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analysis to advance the health of vulnerable populations

Health Benefit Plan Contracting: A Background Paper

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Table of Contents

Introduction	1
Standards for Certification and Accreditation of Qualified Health Plans	2
Qualified Health Plan Certification.....	2
Qualified Health Plan Accreditation.....	3
Exchange-Developed Certification Requirements and Contracting Model	4
Premium Rate Review	4
Background: Maryland’s Small Group and Individual (Non-Group) Markets.....	4
Maryland Insurance Administration	5
MIA Rate Review Standards.....	6
MIA Rate Review Process.....	6
The ACA’s Impact on MIA’s Rate Review Process	7
Maryland’s HealthChoice Program: “Every Willing and Qualified Provider”	7
MCO Qualifications Review Standards – Regulatory Framework.....	8
MCO Qualifications Review Process	9
Ongoing Access and Quality Monitoring.....	10
State Employee Health Benefits	12
Regulatory Framework.....	13
2008 State Employee Health Benefits Procurement - Selection Criteria	14
Scoring the Proposals	15
Health Plan Performance	16
Summary.....	18
Glossary	20
References	22



Introduction

The Affordable Care Act (ACA) requires states to either establish and operate a Health Insurance Exchange by 2014 or participate in the federal Exchange. On April 12, 2011, Governor O'Malley signed the Maryland Health Benefit Exchange Act of 2011, which establishes Maryland's Exchange as an independent unit of the state government. The Exchange will provide a marketplace for qualified health plans (QHPs) and assist individuals and employers in accessing these health plans and accompanying tax credits. The Maryland Health Benefit Exchange Act also establishes a Board of Trustees to oversee the Exchange and requires the Exchange to study and make recommendations on a specified list of topics to the Maryland General Assembly by December 23, 2011. One of these required topics is "the feasibility and desirability of the Exchange engaging in selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care by certifying only those health benefit plans that meet certain requirements, such as:

- Promoting patient-centered medical homes
- Adopting electronic health records
- Meeting minimum outcome standards
- Implementing payment reforms to reduce medical errors and preventable hospitalizations
- Reducing disparities
- Ensuring adequate reimbursements
- Enrolling low-risk members and underserved populations
- Managing chronic conditions
- Promoting healthy consumer lifestyles
- Value-based insurance design
- Adhering to transparency guidelines and uniform price and quality reporting" (Maryland Health Benefit Exchange Act of 2011, §5).

The Exchange Board issued a request for proposal (RFP) in August 2011 for a vendor to conduct a study to examine the operating model to be adopted by the Exchange, whether the Exchange should engage in selective contracting and multistate or regional contracting, and the rules under which health benefit plans should be offered inside and outside the Exchange, including risk selection, reinsurance, and risk corridors. The Exchange Board will use the results of the vendor's study to make recommendations to the Maryland General Assembly.



The purpose of this report is to provide background information on health plan contracting to the Maryland Exchange Board Advisory Committee and to provide foundational support for the analysis conducted by the vendor selected to perform the study. This report first provides an overview of health plan certification under the ACA and associated regulations recently proposed by the U.S. Department of Health and Human Services (HHS). It then describes Maryland's individual and small group health insurance markets; the Maryland Insurance Administration's (MIA's) premium rate review process; the non-selective form of contracting currently used by Maryland's HealthChoice (Medicaid managed care) program; and the procurement process employed by the Maryland Department of Budget and Management (DBM) to select health benefit plans offered to Maryland state employees, retirees, and their dependents. Background information presented in this report provides a frame of reference for members of the Exchange to facilitate their consideration of various methods of health plan procurement. It will be up to the Exchange to establish a health plan contracting model that best serves the interests of Marylanders who will seek coverage through the Exchange and the insurers that will provide it.

Standards for Certification and Accreditation of Qualified Health Plans

Qualified Health Plan Certification

Under the ACA and Maryland law, the Exchange will be responsible for certifying QHPs to offer health insurance coverage through the Exchange. The ACA and regulations proposed by HHS prescribe federal minimum certification standards for QHPs. Health plans that meet the federal minimum criteria will be certified if the Exchange determines that making the plan available through the Exchange “is in the interest of qualified individuals and qualified employers” (ACA §1311(e)(1)(b)). The Exchange may adopt additional certification standards, if it chooses to do so, to further state policies not addressed by the federal minimum standards for QHP certification (proposed 45 CFR §§155.1000 and 156.200(d)).

Minimum certification standards for participating QHPs—whether offered in the individual or small group market—and for the [carriers](#) that offer them include the following (ACA §1301(a) and proposed 45 CFR §§155.1050 and 156.200 - .285):

- Being licensed and in good standing to offer health insurance coverage in the state
- Implementing and reporting on a quality improvement strategy that is consistent with ACA requirements
- Complying with federally prescribed risk adjustment strategies
- Offering at least one QHP at the [silver coverage level](#) and at least one QHP at the [gold coverage level](#) (if a carrier participates in the individual market)
- Offering a child-only plan



- Offering QHPs at the same premium rate through the Exchange as they are offered outside the Exchange
- Adhering to nondiscriminatory practices
- Complying with plain language and transparency requirements applicable to premium rates and rating practices, benefits, coverage, and cost sharing
- Complying with state and federal marketing rules
- Meeting provider network adequacy standards established by the Exchange, including those relating to essential community providers
- Complying with limitations on premium rating variation and rating categories
- Complying with prescribed enrollment and coverage termination processes
- Complying with additional Small Business Health Options Program (SHOP)-specific premium rating, premium payment, enrollment, and termination of coverage requirements (if the carrier offers QHPs through SHOP)

Qualified Health Plan Accreditation

Within a timeframe established by the Exchange, a QHP carrier must be accredited by an accrediting entity recognized by HHS and maintain accreditation for as long as it offers QHPs through the Exchange. Accreditation will be based on the local performance of each of the carrier's QHPs in specified categories, including:

- Clinical quality measures (e.g., the Healthcare Effectiveness Data and Information Set [[HEDIS](#)])
- Patient experience ratings (how patients rate their health plan and providers; e.g., in the Consumer Assessment of Healthcare Providers and Systems [[CAHPS](#)] survey)
- Consumer access to care
- [Utilization management](#)
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs (ACA §1311(c); proposed 45 CFR §156.275)



Exchange-Developed Certification Requirements and Contracting Model

The ACA and proposed regulations prescribe the specific *minimum* standards (discussed above) that the Exchange must apply in its QHP certification process. In addition, the Exchange may choose to establish additional certification standards to further state policy goals such as population health, health care quality, and enhanced access to care (Corlette & Volk, 2011).

Moreover, the ACA allows the Exchange to decide on the method it will use to determine whether a plan's participation is in the interest of qualified consumers and qualified employers. Methods of determining which health plans may participate in the Exchange include an "any willing and qualified plan" model, which would permit all plans that satisfy the minimum federal certification requirements to offer coverage through the Exchange. Alternatively, a form of selective contracting such as competitive bidding or price negotiation would allow the Exchange to limit participation to only those health plans that score the highest on certification criteria established by the Exchange (HHS, 2011).

Price considerations—i.e., premiums charged for enrollment in QHPs offered through the Exchange—are embedded in the ACA's minimum certification standards. For example, QHPs must comply with limitations on premium rating variation and rating categories. In addition to the federally prescribed standards, the Exchange may choose to adopt additional requirements relating to price and may include price as an important factor in the QHP certification/selection model it adopts.

Premium Rate Review

Background: Maryland's Small Group and Individual (Non-Group) Markets

According to the Maryland Health Care Commission (MHCC) (2010), about 13 percent of Marylanders have health insurance through a small employer (one that employs between 2 and 50 employees), and approximately 4 percent of Marylanders have individual health insurance policies. Maryland law requires that all health benefit plans sold to small employers cover the same comprehensive set of benefits and meet uniform standards for copayments, deductibles, and other forms of cost sharing. Required benefits and uniform cost sharing requirements apply across delivery systems (e.g., [indemnity](#), [preferred provider organization \[PPO\]](#), [point of service \[POS\]](#), and [health maintenance organization \[HMO\]](#) plans). These requirements are part of Maryland's Comprehensive Standard Health Benefit Plan (CSHBP), which specifies additional important features of all small group coverage issued or delivered in Maryland. These CSHBP features include:

- **Guaranteed issue:** If a small employer offers health benefits to its employees, no eligible employee may be denied coverage under the plan because of the employee's health status or preexisting condition.



- **Guaranteed renewal:** An employee enrolled in a small group health plan has the right to continue coverage under the plan as long as the employee continues to be employed by the firm and pays premiums on a timely basis. Premiums may not be increased on an individual, employee-specific basis.
- **Community rating:** Premiums for small group health plans must be based on the carrier's historic [experience](#) associated with all risks the health plan covers. This "community rate" generally may not be adjusted except on the basis of age, geography, and family composition. Health status may not be considered, except during the three-year period after a small employer first begins to offer *any* health benefit plan to its employees (Md. Code Ann., Insurance Article §15-1205(a)(2) and (f)).
- **Affordability:** MHCC, which developed the CSHBP in 1993, monitors and updates it annually to ensure that premium costs average no more than 10 percent of Maryland's average annual wage (MHCC, n.d.).

As of 2009, 763,034 Marylanders (about 13 percent of the state's population) were covered under a CSHBP small group health benefit plan (MHCC, n.d.). Of the eight carriers that offer health plans in Maryland's small group market, CareFirst currently dominates, with over 75 percent of market share (Maryland Health Care Reform Coordinating Council [HCRCC], 2011).

In contrast to Maryland's small group coverage requirements and premium limitations, in the individual market, premium rates are subject to medical [underwriting](#). That is, an individual's health status can affect the amount the individual pays in premiums, as well as the policy's coverage limitations, and can result in denial of coverage. Currently, health insurance coverage for about 244,000 Marylanders (roughly 4 percent of the state's total population) was purchased through the individual market (Kaiser Family Foundation, 2009). Seven carriers operate in Maryland's non-group market. CareFirst is dominant in this market as well, with over 80 percent of market share (HCRCC, 2011).

Maryland Insurance Administration

MIA is an independent unit of state government under the control and supervision of the Insurance Commissioner. The Commissioner is appointed to a four-year term by the Governor, to whom the Commissioner is directly responsible. MIA is charged with regulating the state's insurance industry. Its functions include monitoring compliance with Maryland's insurance laws to protect the public from unfairness in insurance pricing and claims settlement, as well as from a carrier's insolvency. Of primary relevance to the Exchange is MIA's health insurance rate review function. Maryland law and regulations require health insurance carriers to file health insurance forms—accompanied by premium rates—for approval by the Commissioner (Md. Code Ann., Insurance §12-203; COMAR 31.10.01.02; Tomczyk, Welch, & Bender, 2011).



MIA Rate Review Standards

The Commissioner has the authority to disapprove (or to withdraw approval previously given to) a [form](#) that provides for benefits that are “unreasonable in relation to the premium charged” (Md. Code Ann., Insurance § 12-205(b)(6)) or, with respect to HMO rates, are “excessive inadequate, or unfairly discriminatory” (COMAR 31.12.02.08D; Tomczyk et al., 2011, p. 12).

One factor in determining the reasonableness of health insurance rates is the plan’s projected [medical loss ratio \(MLR\)](#). As a result of the ACA and Maryland law effective July 1, 2011, Maryland carriers now must demonstrate prospectively that their rates will produce an MLR of at least 80 percent in the individual and small group markets. If these ratios are not met, MIA may require the carrier to file new rates. Under the ACA, carriers, out of compliance with the federal MLR requirement must rebate excess premiums collected (Insurance Art., §15–137.1; 2011 Md. Laws, Chs. 3 and 4; ACA §1001; Jost, 2010).

In addition to enforcing the minimum MLR requirement, MIA is required to disapprove a rate change that appears unreasonable in relation to benefits based on statistical analysis and reasonable assumptions. A health insurance form must be disapproved if it contains unfair or misleading representations of coverage. With respect to a nonprofit health service plan (i.e., CareFirst), MIA may also consider the carrier’s past and prospective loss experience, its underwriting practice and judgment, a reasonable margin for reserves, past and prospective expenses, and other relevant factors (Md. Code Ann., Insurance §14-126(b)(3)).

MIA Rate Review Process

MIA reviews health plan premium rates to determine whether they are reasonable, taking into consideration the characteristics of the covered population, health care services that population is expected to use, the cost of medical care, and the health plan’s reasonable administrative costs. (Lopez, 2011). The central inquiry for both health insurance rate development and rate review is the assessment of risk. Risk assessment is based on assumptions about the characteristics and health status of individuals expected to enroll in the plan, as well as their expected medical costs during the coverage period. Future medical costs are projected by using a carrier’s historic claims experience to establish a percentage (trend) that describes the projected average annual change in medical costs. For 2008 to 2010, average annual medical cost trends ranged from 8 to 13 percent in the individual and small group markets (PricewaterhouseCoopers, 2010). In 2012, the medical cost trend is expected to reach 8.5 percent, an increase of 0.5 percent from 8 percent in 2011 (PricewaterhouseCoopers, 2011).

The rate review processes for the individual and small group markets are similar. Carriers must submit a rate filing whenever a rate change is needed—usually about once a year. CareFirst, the state’s sole nonprofit health service plan and its largest carrier, files on a quarterly basis. At least 60 days before the form’s initial issuance or delivery in Maryland (90 days for a previously approved form), a carrier must submit its form and rate filing, accompanied by an actuary’s



description of the assumptions and methods on which it is based. For approval, supporting historical experience data presented with the submission must be sufficient to demonstrate that the rates proposed by the carrier are adequate and neither excessive nor unfairly discriminatory (Md Code Ann., Insurance §12-203; COMAR 31.10.01.02; Tomczyk et al., 2011; The Hilltop Institute, 2011).

The ACA's Impact on MIA's Rate Review Process

The ACA requires the Secretary of HHS to collaborate with the states to establish annual review of “unreasonable” premium rate increases. HHS regulations finalized in May 2011 require that, beginning September 2011, carriers must justify health plan premium increases of 10 percent or more to state or federal rate reviewers (Lopez, 2011). (The 10 percent review standard will be replaced effective September 2012 with state-specific thresholds based on health care cost trends in each state.) Reviewers will determine that a rate increase is unreasonable if it is:

- Excessive: The premium is unreasonably high in relation to the benefits provided, considering compliance with the MLR requirement, whether assumptions underlying the rate increase are supported by substantial evidence, and whether the choice or combination of assumptions is reasonable
- Unjustified: Data submitted to support the rate increase are incomplete, inadequate, or provide an insufficient basis for determining the reasonableness of the increase
- Unfairly Discriminatory: Premium differences between plan enrollees in similar risk categories that are either impermissible under applicable state law or—if there is no applicable state law—are inconsistent with differences in expected costs (proposed 45 CFR §154.205)

In early 2011, supported by a Premium Rate Review grant awarded by HHS, MIA engaged an outside consultant to make recommendations as to how MIA's health insurance rate review process might be improved. The study and recommendations were completed May 18, 2011, and presented at a public hearing on June 23, 2011 (MIA, 2011a). On July 6, 2011, HHS announced its determination that Maryland has an “effective rate review program” that satisfies criteria established by the new federal regulations. This means that MIA's determinations regarding the reasonableness of proposed rate increases will be adopted by HHS (MIA, 2011b) as long as MIA complies with federal transparency requirements that it 1) provide access through its website to rate justifications submitted in connection with carriers' rate filings and 2) has a mechanism to receive public input on proposed rate increases (45 CFR §154.301).

Maryland's HealthChoice Program: “Every Willing and Qualified Provider”

HealthChoice is a public risk-based managed care program that delivers comprehensive health care benefits to most of Maryland's Medicaid population, with the exception of older adults and some other special populations. Medical benefits and services are delivered through seven



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managed care organizations (MCOs) contracted by the Maryland Department of Health and Mental Hygiene (DHMH) on a non-competitive basis in which price is not a consideration. All willing and qualified plans may participate. DHMH establishes the amount of per member per month (PMPM) capitation payments using a rate setting methodology specified in program regulations (COMAR 10.09.65.18-1 to .19-5). MCO payment rates are updated at least semiannually.

The program was initially implemented in 1997 pursuant to a “Research and Demonstration” waiver approved by the Centers for Medicare and Medicaid Services (CMS) under §1115 of the Social Security Act. As of July 2011, HealthChoice provided comprehensive medical benefits to about 75 percent of Maryland’s Medicaid population and to 100 percent of the Maryland Children’s Health Program (MCHP) population, for a total of 738,272 covered individuals. Five of the seven current HealthChoice MCOs also deliver a limited benefit package covering primary and emergency care services to the 53,073 enrollees of Maryland’s Primary Adult Care (PAC) program (DHMH, 2011).

The seven MCOs participating in the HealthChoice program are: Amerigroup Community Care, Diamond Plan (Coventry Health Care, Inc.), Jai Medical Systems, Maryland Physicians Care, Medstar Family Choice, Priority Partners, and United Healthcare (Delmarva Foundation, 2011). This section of the report discusses the MCO review/approval process for HealthChoice, as well as quality and compliance audits conducted by the state to ensure that HealthChoice MCOs are performing at acceptable levels.

MCO Qualifications Review Standards – Regulatory Framework

To participate in the HealthChoice program, a health plan must be approved by DHMH, consistent with qualification standards outlined in COMAR 10.09.64. The MIA is responsible for reviewing and either approving or disapproving an MCO applicant’s financial qualifications.

DHMH’s MCO contracting process is designed to ensure that participating MCOs are capable of offering accessible, high-quality medical services. The qualification process begins when a health plan submits an MCO application to DHMH. The application is the vehicle by which a prospective MCO demonstrates its ability to deliver the HealthChoice benefit package to its enrollees consistent with program standards. The application must include evidence of the applicant’s compliance (or ability to comply) with standards relating to:

- Financial soundness (for review by MIA): Evidence of insurance coverage, liquid funds, cash flow, financial statements, and a description of how the MCO would prevent insolvency and limit financial risk (COMAR 10.09.64.04)
- Access and Capacity Standards:
 - Electronic provider data listing all network providers by provider and specialty type and location (COMAR 10.09.64.05)



- A description of the enrollee population to be served, and evidence that the plan will meet regulatory standards for enrollee-to-primary care provider (PCP) ratios. (COMAR 10.09.64.05 and 10.09.66.05B (7))
- **Benefits and Appointments:** Descriptions of how the applicant will provide covered benefits, case management, continuity of care, and timely access to covered health care services (COMAR 10.09.64.06)
- **Contracts and Provider Applications:** A description of the applicant's hiring and subcontracting policies, and copies of all provider contract forms for DHMH review and approval (COMAR 10.09.64.05)
- **Quality Assurance System:** A description of the applicant's quality assurance plan, its peer review committee process and structure, and its review system for handling provider complaints, grievances, and appeals (COMAR 10.09.64.09)
- **Special Needs Populations:** A description of the clinical expertise of the plan's provider network, and its experience with special needs populations (e.g., children with special health care needs and individuals with HIV/AIDS), and written evidence of the plan's ability to offer clinical and support services for these groups (COMAR 10.09.64.04 and 10.09.65.04-.10)
- **Management Information System and Data Reporting:** A description of the applicant's management information system software and capacities, and evidence of its ability to report specific encounter data in the required format (COMAR 10.09.64, 10.09.65.04, and 10.09.66.05).

MCO Qualifications Review Process

Completeness Review

Upon receipt of an MCO application, DHMH reviews it for completeness. During this step of the qualifications review process, DHMH determines whether the applicant has provided a response to each element of the application and identifies any additional information or documentation the applicant must submit before the application can be considered complete.

Substantive Desk Review

After the applicant has submitted all materials necessary to complete its application, DHMH begins a qualitative evaluation of the applicant's responses for consistency with program regulations (COMAR 10.09.63-10.09.74). DHMH then notifies the applicant of the results of its review. Through what is typically an iterative process, the applicant adjusts its proposals to achieve consistency with program standards. DHMH will schedule an on-site readiness review when all of the following conditions have been met:

- No further written submissions are required of the applicant



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- MIA has verified that the applicant is financially sound
- The applicant's provider network data have been reviewed and are determined to be useable
- The application is substantially compliant with program standards

On-site Readiness Review

The next step of the qualifications review process is the on-site readiness review. The primary purpose of this review is to confirm that the systems described in the application are in place and operational. Upon completion of the site visit, DHMH reports its results to the applicant. If the applicant has not been successful, the letter lists deficiencies and explains how they can be addressed to meet program standards. If the applicant is successful, DHMH offers it a standard MCO agreement that incorporates by reference all HealthChoice regulatory standards as terms of the MCO contract. After the contract is executed, DHMH will enroll HealthChoice beneficiaries in the new MCO, consistent with DHMH's determination of the MCO's provider network capacity.

Ongoing Access and Quality Monitoring

Provider Network Adequacy

To ensure enrollee access to needed health care services, each MCO is required to maintain a provider network that is adequate to serve its enrollees. As part of the application review process, MCOs must submit provider network data to DHMH to establish network adequacy. Thereafter, regular updates are required. The purposes of these submissions is to generate provider directories, confirm that MCO enrollment does not exceed capacity, and allow DHMH to evaluate potential network deficiencies (DHMH, 2010a).

In addition to providing primary care services through PCPs, MCOs must provide all medically necessary covered specialty care services. An MCO's provider network must include providers in sufficient numbers and varieties of specialty areas to meet the needs of its enrollees. Geographic access standards, which take into consideration driving time and distance, apply to primary care, pharmacy, OB/GYN, and diagnostic laboratory and X-ray services (COMAR 10.09.66.06). In addition, 14 "major" specialty areas must be included in an MCO's provider network, and eight "core" specialties must be represented in each of the ten regions the MCO serves (COMAR 10.09.66.05-1). DHMH monitors compliance with provider network adequacy standards through review of MCOs' provider data and required reports of service denials and consumer complaints.



Data Management and Reporting for Quality Assurance and Improvement

HealthChoice MCOs must have a quality assessment and improvement program to assess, measure, and monitor the quality of services provided to HealthChoice enrollees. To facilitate ongoing quality monitoring, MCOs must collect and report data to DHMH, including [encounter data](#) (which enables DHMH to track services delivered to enrollees) and specified quality, access, and performance data. Examples of required reports include those relating to service denials and reductions, analyses of enrollee appeal and grievance logs, and caller abandonment rates and average hold times for member services and provider authorization/preauthorization lines. MCOs must also submit a copy of the MCO's drug formulary each year, and provide notice of any revisions to the MCO's quality assurance, utilization management, and case management plans. An annual report of the MCO's health care delivery and organizational performance using HEDIS measures (explained below) is also required.

HEDIS Measures

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance. DHMH uses HEDIS measures to evaluate access to, use of, and effectiveness of health care services provided by HealthChoice MCOs (HealthcareData Company, 2010). Maryland regulations require DHMH to choose HEDIS measures to be collected each year based on their significance to the HealthChoice population. At least one measure must be collected annually on prenatal, perinatal, and postnatal care; screening and preventive services for children and women; and individuals with special health care needs (COMAR 10.09.65.03).

For calendar year 2009, HealthChoice MCOs were required to report 21 HEDIS measures on services provided that year. Examples include adolescent immunizations, well-child visits in the first 15 months of life, and adult access to preventive services (HealthcareData Company, 2010).

Value-Based Purchasing

Maryland uses a value-based purchasing model to reward and penalize MCOs based on their performance with respect to ten performance measures (e.g., “childhood immunization status” and “eye exams for diabetics ages 18-75”) (DHMH, 2010b). Target percentages for each measure are established, with specified percentages defining three levels of performance: “disincentive” (performance below minimum target), “neutral” (meets minimum target), and “incentive” (exceeds minimum target). An MCO will receive an incentive payment (0.1 percent of the MCO's total capitation payments during the measurement year) for each measure it exceeds, and a commensurate deduction from its total capitation payments for each measure it fails to meet, with a disincentive cap of 0.5 percent (DHMH, 2010b).



Systems Performance Review (SPR)

The annual Systems Performance Review (SPR) is a key quality monitoring activity required by law and regulations. To assess an MCO's ability to provide care, DHMH contracts with an external quality review organization (EQRO) to conduct a review of each MCO's structure and operations. Compliance rates for MCOs are evaluated based on 11 performance standards, which each contain multiple quality elements.

The EQRO visits each MCO for an on-site assessment and submits the results in a draft report to each MCO. If an MCO's score for a performance standard is lower than the acceptable threshold determined by DHMH, then the MCO must develop a corrective action plan (CAP). The EQRO will determine whether an MCO's CAP is adequate. If it is not, the EQRO will provide technical assistance to the MCO until it submits a satisfactory CAP. If the MCO does not satisfactorily implement corrections described in its CAP, the EQRO will notify DHMH for further action (COMAR 10.09.65.03; Delmarva Foundation, 2010).

Consumer and Provider Satisfaction Survey

Another required quality assessment activity is an annual enrollee satisfaction survey using the most recent version of CAHPS. DHMH contracts with a certified CAHPS vendor to conduct this survey with adult and child HealthChoice enrollees from the seven MCOs to assess their rating of and experience with the health care they received. For example, enrollees are asked to rate their personal doctor, specialist, health care, and health plan on a scale from 0 to 10. In addition, the survey assesses enrollees' experience with respect to accessing needed care, getting care quickly, communicating with doctors, customer service, and coordination of care. The CAHPS vendor lists the HealthChoice-wide overall score for each measurement and each MCO's individual score. DHMH uses these results to determine how well MCOs are meeting their enrollees' needs, to help MCOs improve quality, and to enhance MCO accountability (WBA Market Research, 2010a).

DHMH also contracts with a vendor to conduct a provider satisfaction survey with PCPs participating in each HealthChoice MCO. The purpose of this survey is to evaluate whether MCOs are meeting PCPs' expectations and needs. Providers are asked about their overall satisfaction with their MCO, whether they would recommend the MCO to patients and other doctors, and to rate their experiences with MCO financial, customer service, case management, and utilization management issues. The vendor lists the overall HealthChoice-wide score for each measurement and each MCO's individual score. The results of this survey allow DHMH to identify areas for improvement (WBA Market Research, 2010b).

State Employee Health Benefits

In Maryland, one of the largest areas of fiscal impact on the state is expenditures under contracts with private entities for the provision of health benefits to state employees, retirees, and their



dependents. The state employee workforce consists of approximately 79,500 regular positions. In state fiscal year 2011, the state will spend \$7.8 billion on wages and benefits—24.4 percent of the total state operating budget (Maryland Department of Legislative Services [DLS], 2010). Currently, there are 230,000 members enrolled in the Maryland state benefits plan. State law and regulations detail all aspects of the procurement process, which begins with a solicitation and contract awards and continues through all phases of contract administration (DLS, 2010).

Regulatory Framework

Maryland law charges the Secretary of DBM with development and administration of the State Employee and Retiree Health and Welfare Benefits Program (Program), through which health insurance benefit plan options are provided to state employees, retirees, and their dependents. The Secretary has the authority to “arrange as the Secretary considers appropriate any benefit option for inclusion in the Program” and to promulgate regulations for the Program’s administration (Md. Code. Ann., State Personnel and Pensions Art., §2-503). In addition, it is the Secretary’s responsibility to make a recommendation to the Governor each year as to the state’s share of Program costs.

State procurement regulations generally require state agencies to award procurement contracts by one of the following methods (COMAR 21.05.01.01):

- Competitive sealed bidding
- Competitive sealed proposals
- Negotiated award after unsatisfactory competitive sealed bidding

“Competitive sealed bidding” is the preferred method of procurement for goods and supplies, especially if they are standard goods that can be specifically described (e.g., “number 2 wood and graphite 12-inch pencil with eraser tip”) so that price can be essentially the sole selection factor. Specifications for the object of the procurement are set forth in a public “Invitation for Bids” to which prospective vendors (“offerors”) respond (DHMH, n.d.a).

A “competitive sealed proposals” method is more appropriate for services contracts. It is initiated by the public issuance of an RFP that includes in its description of contract deliverables an explanation of the procurement’s overall goals, along with an explanation of how proposals will be scored and ranked. Each qualified offeror must submit a technical proposal detailing its strategy for how it will deliver the services, as well as an explanation of its qualifications. In a separate financial (price) proposal, an offeror proposes a payment rate for services to be delivered under the contract. Technical and financial proposals from each offeror are evaluated and ranked to determine which offer is most advantageous to the state. In this type of procurement, technical ability is often considered more important than price (DHMH, n.d.b).



State procurement regulations specify that the competitive sealed proposals method is preferred for procurements of “human, social, cultural or educational services” (COMAR 21.05.03.01). Since employee health benefits are in this category, DBM employs the competitive sealed proposals process to select health benefit plans and health benefit plan administrators. In 2008, DBM issued an RFP for plan administration and health insurance benefits for state employees, retirees, and their dependents. Contracts were awarded for a period of five years. The current contract period began on July 1, 2009, and extends through June 30, 2014 (DBM, 2008).

DBM’s 2008 RFP solicited proposals in four health plan delivery system models (the RFP uses the language “four functional areas”): self-funded PPO, self-funded POS, fully insured HMO, and self-funded HMO/[EPO](#) (exclusive provider organization). For the self-funded functional areas, the RFP sought vendors to serve as third-party administrators (TPAs) to arrange for the provision of health benefits and services to state employees, retirees, and their dependents, with the state retaining responsibility for claims payment via the TPAs. For the fully insured HMO component, the RFP provided for state capitation payments to the plan, which in turn would be responsible for paying providers’ claims for comprehensive medical services provided to state enrollees.

The RFP limited the number of vendors that would be selected to no more than two PPOs, three POS plans, and three HMOs/EPOs. Separate proposals were required for each functional area in which an offeror wished to compete (DBM, 2008). Plans in all functional areas were required to provide or arrange for the provision of a standardized comprehensive benefit package, so that all employees would be covered for the same benefits regardless of the type of plan in which they would choose to enroll (DLS, 2010). At the time the RFP was issued in 2008, approximately 119,000 members were enrolled in state employee health plans. Enrollment by service delivery system at that time is shown in Table 1 below.

Table 1. 2008 Enrollment Distribution among Delivery Systems

Health Care Delivery System Model	Percentage of State Employees Enrolled
PPO (Self-funded)	52%
POS (Self-funded)	31%
HMO (Fully Insured)	17%

Source: DBM, 2009, p. 17

2008 State Employee Health Benefits Procurement: Selection Criteria

To be considered for a contract award, all offerors responding to DBM’s 2008 employee health benefits RFP were required to meet minimum qualification standards, including having an A.M. Best or Standard & Poor’s insurance rating of no less than “A.” HMO offerors had to be MIA-



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certified to provide health plan services. The RFP directed offerors meeting the minimum qualifications to submit technical proposals that included information, evidence, or assurances regarding (DBM, 2008):

- Plan design
- Provider network adequacy (demonstrating the availability of specified facility types and practitioners in key practice categories)
- Quality improvement activities (e.g., surveys of customer and provider satisfaction)
- Anticipated economic benefits to the state
- The offeror's ability to perform contract requirements with integrity and reliability (e.g., disclosure of any litigation or other government action taken or pending against the offeror in the past five years)
- Financial capacity to provide services under the contract
- Performance guarantees with respect to telephone availability, enrollment eligibility information updates, quarterly plan performance measurement report card, quarterly utilization and case management data reports, claims accuracy standards, and annual hospital records and claims audit

In addition to the technical proposal, the RFP directed qualified offerors to submit a separate financial proposal, including (DBM, 2008):

- A financial compliance checklist
- Details of provider reimbursement
- An explanation of any disruption in claims payments
- Administration and network access fees and expected claims costs based on claims information provided in the RFP
- Hospital utilization charges

Scoring the Proposals

Financial proposals were ranked from lowest to highest total cumulative cost. The criteria that DBM applied in evaluating the technical proposal, in descending order of importance, were:

- Network access and management (network size, accessibility, and stability)
- Ability to cover the current state population
- Comparability of proposed plan designs to existing plan designs



- Corporate experience, capability, and capacity to deliver administrative services (claims processing, member services, eligibility, reporting, comprehensive IT support, and plan administration)
- Staffing plan, and personnel qualification and experience
- Subcontractors
- Economic benefit factors

DBM's selection committee assigned weights to technical and financial factors (DBM, 2008). Under Maryland law and regulations, no resident business preference can be afforded a Maryland-based offeror, except when another qualified offeror is based—and will perform services under the contract primarily—in a state that *does* afford procurement preference to its residents.

DBM has discretionary authority to procure employee health benefit coverage on either a self-funded or fully insured basis. All HMO/EPO contracts were awarded on a self-insured basis. Vendors selected through the DBM's 2008 employee health benefits procurement are now providing health care services to state employees under those contracts. Pursuant to that procurement, contracts were awarded in 2009 as follows:

- CareFirst (PPO, POS, EPO)
- United Healthcare (PPO, POS, EPO)
- Aetna (POS, EPO)

Health Plan Performance

Mechanisms for Oversight and Accountability

Quality Standards

The 2008 RFP requires that each health care delivery system (PPO, POS, and HMO/EPO) commit to meeting specified quality standards focusing on:

- Enrollment eligibility
- Notice of changes to plan benefits or changes in participating providers
- Member information (24/7 live customer service call line to answer questions, process claims, and explanation of benefits)
- Compliance with member privacy standards (e.g., HIPAA)
- Monthly, quarterly, and annual reporting of clinical and claims data to the state for audit review



- Procedures to prevent billing members in excess of network allowances

DBM issues a separate RFP to contract audit services for the State Employee and Retiree Benefits Program. The contract awarded requires the auditing agency to complete annual external audits of contracting health plans' claims adjudication and payment functions, clinical functions, administrative performance, and internal audits conducted by—or at the direction of—the TPA (DBM, 2010).

Access Standards

At the time it submits its technical proposal, an offeror must be compliant with access standards specified in the RFP for each health care delivery system (PPO, POS, and HMO/EPO). Access standards are subdivided into provider categories: adult primary care providers, pediatricians, OB/GYN, and hospitals. For each category, the offeror must demonstrate that the number of network providers and facilities in its provider network sufficiently satisfies minimum provider-to-member ratios in each geographic area of the state. In addition, it must commit to maintaining these ratios throughout the contract period.

Performance Measures

In order to ensure that selected vendors deliver services in accordance with the state's quality and access, the RFP establishes specific performance measures that a contract awardee must meet, such as:

- Telephone availability (95 percent of calls answered by a live service representative with knowledge of Maryland employee coverage)
- Call abandonment rate (less than 5 percent)
- Delivery of quarterly plan performance and utilization and case management data reports
- Financial accuracy standards (99 percent claims processing accuracy)
- Payment accuracy (97 percent)
- Claims processing time (95 percent of all claims are adjudicated within 14 calendar days; and 98 percent of all claims are adjudicated within 30 calendar days)
- Member satisfaction (member satisfaction rate of at least 85 percent, as assessed by the state's annual customer satisfaction survey)

Reporting Requirements

To facilitate the state's monitoring of performance standards and other aspects of contract performance, an awardee must submit specified reports, which include:



- Quarterly hospital claims audit reports (including clinical and billing issues for each admission in excess of \$25,000 and a minimum of 2 percent of all hospital claims)
- Quarterly reports of estimated and actual cost data
- An annual financial plan detailing projected costs (e.g., provider reimbursement rates, administrative fees, and hospital utilization)

A contractor's failure to submit required reports or meet performance measure acceptability thresholds can be grounds for termination of the contract.

Summary

A key provision of the ACA is its establishment of American Health Benefit and SHOP Exchanges as new mechanisms for individuals and small businesses to purchase health insurance. The ACA outlines multiple requirements for state exchanges, including the certification of health plans as QHPs. Both the ACA and regulations proposed by HHS prescribe minimum QHP certification criteria while allowing flexibility for state exchanges to establish additional requirements to determine whether making a plan available through the Exchange "is in the interest of qualified consumers and qualified employers" (ACA §1311(e)). Maryland's Exchange will also decide what procurement model it will use to contract with QHPs.

The Maryland Health Benefit Exchange Act of 2011 established Maryland's Exchange and an advisory board to oversee it. It requires the Exchange to study and make recommendations to the Maryland General Assembly on a specified list of topics by December 23, 2011. One of these required topics is "the feasibility and desirability of the Exchange engaging in selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care by certifying only those health benefit plans that meet certain requirements" (2011 Md. Laws, Ch. 1, §5).

The ACA requires the Secretary of HHS to collaborate with the states to establish annual review of "unreasonable" premium rate increases. HHS regulations finalized in May 2011 require that, beginning September 2011, carriers must justify health plan premium increases of 10 percent or more to state or federal rate reviewers (Lopez, 2011). MIA's rate review process for commercial health insurance markets has been federally recognized as an "effective rate review program" that satisfies criteria established by the new regulations; MIA's determinations as to the reasonableness of proposed rate increases will be adopted by HHS (MIA, 2011b; 45 CFR §154.301).

Examples of non-selective and selective health plan contracting in Maryland include the HealthChoice program's non-selective contracting ("any willing and qualified plan" model) and DBM's procurement process for state employee health insurance benefits (selective contracting model). Both models include protections for enrollees with respect to access to care, quality of



care, and financial standards, and both are designed to ensure that the purchaser receives fair value for payments made under health plan contracts.



Glossary

“Carrier” means an authorized insurer, a nonprofit health service plan, an HMO, a dental plan organization, or any other entity providing a health insurance plan or health services authorized under the ACA (Md. Code Ann. §13-101(d)).

“Consumer Assessment of Healthcare Providers and Systems (CAHPS)” is a range of standardized, evidence-based surveys and related tools, developed by the federal Agency for Healthcare Research and Quality (AHRQ) for assessing patients’ health care experiences in areas such as provider communication and access to health care services (AHRQ, 2008).

“Delivery system” refers to the way in which health care benefits are delivered to insured individuals. Examples include indemnity plans and HMO plans (MHCC, n.d.).

“Encounter data” means information documenting the delivery of a service to an enrollee (COMAR 10.09.62.01).

“Experience” means the historical loss record associated with risks covered by the health plan.

“Exclusive Provider Organization” or “EPO” refers to a type of managed care plan that provides health care services to enrollees exclusively through its provider network (except members may access emergency services out-of-network). Some but not all EPOs require members to select an in-plan primary care provider. An EPO network is typically larger than an HMO network.

“Form” refers to any application, policy, certificate, contract, rider, and endorsement that relates to health insurance (COMAR 31.10.01.01).

“Gold coverage level” refers to a level of benefits coverage offered by a QHP that is “designed to provide benefits that are “actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan” (ACA §1302(d)(1)(C)).

“Healthcare Effectiveness Data and Information Set” or “HEDIS” is a quality measurement tool that measures health plan performance in specifically identified domains of health care services.

“Health maintenance organization” or “HMO” is a health benefit plan that requires enrollees to select an in-plan PCP that functions as a “gatekeeper.” Enrollees may receive services only from an in-plan specialist and only with a referral from the enrollee’s PCP.

“Indemnity plan” refers to a health benefit plan that reimburses claims for health care services delivered to an enrollee by providers selected by the insured individual, without limitations based on the provider’s “in-plan” or “out-of-plan” status. Indemnity plan premiums typically are higher than premiums for comparable coverage through delivery systems that restrict an enrollee’s



choice of providers or reimburse claims for services delivered by out-of-plan providers at a lower rate.

“Medical loss ratio (MLR)” means the ratio of incurred claims to premiums earned (i.e., the percentage of premium revenues spent on medical care) (DLS, 2010),

“Point of service” plan or “POS” is a health benefit plan that requires enrollees to select an in-plan PCP that functions as a “gatekeeper;” generally an enrollee may access services from a specialist only with the PCP’s prior authorization (MHCC, n.d.).

“Preferred provider organization” or “PPO” means a health benefit plan that requires enrollees to select providers from a panel of network providers with which the PPO contracts. Services may be accessed from out-of-network providers, but at greater cost to the enrollee (MHCC, n.d.).

“Silver coverage level” refers to a level of benefits coverage offered by a QHP that is “designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan” (ACA §1302(d)(1)(B)).

“Underwriting” is the process of identifying and classifying the degree of risk represented by a proposed insured, based on individual characteristics such as health status (National Association of Insurance Commissioners, n.d.).

“Utilization management” or “utilization review” is the process of evaluating medical necessity, appropriateness, and efficiency of health care services delivered to plan enrollees under the terms of a health benefit plan (URAC, n.d.).



References

- 2011 Maryland Laws, chs 1 and 2. Retrieved from
http://mlis.state.md.us/2011rs/chapters_noln/Ch_1_sb0182T.pdf
http://mlis.state.md.us/2011rs/chapters_noln/Ch_2_hb0166T.pdf
- Agency for Healthcare Research and Quality. (2008). *CAHPS: Assessing health care quality from the patient's perspective*. Retrieved from:
<https://www.cahps.ahrq.gov/content/cahpsOverview/07-P016.pdf>
- The Annotated Code of Maryland. (n.d.) Retrieved from
http://mlis.state.md.us/asp/web_statutes_2012.asp
- Carey, R., L. & Gruber, J. M. (2010). *A health insurance exchange for Maryland? Comparing Massachusetts and Maryland*. Maryland Association of Health Underwriters and National Association of Insurance and Financial Advisors of Maryland. Retrieved from
http://www.marylandahu.com/downloads/mahu_exchange_study.pdf
- Code of Maryland Administrative Regulations (COMAR). (n.d.) Retrieved from
<http://www.dsd.state.md.us/comar/comar.aspx>
- Corlette, S., & Volk, J. (2011, June). *Active purchasing for health insurance exchanges: An analysis of options*. National Academy of Social Insurance. Retrieved from
<http://www.nasi.org/research/2011/active-purchasing-health-insurance-exchanges-analysis-option>
- Delmarva Foundation. (2010, August). *Medicaid managed care organization systems performance review statewide executive summary – Final report for CY 2009*. Easton, MD: Author.
- Delmarva Foundation. (2011, January). *Medicaid managed care organization value-based purchasing activities report – Final report calendar year 2009*. Easton, MD: Author.
- Department of Health and Human Services. (2011). *Notice of proposed rulemaking*. 76 Fed. R. 41891.
- HealthcareData Company, LLC. (2010, September). *Statewide executive summary HealthChoice and Primary Adult Care participating organizations – HEDIS 2010*. Mechanicsburg, PA: Author.
- The Hilltop Institute. (2011, January). *Premium rate reviews of private health insurers in Maryland and opportunities for state regulatory coordination under health care reform*. Baltimore, MD: UMBC.



- Jost, T. (2010, November 23). *Implementing health reform: Medical loss ratios*. Retrieved from <http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios>
- Kaiser Family Foundation. (2009). *Maryland: Health insurance status*. Retrieved from <http://www.statehealthfacts.org/profileind.jsp?sub=39&rgn=22&cat=3>
- Lopez, N. (2011). *Update: Disclosure and review of unreasonable premium increases*. Retrieved from <http://healthreformgps.org/resources/update-disclosure-and-review-of-unreasonable-premium-increases/>
- Maryland Department of Budget and Management. (2008, April). *Request for proposals - Health plan administration and services (PPO, POS, HMO) - Project NO. F10B8200015*. Retrieved from <http://dbm.maryland.gov/contractors/contractlibrary/Documents/EmpBenHealthPlans/healthplanf10b8200015rfp.pdf>.
- Maryland Department of Budget and Management. (2010, April). *Request for proposals: Audit services for state employee and retiree benefits program solicitation No. F10B0400010*. Retrieved from <http://dbm.maryland.gov/contractors/contractlibrary/Documents/SvcsBenefitsAudit2011/AuditBenefitServicesRFP.pdf>
- Maryland Department of Health and Mental Hygiene. (n.d.a). *Competitive sealed bids (Invitation for bids)*. Retrieved from <http://dhmh.maryland.gov/opass/vendorsguide/pdf/VenGuideCSB.pdf>
- Maryland Department of Health and Mental Hygiene. (n.d.b). *Competitive sealed proposals (Request for proposals)*. Retrieved from <http://www.dhmh.state.md.us/opass/vendorsguide/pdf/VenGuideCSP.pdf>
- Maryland Department of Health and Mental Hygiene. (2007, November 30). *Maryland HealthChoice program – §1115 waiver renewal application*. Retrieved from http://www.dhmh.maryland.gov/mma/healthchoice/pdf/Waiver_Renewal_Application.pdf
- Maryland Department of Health and Mental Hygiene. (2010a, July 1). *Maryland HealthChoice program – §1115 waiver renewal application*.
- Maryland Department of Health and Mental Hygiene. (2010b, November 18). *Overview of 2010 quality assurance activities*. Retrieved from http://www.dhmh.maryland.gov/mma/docs/2010/nov10/Quality_Presentation_Nov_2010_1.ppt



- Maryland Department of Health and Mental Hygiene. (2011, June). *Decision support system*.
- Maryland Department of Legislative Services. (2010). *Legislative handbook volume V. Maryland state personnel, pensions, and procurement*. Retrieved from http://mlis.state.md.us/2010rs/misc/Legislative_handbooks/Volume_V.pdf
- Maryland Health Benefit Exchange Act of 2011. (2011). 2001 Maryland Laws, Chapter 1.
- Maryland Health Care Commission. (n.d). *A guide to purchasing health insurance for small employers*. Retrieved from http://mhcc.maryland.gov/smallgroup/cshbp_brochure.htm
- Maryland Health Care Commission. (2010, May 20). *Summary of carrier experience for the year ending December 31, 2009 (presentation)*. Retrieved from <http://mhcc.maryland.gov/smallgroup/carrierexp0510.pdf>
- Maryland Health Care Reform Coordinating Council. (2011, January 1). *Final report and recommendations*. Retrieved from <http://dhmh.maryland.gov/healthreform/pdf/110110FINALREPORT.pdf>
- Maryland Insurance Administration. (2011a, May 31). *Bulletin 11-12*. Retrieved from <http://www.mdinsurance.state.md.us/sa/documents/BulletinLH11-12-ratereviewhearing.pdf>
- Maryland Insurance Administration. (2011b, July 6). *Maryland Insurance Administration announces HHS determination of effective health insurance rate review program*. Retrieved from http://www.mdinsurance.state.md.us/sa/documents/MIA_effective_rate_review_7-5-10.pdf
- National Association of Insurance Commissioners. (n.d.). *Glossary of insurance terms*. Retrieved from http://www.naic.org/consumer_glossary.htm.
- The Patient Protection and Affordable Care Act (ACA), P.L. 111-148. (2010). as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.
- PricewaterhouseCoopers Health Research Institute. (2010). *Behind the numbers, medical cost trends for 2011 (an in-depth discussion)*. Dallas, TX: Author.
- PricewaterhouseCoopers Health Research Institute. (2011). *Behind the numbers, medical cost trends for 2012*. Dallas, TX: Author. Retrieved from <http://www.pwc.com/us/en/health-industries/index.jhtml>



Tomczyk, T., Welch, D., & Bender, K. (2011, May 18). *Recommendations to the commissioner to enhance regulatory review and oversight – Maryland Insurance Administration*. Milwaukee, WI: Oliver Wyman.

United States Code of Federal Regulations. (n.d.).

URAC. (n.d.). *What is care management?* Retrieved from <http://www.urac.org/resources/careManagement.aspx>

WBA Market Research. (2010a, November). *State of Maryland HealthChoice adult and child populations CAHPS 2010 4.0 adult and child Medicaid survey results – Executive summary*. Retrieved from <http://www.dhmf.state.md.us/mma/healthchoice/pdf/CY2009/Executive-Summary-Adult-and-Child-CAHPS-Final.pdf>

WBA Market Research. (2010b, November). *State of Maryland primary care provider population 2010 provider satisfaction survey – Executive summary*. Retrieved from <http://dhmf.maryland.gov/mma/healthchoice/pdf/CY2009/Executive-Summary-Provider-FINAL.pdf>





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