not be considered a substitute for the implementation of strong quantitative measures for network adequacy currently being developed by the MIA.

5. Additional Information within SBC Link (p. 26) -- We object to the removal of standards included in the 2017 Final Issuer Letter, namely the requirement that "issuers include a URL that links to each QHP's complete benefits or terms through a policy contract or an in-depth plan document on the Summary of Benefits and Coverage form."[3] It is critical that consumers be able to access detailed coverage documents when shopping for plans, so we strongly recommend that this standard be included for 2018.

6. Essential Community Providers (pp. 28-29) -- We support a requirement for carriers to offer contracts in good faith to willing local health departments, and for MHBE to assess during 2017 whether separate threshold standards are needed for mental health or substance use disorder providers. CHF strongly endorsed comments submitted on the 2017 Issuer Letter by the Drug Policy Clinic, University of Maryland Carey School of Law, that recommended a separate 30% contracting requirement for mental health and substance use disorder providers. We supported that requirement to address the very limited number of specialized substance use disorder providers in carrier networks, as evidenced by data reported in MHCC's 2015 Consumer Edition Quality Report. Additionally, the inclusion of substance use treatment programs in the "other ECP provider" category along with local health departments will inherently limit the number of substance use providers selected. Expanded access to substance use treatment is needed to help Maryland address its staggering opioid epidemic.

7. Formulary (p. 32) -- Given the impact of prescription drug prices on consumers' ability to pay for their care, we support MHBE's proposal to work with stakeholders to determine if additional information about formularies would be helpful.

8. Special Enrollment Periods (p.34) -- We fully endorse the expansion of SEPs and, in particular, an SEP which allows the victim, or dependent of a victim, of abuse or abandonment to access coverage separate from the perpetrator. This is a necessary step for vulnerable individuals. We also believe that an SEP should be established for pregnancy but recognize the

[3] http://www.marylandhbe.com/wp-content/uploads/2016/01/2017-Final-Letter-to-Issuers-1.22.pdf, p. 26.

challenges associated with this and suggest that this be considered in the future.

9. Provider Directory -- As of January 1, 2017, all carriers must ensure the accuracy of their provider directories in one of two ways: (1) a periodic review of a reasonable sample size of its network directory; or (2) contact providers listed in the carrier's network directory who have not submitted a claim in the last six months to determine if the provider intends to remain in the network. The Insurance Commissioner may request documentation from a carrier that the carrier has taken one of these two steps to ensure the accuracy of its provider directory. The accuracy of a carrier's provider directory is particularly important to consumers making plan selections during open enrollment as they assess access to care for particular health care services. For this reason, we encourage the MHBE to reconsider removing this requirement. We recommend that MHBE ask each carrier to disclose on its application the method it uses to ensure the accuracy of its provider directories and to certify that the carrier conducts this review on no less than an annual basis.

10. SHOP - Expanded Employee Choice (pp. 32-33) -- We are in full agreement that the employee choice model should be expanded. Not only is this in the best interests of consumers, but we believe that it is important to provide a strong incentive for employers to purchase through SHOP.

In addition to the above, it was proposed that MHBE remove the standard that called for the development of a "timeline to evaluate efficacy of MHPA's **continuity of care policies**. In its place, MHBE recommended that this be addressed through the Standing Advisory Committee. We believe this approach is adequate but would suggest that this process move forward in a timely manner.

We thank you again for the opportunity to provide comments in support of consumer interests.

Sincerely,

Leni Preston
President, Consumer Health First
Member, MHBE Standing Advisory Committee

Signatory Organizations:

Advocates for Children and Youth

American College of Nurse Midwives, Maryland Affiliate

Center for Black Equity-Baltimore

Center for Children, Inc.

Drug Policy Clinic, University of Maryland Carey School of Law, Clinical Law Program

Greater Baltimore HIV Health Services Planning Council

League of Women Voters of Maryland

Maryland Occupational Therapy Association

Mental Health Association of Maryland

NAMI Anne Arundel County

NAMI Howard County

NAMI Harford County

NAMI Maryland

NAMI Metropolitan Baltimore

NAMI Prince George's County

NARAL Pro-Choice Maryland

Planned Parenthood of Maryland

Primary Care Coalition

Progressive Cheverly Health Committee

Sisters Together and Reaching, Inc.