

# Appendix C: Detailed Table Comparing Consumer Protections for Medicare Advantage, Marketplace Qualified Health Plans, and Medicaid Managed Care Organizations

|                           | Medicare Advantage (MA)  | Marketplaces (QHPs)  | Medicaid MCOs <sup>28</sup>  |
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| <p><b>Eligibility</b></p> | <p><i>MA plans, QHPs and Medicaid managed care plans are similar in that they are all generally prohibited from basing eligibility on health status, may not impose pre-existing condition exclusions or discriminate based on enrollee need for health services. MA plans, however, may generally exclude individuals with ESRD, and MA Special Needs Plans (SNPs) are available only to Medicare-eligible individuals who meet certain requirements.</i></p> <p><i>Individuals must be eligible for Medicare Part A and B in order to enroll in an MA plan and individuals must be eligible for Medicaid in order to enroll in a Medicaid managed care plan. Similar to eligibility requirements for the purchase of QHPs, this includes: (1) citizenship and residency requirements, and (2) non-incarceration.</i></p> <p><i>Individuals are eligible to enroll and purchase QHP coverage as a family plan while MA plan coverage and Medicaid managed care is individual-only coverage.</i></p> |  |  |
|                           | <p>Must have Parts A and B of Medicare.<br/>           42 U.S.C. § 1395w-21(a)(3)(A); 42 C.F.R. § 422.50(a)(1)</p> <ul style="list-style-type: none"> <li>- Eligibility for Medicare is based on entitlement to Social Security retirement, Social Security Disability Insurance (SSDI), and Railroad Retirement or disability or individuals with end-stage renal disease (ESRD.) People with amyotrophic lateral sclerosis (ALS) on SSDI may have their 24 month waiting period waived.<br/>           42 U.S.C. § 1395c<sup>29</sup></li> <li>- Individuals who are not otherwise eligible for Medicare, but who are over age 65 and are U.S. citizens or permanent residents for 5 years may purchase coverage by paying a monthly premium for Part A.<br/>           42 U.S.C. § 1395i-2</li> </ul> <p>Individuals with ESRD are not eligible for MA plans (with exceptions).</p>   | <p>Must meet qualified individual status. A qualified individual is:</p> <ol style="list-style-type: none"> <li>1. A citizen of the US or lawfully present</li> <li>2. Not incarcerated</li> <li>3. Meets residency requirements</li> </ol> <p><i>See, generally, 42 C.F.R. § 155.305</i></p> <p>Guaranteed Issue.<br/>           42 U.S.C. 300gg-1; 45 § C.F.R. 147.104</p> <p>Plans prohibited from basing eligibility on health-status related factors, including medical conditions (both physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, and any other health status related factor determined appropriate by HHS.<br/>           42 U.S.C. § 300gg-4 45 C.F.R. § 147.110</p> <p>Plans prohibited from imposing pre-</p> | <p>Must meet Medicaid eligibility based on low-income status or disability status at slightly higher incomes; beneficiaries also must meet non-financial eligibility criteria, such as state residency, citizenship, and immigration status; federal law contains mandatory coverage groups with additional groups covered at state option.<sup>30</sup></p> <p>Plans are prohibited from discriminating on the basis of an enrollee’s health status or need for health care services.<br/>           42 USC § 1396b(m)(2)(A)(v); 42 C.F.R. § 438.6(d)(3)</p> <p>Must live in geographic region covered by plan.</p> |

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|  | <p>42 U.S.C. §1395w-21(a)(3)(B); 42 C.F.R. §422.50(a)(2); 42 C.F.R. §422.66(d); also see MMCM, Ch. 2, §20.2, et seq.</p> <p>Must live in geographic area covered by plan.<br/>42 U.S.C. 1395w-21(b)(1)</p> <ul style="list-style-type: none"> <li>- Incarcerated individuals are considered not to be within a plan’s service area<br/><i>Medicare Managed Care Manual, Ch. 2, §20.3</i></li> </ul> <p>MA Special Needs Plans (SNPs) – limit enrollment to individuals who meet the definition of special needs individuals (dually-eligible for Medicare and Medicaid (D-SNPs), individuals requiring an institutional level of care (I-SNPs), and individuals with certain severe or disabling chronic conditions as determined by the plan (C-SNPs)).<br/>42 U.S.C. §1395w-28(b)</p> <p>An individual who is a Qualified Medicare Beneficiary (QMB), a Specified Low-Income Beneficiary (SLMB), a Qualified Disabled and Working Individual (QDWI) or otherwise eligible for Medicaid and entitled to Medicare cost-sharing assistance under a state Medicaid program cannot enroll in a MA Medical Savings Account (MSA) plan.<br/>42 U.S.C. §1395w-21(b)(3)</p> <p>MA plan coverage may only be purchased as individual coverage or through an employer-based retiree plan (not family coverage); note that in 2014, 19% of all MA enrollees were in employer group health plans. (MedPAC, 2014)</p> | <p>existing conditions exclusions.<br/>42 USC 300gg-3; 45 C.F.R. 147.108</p> <p>Must live in geographic area covered by plan.</p> |  |
| <p><b>Enrollment and Disenrollment</b></p> | <p><i>Medicare Advantage and QHPs are similar in that they may generally restrict enrollment into and disenrollment from plans to limited time periods of the calendar year and special enrollment periods triggered by certain events.</i></p>   |   |  |

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| <p><i>Medicaid applications are accepted year-round, so an individual can enroll in a Medicaid managed care plan whenever she is initially determined eligible for Medicaid. An individual may likewise enroll in MA when he or she first becomes eligible for Medicare.</i></p> <p><i>MA enrollment is voluntary. So is enrollment in a QHP, although uninsured individuals may owe a tax penalty for not having minimum essential coverage and premium tax credit subsidies for nongroup coverage are only available for people enrolled in QHPs. States can choose to offer Medicaid managed care and whether to make enrollment voluntary or mandatory, except that CMS must approve the mandatory enrollment of certain populations.</i></p> <p><i>A crucial <u>difference</u> between MA, QHPs and Medicaid MCOs relates to disenrollment. If an individual dis-enrolls from an MA plan, they are re-enrolled into traditional Medicare coverage as a default. If an individual dis-enrolls from a QHP, there is no default – the person is left without coverage. With CMS permission, states may require beneficiaries to receive their Medicaid services through managed care. Without CMS permission to require managed care enrollment, Medicaid beneficiaries may dis-enroll from managed care and default into fee-for-service Medicare the way an MA plan beneficiary defaults into traditional fee-for-service Medicare.</i></p> <p><i>The limited circumstances in which a plan can involuntarily dis-enroll an individual are similar between QHPs and MA plans (e.g., failure to pay premiums, a move outside of the service area), however, unlike QHPs, MA plans have the option to dis-enroll someone based upon “disruptive behavior” (with CMS’ approval). Medicaid managed care plans and QHPs generally may not dis-enroll beneficiaries for disruptive behavior; however, Medicaid managed care plans may do so in extreme cases upon CMS approval.</i></p> <p><i>For similarities and differences in special enrollment period (SEP) rights between MA and QHPs, see Appendix D, below. Note that there are no equivalent SEP rights in Medicaid managed care.</i></p> |   |   |
| <p><b>Default Coverage</b></p>  |   |   |
| <p>MA enrollment, as an option for receiving Medicare services guaranteed through federal entitlement, is voluntary for Medicare beneficiaries. Correspondingly, if a person chooses to dis-enroll from an MA plan, or is involuntarily dis-enrolled, the default is traditional Medicare coverage.<br/>42 U.S.C. § 1395w-21(c)(3)(A)(i), (g)(3)(c)</p>   | <p>Since QHPs are not built on the foundation of a federal entitlement, if an individual is dis-enrolled from a QHP there is no default – they are left without coverage unless and until they can exercise enrollment rights and opportunities to gain new coverage.</p> | <p>States can choose to adopt Medicaid managed care with voluntary or mandatory enrollment for beneficiaries, except that states need CMS waiver approval to require managed care enrollment for children with special needs, beneficiaries dually eligible for Medicare and Medicaid, and Native Americans.<br/>42 U.S.C. § 1396u-2(a)(1)(A), (2); 42 U.S.C. § 1396n(b)(4); 42 C.F.R. § 438.50(a), (d)</p> <p>States must have a default enrollment process for assigning beneficiaries subject to mandatory enrollment to a plan; process must seek to preserve existing provider-beneficiary relationship and relationships with</p> |

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|   |  | <p>providers that traditionally serve Medicaid beneficiaries if possible, otherwise state must distribute beneficiaries equitably among plans. § 1396u-2(a)(4)(D); § 438.50(f)</p> <p>State must give beneficiaries who are required to enroll a choice of at least 2 plans except for rural area residents. § 1396u-2(a)(3); § 438.52</p>  |
|   | <b>Enrollment Periods</b>  |   |
| <p>Prescribed enrollment periods.<br/>42 U.S.C. § 1395w-21(e); 42 C.F.R. § 422.62</p> <ul style="list-style-type: none"> <li>- Initial Coverage Election Period (ICEP) – period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan; begins 3 months immediately before the individual’s first entitlement to both Medicare Part A and Part B and ends on the later of: <ol style="list-style-type: none"> <li>1. The last day of the month preceding entitlement to both Part A and Part B, or;</li> <li>2. The last day of the individual’s Part B initial enrollment period.</li> </ol> </li> <li>- Annual Coordinated Election Period (ACEP) – allows individuals to join, switch, or disenroll from MA and Part D plans</li> <li>- October 15 – December 7 of every year, with election/choice effective the following January 1</li> <li>- Medicare Advantage Disenrollment Period (MA-DP) – allows MA enrollee to disenroll from MA plan and return to Traditional Medicare, with right to pick up a stand-alone Part D</li> </ul> | <p>Enrollment restricted to Open Enrollment and Special Enrollment Periods.<br/>42 U.S.C. § 300gg-1; 45 § C.F.R. 147.104</p> <p>2013 Initial Open Enrollment Period (very first enrollment period and lasted six months).<br/>45 C.F.R. § 155.410</p> <p>2014 Annual Open Enrollment Periods Oct. 15- Dec. 7<sup>th</sup> 2014. Second annual Open Enrollment Period Nov. 15<sup>th</sup> to Feb. 15<sup>th</sup> 2015.<br/>45 C.F.R. 155.410</p> <p>Special Enrollment Periods.<br/>45 C.F.R. § 155.420; <i>see Appendix D, below</i></p> <p>Proposed rule on automatic re-enrollment.<br/>45 C.F.R. § 155.335(a)</p> <p>Currently, individuals enrolled in QHPs will generally be automatically re-enrolled at the end of the plan year if the individual does not affirmatively act to renew or change coverage. Proposed changes to automatic renewal process are under discussion, in part, because an individual’s</p> | <p>Medicaid applications are accepted year-round so beneficiaries can enroll in a plan when initially determined Medicaid-eligible, if state offers or requires managed care.<br/>42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906</p> <p>Beneficiaries must be able to dis-enroll from plan for cause at any time and without cause during the 90 days following initial enrollment and at least once annually thereafter.<br/>42 U.S.C. § 1396u-2(a)(4)(A); 42 C.F.R. § 438.56(c)</p> <p>State must inform enrollees of their disenrollment rights annually.<br/>42 C.F.R. § 438.10(f)(1)</p> |

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|   | <ul style="list-style-type: none"> <li>- prescription drug plan January 1 – February 14 of every year</li> <li>- Special Enrollment Periods (SEPs) (<i>see 42 C.F.R. §422.62(b); Medicare Managed Care Manual, Ch. 2, §§30.4, et seq.</i>)<br/><i>See Appendix D, below; also see “Network Adequacy” section below</i></li> </ul> <p>-Note that there is generally no passive enrollment into MA plans (as there is of LIS-enrolled individuals into stand-alone PDPs) with the exception of dual eligibles in certain areas where, e.g., a county operates an MA plan and requires mandatory managed care enrollment for Medicaid enrollees.</p>   | <p>premium tax credit subsidy amount can vary from year to year and depend on the QHP selected; as a result cost to an individual could vary dramatically due to auto-renewal in some circumstances.</p>  |  |
| <b>Involuntary Disenrollment by Plans</b> |   |   |  |
|   | <p>Disenrollment by MA plan – a plan may not disenroll an individual except (<i>see 42 C.F.R. § 422.74</i>):</p> <ul style="list-style-type: none"> <li>- Optional disenrollment – an MA plan <u>may</u> disenroll an individual if 1) any monthly basic and supplementary premiums are not paid on a timely basis, subject to a grace period; 2) the individual has engaged in disruptive behavior; or 3) the individual provides fraudulent information on his or her election form or permits abuse of his/her enrollment card.</li> <li>- Required disenrollment – an MA organization <u>must</u> disenroll an individual if 1) the individual no longer resides in the MA plan’s service area; 2) the individual is</li> </ul> | <p>General exceptions to guaranteed renewability (i.e., disenrollment):<br/><i>42 U.S.C. 300gg-2(b) &amp; 45 C.F.R. 147.104</i></p> <ol style="list-style-type: none"> <li>1. Non-payment of premiums</li> <li>2. Fraud</li> <li>3. Termination of coverage</li> <li>4. Move outside service area</li> <li>5. Discontinuance of all coverage</li> </ol> | <p>The plan’s contract with the state Medicaid agency must specify the reasons for which a plan may request disenrollment of a beneficiary.<br/><i>42 C.F.R. § 438.56(b)(1)</i></p> <p>Plans generally may not request disenrollment due to an adverse change in enrollee health status or an enrollee’s utilization of health care services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee’s special needs.<br/><i>42 C.F.R. § 438.56(b)(2)</i></p> <p>However, plans may request disenrollment when continued enrollment seriously impairs a plan’s ability to furnish services to that enrollee or other enrollees.<br/><i>42 C.F.R. § 438.56(b)(2)</i></p> |

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|                     | no longer eligible under the plan; 3) the individual loses entitlement to Part A or Part B benefits; or 4) an individual enrolled in a SNP no longer meets the eligibility requirements for that SNP.  |  |  |
| <b>Renewability</b> | <i>MA and QHPs are <u>similar</u> in their renewability. If an MA plan or QHP in which an individual is enrolled continues to be offered, the individual will automatically continue to be enrolled in the same plan in the following plan year. Renewability of Medicaid managed care enrollment varies by state.</i>   |  |  |
|                     | <p>Maintenance of enrollment – an individual who has made an election is considered to have continued that election until either:</p> <ul style="list-style-type: none"> <li>- the individual changes the election, or</li> <li>- the elected MA plan is discontinued or no longer serves the area in which the individual resides.</li> </ul> <p>42 C.F.R. §422.66(e) – see exception for employer plans at (f)</p>   | <p>A health insurance issuer offering health insurance coverage in the individual, small group, or large group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable.<br/>42 USC § 300gg-2; 45 C.F.R. §147.106(a)</p> <p>Generally, if an enrollee remains eligible for a plan, he will be automatically re-enrolled into the same plan at the end of the plan year.<br/>45 § C.F.R. 155.335(j)</p> <p>A plan is prohibited from rescinding coverage in the absence of fraud on the part of the enrollee.<br/>42 USC 300gg-12; 45 C.F.R. §147.128 (see appeal rights)</p> | <p>If state opts to require managed care enrollment and a plan does not have capacity to serve all individuals seeking enrollment, priority shall be given to continuing enrollment of beneficiaries already enrolled in the plan.<br/>42 U.S.C. § 1396u-2(a)(4)(C); 42 C.F.R. § 438.52(e)</p> |
| <b>Benefits</b>     | <p><u>Overview</u></p> <p><i>All three programs have standards for covered services that private plans must include. All three programs require plans to cover major medical services (hospitalization, ambulatory physician services, diagnostic services, prescription drugs, etc.) In addition, state Medicaid programs generally provide much greater coverage of long-term services and supports compared to MA and QHPs.</i></p> <p><i>All three programs include additional, specific standards for covering Rx drugs. The MCO standards are most comprehensive in the number and type of Rx drugs that must be covered. MA plans are required to cover all FDA approved drugs in certain protected classes and, for other drugs, must cover at least 2 drugs in each USP category or class. No standards for protected</i></p> |  |  |

*drug classes apply for QHPs and QHPs are required to cover the greater of (i) the same number of drugs (relative to the state benchmark plan) in each USP category or class or (ii) at least 1 drug in each USP category or class.*

*All three programs permit private plans some flexibility to vary or supplement the required covered benefit design. QHPs have more flexibility under federal rules compared to MA plans (and states may further limit flexibility of private insurers to modify or vary QHP benefits).*

*MA plan and Medicaid managed care benefits are generally more uniform across the country, with more variation in benefit design in QHPs. Both MA and Medicaid are required by federal law to cover a basic floor of service and have less flexibility than QHPs in determining what exactly these services are. MA plans, QHPs and Medicaid MCOs cover a range of similar services, and also have similar exclusions from coverage but state Medicaid programs generally provide greater coverage of long-term services and supports than MA or QHPs. All cover certain preventive health services without cost-sharing.*

*MA, QHPs and Medicaid managed care plans can offer supplemental benefits – those that are not generally required to be offered by all plans. With respect to prescription drug coverage, MA and Medicaid managed care plans are required to provide broader coverage than QHPs (when states require Medicaid managed care plans to cover prescription drugs).*

*Generally, whereas QHPs cannot impose annual or lifetime dollar limits on essential health benefits, MA plans may impose the same coverage limits set in traditional Medicare. MA plans have some discretion to ease such restrictions but are not required to do so. There are no annual or lifetime dollar limits in the Medicaid program, but Medicaid managed care plans may contract with the state to limit their liability, with any costs exceeding a certain amount covered by Medicaid FFS.*

*The following sections provide comparisons of Benefit Package Design, Benefits NOT covered by MA plans and QHPs, Prescription Drug Coverage, Supplemental Benefits and Limits on Services.*

#### *Benefit Package Design*

*QHP benefit packages include 10 categories of essential health benefits as modified by a state's chosen benchmark plan. Plans are allowed to use actuarially equivalent substitutes for all services within the 10 categories of essential health benefits. Thus, actual benefits offered within a category of essential health benefit by a QHP will vary from state to state and plan to plan.<sup>31</sup>*

*MA benefit packages are based on traditional Medicare benefits. Medicaid managed care benefit packages are based on Medicaid standards, which vary based on the state, subject to federal minimum requirements, and which may vary based on an individual's Medicaid eligibility group.*

*Some MA plans and Medicaid managed care plans may choose to offer supplemental benefits not offered through traditional Medicare or in the Medicaid state plan benefit package.*

*MA, QHP and Medicaid Managed Care benefit packages are similar in that they both work off a basic framework (traditional Medicare for MA, EHB for QHPs, the Medicaid state plan benefits.) However, the actual benefits offered by a particular MA plan or QHP may vary considerably, although variation in benefit design will tend to be more pronounced in QHPs than MA. Likewise, benefits covered in Medicaid managed care plans vary by state, depending on which benefits, including optional federal benefits, a state chooses to include in its plan contracts and the Medicaid enrollees' coverage group.*

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|  | <p><i>Both MA and QHPs cover:</i></p> <ol style="list-style-type: none"> <li>1. <i>inpatient hospitalization</i></li> <li>2. <i>outpatient services including lab services</i></li> <li>3. <i>emergency services</i></li> <li>4. <i>rehabilitative and habilitative services</i></li> <li>5. <i>preventative benefits without cost-sharing</i></li> <li>6. <i>pregnancy</i></li> </ol> <p><i>Medicaid managed care comprehensive risk contracts must cover inpatient hospital services and any of the following services, or any three or more of the following services:</i></p> <ol style="list-style-type: none"> <li>1. <i>Outpatient hospital services</i></li> <li>2. <i>Rural health clinic services</i></li> <li>3. <i>Federally qualified health center services</i></li> <li>4. <i>Other laboratory and x-ray services</i></li> <li>5. <i>Nursing facility services</i></li> <li>6. <i>Early periodic screening diagnostic and treatment services</i></li> <li>7. <i>Family planning services</i></li> <li>8. <i>Physician services</i></li> <li>9. <i>Home health services</i></li> </ol> <p><i>The benefits covered by Medicaid managed care plans are specified in their contract with the state Medicaid agency. Any Medicaid state plan benefits not included in the managed care contract are provided by the state through fee-for-service or separate managed care contracts at state option.</i></p> <p><i>Neither MA plans nor QHPs nor Medicaid managed care plans are required to offer adult dental or vision coverage.</i></p> |  |  |
|  | <p>MA plans must provide benefits under Traditional Medicare Parts A and B (except for hospice care).<br/>42 U.S.C. §1395w-22(a)</p> <ul style="list-style-type: none"> <li>- Part A covers care in certain settings, often with duration and other limitations (see, generally, 42 U.S.C. §1395d):</li> <li>- inpatient hospitalization (up to 90 days per benefit period, with 60 lifetime reserve days);</li> <li>- skilled nursing facility (SNF) care (up to 100 days);</li> <li>- home health (60 day episodes of care, no limit on number of episodes);</li> <li>- hospice services (for those</li> </ul>   | <p>Essential health benefits (EHB):<br/>42 U.S.C. 300gg-6(a) and 42 USC 18022(a)</p> <ol style="list-style-type: none"> <li>1. Ambulatory patient services</li> <li>2. Emergency services</li> <li>3. Hospitalization</li> <li>4. Maternity and newborn care</li> <li>5. Mental health and substance use disorder services, including behavioral health treatment</li> <li>6. Prescription drugs</li> <li>7. Rehabilitative and habilitative services and devices</li> <li>8. Laboratory services</li> <li>9. Preventive and wellness services and chronic disease management</li> </ol> | <p>State Medicaid programs must cover certain services (such as inpatient, outpatient, and laboratory services, among others) and may opt to include other services (such as prescription drugs, dental, physical therapy, private duty nursing, personal care, and case management services, among others);<sup>32</sup> the services for which managed care plans are responsible are specified in the plan’s contract with the state Medicaid agency.<br/>42 U.S.C. § 1396u-2(b)(1)</p> <p>Medicaid MCOs must have a comprehensive risk contract with the state Medicaid agency to cover inpatient hospital services and any of</p> |



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|                          | <p>diagnosed as being terminally ill);</p> <ul style="list-style-type: none"> <li>- Part B covers a range of services including physician services, outpatient therapy, diagnostic tests (including certain preventive services with no cost-sharing), durable medical equipment, ambulance services, etc. (see, generally, <i>42 U.S.C. §1395k</i>)</li> <li>- Service restrictions apply to some Part B benefits (e.g., annual cap on coverage of outpatient therapy).</li> </ul> <p>MA plans have some leeway to ease coverage restrictions under Traditional Medicare (e.g., cover longer inpatient hospital stays, waive the 3-day prior inpatient hospitalization requirement for SNF stays)</p> | <p>10. Pediatric services, including oral and vision care</p> <p>States must select a benchmark plan in order to define EHB. All benchmarks must include EHB or be modified to include any missing benefit categories (e.g., pediatric dental). The benchmark must be chosen from 10 existing plans in each state as specified in federal guidance: the three largest small group plans in the state, based on enrollment; the three largest federal employee health plans based on enrollment; the state's largest commercial HMO plan. If a state does not select a plan, it will default to the largest small group plan in the state based on enrollment.<br/><i>45 C.F.R. 156.110; see also 45 C.F.R. 156.115</i></p> <p>Individual plans may determine which covered services belong in each EHB category. Insurers also have flexibility to modify benchmark coverage, substituting actuarially equivalent services within an EHB category and notifying the applicable insurance regulator when they do so.<br/><i>45 C.F.R. §156.115(b); 45 C.F.R. §156.200</i></p> <p>Coverage of preventative health services without cost-sharing.<br/><i>42 U.S.C. § 300gg-13, 45 C.F.R § 147.130</i></p> | <p>the following services, or any three or more of the following services:</p> <ol style="list-style-type: none"> <li>1. Outpatient hospital services</li> <li>2. Rural health clinic services</li> <li>3. Federally qualified health center services</li> <li>4. Other laboratory and x-ray services</li> <li>5. Nursing facility services</li> <li>6. Early periodic screening diagnostic and treatment services</li> <li>7. Family planning services</li> <li>8. Physician services</li> <li>9. Home health services</li> </ol> <p><i>42 C.F.R. § 438.2</i></p> <p>Plan contracts must assure coverage of emergency services without prior authorization or network restrictions.<br/><i>42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. § 438.114</i></p> <p>Public Health Service Act requirements (<i>42 U.S.C. § § 300gg-25, 300gg-26</i>) for maternity care and mental health parity apply to Medicaid managed care plans.<br/><i>42 U.S.C. § 1396u-2(b)(8)</i></p> |
| <b>Benefits (cont'd)</b> | <b>Benefits NOT Covered</b>  |  |   |
|                          | Benefits Not Covered by Traditional Medicare:  | Benefits not Covered as EHB:   | Adult vision and dental and long-term services and supports other than  |

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|  | <p>- Traditional Medicare does not cover certain services, including most dental or vision care, hearing aids and non-skilled long-term care; MA plans may offer services not covered by traditional Medicare.</p>   | <ol style="list-style-type: none"> <li>1. Adult vision</li> <li>2. Adult dental</li> <li>3. Long-term care</li> </ol>  | <p>nursing facility care and home health services for beneficiaries who qualify for nursing facility care are optional Medicaid state plan benefits; however, state Medicaid programs may or may not deliver these services through managed care arrangements.</p>  |
|  | <p><u>Prescription Drug Coverage</u></p> <p><i>MA plans and Medicaid managed care plans are generally required to provide broader drug coverage than QHPs. MA plans must cover at least two drugs per category and class whereas QHPs must cover only one. MA plans must cover all or substantially all drugs within certain protected classes; there are no protected classes of drugs within QHPs. In addition, not all MA plans offer Part D prescription drug coverage, whereas prescription drug coverage is a required essential health benefit for QHPs.</i></p>  |  |   |
|  | <p>Certain drugs in certain settings are covered under Parts A and B of Medicare (which in turn must be covered by MA plans); Part D is a separate, voluntary benefit that provides coverage of prescription drugs.</p> <p>Not all MA plans offer Part D coverage (but most do – 86% of plans in 2015); MA sponsors may not offer an MA plan in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage.<br/><i>42 U.S.C. § 1395w-131(a)</i></p> <p>MA plans offering Part D prescription drug coverage are known as Medicare Advantage-Prescription Drug plans (MA-PDs) and must follow Part D rules re: drug coverage.</p> <p>MA plans offering Part D prescription drug coverage must also establish pharmacy and therapeutics (P&amp;T) committees that will develop plan drug formularies. Decisions about drug inclusions and exclusions must be based on scientific evidence.</p> | <p>QHPs must cover at least the greater of: 1 drug per US Pharmacopeia category or class; OR the same number of drugs in each category and class as EHB state benchmark plan. Drug products listed must be chemically distinct.<br/><i>45 C.F.R. § 156.122</i></p> <p>Starting in 2017, QHPs must also establish pharmacy and therapeutics (P&amp;T) committees, similar to those under Medicare Part D, that will develop plan drug formularies. Decisions about drug inclusions and exclusions must be based on scientific evidence. Newly approved drugs and new uses of existing drugs must be reviewed within 90 days and coverage decision made within 180 days of market release.<br/><i>45 C.F.R. § 156.122</i></p> <p>Plans may use tiering and other utilization management tools but non-discrimination rules in benefit design rules at <i>45 § C.F.R. 156.125</i> apply to prescription drug benefit.</p> <p>QHPs must have procedures in place that allow an enrollee to request and</p> | <p>Prescription drug coverage is optional for state Medicaid programs, although all states currently cover prescription drugs.<br/><i>42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.120</i></p> <p>Federal law requires state Medicaid programs that choose to include prescription drugs to cover all FDA-approved drugs whose manufacturers have entered into a rebate agreement.<br/><i>42 U.S.C. § 1396r-8</i></p> <p>Whether Medicaid managed care plans are responsible to deliver and coordinate prescription drug coverage is specified in the plan’s contract with the state Medicaid agency.</p> <p>For beneficiaries dually eligible for Medicare and Medicaid, Medicare provides primary drug coverage, supplemented by Medicaid.</p> |

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|  | <p>An individual enrolled in an MA plan can also enroll in a stand-alone Part D plan (PDP) only if his/her MA plan does not offer Part D coverage.<sup>33</sup></p> <p>Overview of Part D coverage rules: (see, generally, 42 U.S.C. §1395w-102(e))</p> <ul style="list-style-type: none"> <li>- Drugs coverable under Part D are those approved by the FDA, for which a prescription is required and for which payment is required under Medicaid.</li> <li>- Biological products, including insulin and insulin supplies and smoking cessation drugs are covered.</li> <li>- Excluded from coverage are those categories of drugs for which Medicaid payment is optional, over the counter drugs, and drugs for which payment could be made under Part A or B.</li> <li>- Part D plans (including MA-PDs) are not required to pay for all covered drugs; they may establish their own formularies and cost-sharing (tiering) structures as long as their formularies and benefit structures are not found by CMS to discourage enrollment by certain Medicare beneficiaries (anti-discrimination) (see 42 C.F.R. §§423.120(b), .272(b)).</li> <li>- Part D plans (including MA-PDs) must include in their plans' formularies all or substantially all drugs in a category or class</li> </ul> | <p>gain access to clinically appropriate drugs not "on formulary." 45 C.F.R. §156.122(c); see also 2015 letter to issuers p. 28 &amp;29.</p> <p>As part of the QHP Application, issuers must provide a URL to their formularies and must also provide information regarding formularies to consumers, pursuant to 45 C.F.R. §147.200(a)(2)(i)(K) (see consumer information below).</p> <p>See, generally, 45 C.F.R § 156.122</p> |  |
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|                          | identified by CMS (“protected classes” - anticonvulsants, antidepressants, antipsychotics, antiretrovirals, and immunosuppressants; see PPACA § 3307); plans are prevented from imposing certain utilization management tools on protected classes.   |  |  |
| <b>Benefits (cont’d)</b> | <p><b>Supplemental Benefits</b></p> <p>MA Plans can offer supplemental benefits:</p> <ul style="list-style-type: none"> <li>- As a result of a rebate payment from Medicare due to a plan’s bid being below the CMS-established benchmark rate; plans receiving such rebates must return the rebates to enrollees in the form of either lower premiums or supplemental benefits;<sup>34</sup> or</li> <li>- Plans may offer supplemental benefits (things not covered under Part A or B) for which a separate premium may be charged.</li> </ul> <p>42 U.S.C. §1395w-22; 42 C.F.R. §422.102</p>   | <p>QHPs can offer supplemental benefits (“other covered services”) that go above and beyond EHB.</p> <p>See section on premium subsidy and cost-sharing subsidy below. Subsidies only apply to EHB, not supplemental benefits.</p> | <p>Medicaid managed care plans can cover services in addition to those offered under the Medicaid state plan, although those costs cannot be included in contract payment rates.</p> <p>42 C.F.R. § 438.6(e)</p> |
| <b>Benefits (cont’d)</b> | <p><u>Limits on Services</u></p> <p><i>QHPs cannot impose annual or lifetime dollar limits on essential health benefits, but can impose limits on the number of covered days or services that may have applied under the benchmark plan. Special parity rules apply to mental health and substance abuse treatment services. MA plans may impose the same coverage limits set in traditional Medicare. For example, MA plans may impose a limit on inpatient hospital days (lifetime hospital reserve days). MA plans have some discretion to ease such restrictions but are not required to do so. Both MA plans and QHPs are prohibited from designing benefit packages that discriminate against consumers with expensive health conditions. While there are no annual or lifetime dollar limits in the Medicaid program, Medicaid managed care plans may contract with the state to limit their liability, with any costs exceeding a certain amount covered by Medicaid FFS.</i></p> <p><i>Mental Health Benefits: traditional Medicare rules and hence MA plans may impose a lifetime limit on inpatient days at a psychiatric hospital (up to 190 days). Medicaid managed care plans and QHPs must adhere to mental health parity guidelines so that limits on covered mental health services are not more stringent than those on physical health services.</i></p> |  |  |

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|                 | <p>Anti-discrimination provision: MA plans may not deny, limit, or condition the coverage or provision of benefits based on any health status-related factor; similarly, MA plans cannot design plan benefits in such a way that is likely to substantially discourage enrollment by certain individuals.<br/>42 U.S.C. § 1395w-22(b)</p> <p>MA plans offer a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan.<br/>42 C.F.R. § 422.2</p> <p>MA plans are generally bound by limits set in traditional Medicare (e.g., hospital lifetime reserve days).</p> | <p>Plans are prohibited from designing benefit packages that discriminate against individuals based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.<br/>45 § C.F.R. 156.125</p> <p>Plans are prohibited from placing lifetime or annual dollar limits on Essential Health Benefits.<br/>42 USC § 300gg-11; 45 C.F.R. § 147.126</p> <p>Frequency limits (day/visit) on covered benefits are permitted/allowed consistent with benchmark plan standards and non-discrimination provisions at 45 § C.F.R. 156.125.</p> <p>Mental health and substance abuse services must meet parity requirements. A QHP cannot impose a financial requirement (such as a copayment or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance use disorder benefits that is more restrictive than the financial requirements or quantitative treatment limitations that apply to at least 2/3 of medical/surgical benefits in the same classification.<br/>42 U.S.C. § 300gg-26; 42 U.S.C. § 1396u-2(b)(8)</p> | <p>Plan contracts must identify, define, and specify the amount duration and scope of each service that the plan is required to offer; plans may place appropriate limits on a service based on criteria applied under the state plan, such as medical necessity or for utilization control provided that services can reasonably be expected to achieve their purpose.<br/>42 C.F.R. § 438.210(a)</p> <p>Medicaid managed care plans must meet the mental health parity requirements at 42 U.S.C. § 300gg-26. 42 U.S.C. § 1396u-2(b)(8)</p> |
| <b>Premiums</b> | <p><i>Both MA plans and QHPs are limited in how much they can vary premiums. MA plans can only vary premiums by county. QHPs can vary premiums by rating area, which must be approved by the state. In addition, QHPs can also vary premiums by age and tobacco use; MA premiums may not vary based on these factors. In general, Medicaid managed care plans impose no premiums in addition to what may be charged by the underlying state Medicaid program (similar to the underlying Part B premium in Medicare). Under federal law, Medicaid premiums are limited to certain populations and amounts.</i></p>   |   |  |
|                 | In general, MA premiums based upon the  | In general, QHP plan premiums can   | In general, Medicaid managed care  |

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|                            | <p>difference between Medicare payments to the plan and the plan’s costs (or bid submitted to Medicare); these amounts vary by county.<sup>35</sup></p> <p>MA coverage is only available to individuals or through employer-based (retiree) plans – it is not available as family coverage.</p> <p>No rate review, but plan bids submitted to CMS are reviewed for reasonableness.</p> <p>Since federal payments to plans typically exceed plans’ estimated costs, most MA plans do not have a premium for the MA benefits, but often charge a premium for the Part D benefits.</p> <p>Enrollees must continue to pay Part B premium regardless of MA premium amount (\$104.90 in 2015 for most individuals).</p> <ul style="list-style-type: none"> <li>- Note MA plans are allowed to offer reduced Part B premiums as an additional benefit to their enrollees.</li> </ul>   | <p>only vary based on:</p> <ol style="list-style-type: none"> <li>1. individual or family coverage</li> <li>2. Rating area</li> <li>3. Age (3:1 ratio)</li> <li>4. Tobacco usage (1.5:1)</li> </ol> <p>42 USC 300gg-6(c); 42 C.F.R. § 147.102</p> <p>Rate review required for annual premium increases <math>\geq</math> 10%.<br/>45 C.F.R. § 155.1020</p> | <p>plans impose no premiums beyond what may be charged by the underlying state Medicaid program. Under federal law, Medicaid premiums are limited to certain populations and amounts.</p>   |
| <p><b>Cost-Sharing</b></p> | <p><i>Cost-sharing requirements in MA and QHPs are <u>similar</u> in that protections only apply to essential health benefits (EHB) in QHPs and traditional Medicare equivalent services in MA plans. While QHPs can impose substantial deductibles, MA plans are generally more limited in their ability to do so due to rules requiring that MA cost-sharing be more-or-less equivalent to cost-sharing in traditional Medicare. Medicaid cost-sharing in managed care is at state option and is subject to federal exemptions and limits. Any Medicaid managed care cost-sharing must follow strict federal rules.</i></p> <p><i>QHPs and Medicaid have a “hard” cap on out-of-pocket expenses. Conversely, while MA plans have a maximum out-of-pocket limit for medical services – which is higher than the corresponding QHP cap – prescription drug coverage under Part D has a separate, “soft” cap that requires some additional cost-sharing even after the threshold is met.</i></p> |  |   |
|                            | <p><b>Cost-Sharing in Benefit Design</b></p> <p>MA plans may impose copayments and deductibles that are different from those under Parts A and B, as long as cost-sharing is “actuarially equivalent” to cost-sharing under Traditional Medicare (in other words, total MA cost-sharing for Part A and B services must not exceed cost-</p>   | <p>QHPs cost-sharing varies based on Actuarial Value “metal levels”:</p> <ul style="list-style-type: none"> <li>Bronze (60%)</li> <li>Silver (70%)</li> <li>Gold (80%)</li> <li>Platinum (90%)</li> </ul>  | <p>Medicaid managed care plan contracts with the state must provide that any cost-sharing is in accordance with federal Medicaid rules; Medicaid cost-sharing is imposed at state option, and federal law exempts certain populations and services from cost-</p> |

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|  | <p>sharing for those services in Traditional Medicare).<br/> <i>42 U.S.C. § 1395w-24(e)</i></p> <ul style="list-style-type: none"> <li>- Note that CMS also applies this requirement separately to certain service categories (see, e.g., Call Letter<sup>36</sup>)</li> <li>- MA plans cannot vary cost-sharing among enrollees in a plan</li> </ul> <p>Plans can charge cost-sharing for services for which there is no cost-sharing charged in traditional Medicare Parts A and B (e.g., hospice care) as long as overall cost-sharing remains actuarially equivalent.<br/> <i>42 U.S.C. § 1395w-22(a)(1)(B)(v)</i></p> <p>Limitation on variation of cost-sharing – following services cannot exceed cost-sharing under Parts A and B:</p> <ul style="list-style-type: none"> <li>- renal dialysis services</li> <li>- chemotherapy</li> <li>- skilled nursing facility care<sup>37</sup></li> <li>- such other services Secretary of HHS deems appropriate (no other services designated yet)<br/> <i>U.S.C. § 1395w-22(a)(1)(B)(iv)</i></li> </ul> <p>CMS reviews plan bids to ensure proposed cost-sharing is within permissible limits.</p> | <p>Enhanced silver plans include cost-sharing reductions (CSR) for enrollees with income below 250% FPL. The actuarial value of CSR plans must be 94% (income 100-150% FPL); 87% (income 151-200% FPL); and 73% (income 201-250% FPL) respectively.</p> <p>As long as plans meet AV and out of pocket caps, and follow nondiscrimination standards, law does not specify how combination of cost-sharing (co-pays, co-insurance and deductibles) is structured.</p> <p>Coverage of preventative health services without cost-sharing.<br/> <i>42 U.S.C. 300gg-13</i></p> <p><i>See, generally, 45 C.F.R. 156.140</i></p> | <p>sharing; federal law also limits Medicaid cost-sharing to nominal amounts for people below the federal poverty level and sets federal maximums for people with higher incomes; any Medicaid premiums and cost-sharing is capped at 5% of monthly or quarterly income.<br/> <i>42 C.F.R. § 438.108</i></p> |
|  | <p><b>Limits on Provider Billing</b></p> <p>Plan enrollees are protected against balance billing (they generally pay only plan-allowed cost-sharing) when they obtain plan-covered services, including from non-contracted providers.<br/> <i>Medicare Managed Care Manual, Ch. 4, § 180, et seq.</i></p> <p>MA has a prior-authorization process: if an enrollee wishes to receive a service from an in-network provider, the provider must seek prior authorization from the plan and</p>   | <p>Emergency services received out-of-network must be covered at in-network rates.<br/> <i>42 U.S.C § 18022</i></p> <p>However, there is no prohibition against provider balance-billing for out-of-network emergency services.<br/> <i>Id.</i></p>  | <p>Medicaid MCOs must adequately and timely cover services out-of-network at no more than in-network cost to enrollee, if service cannot be provided in-network, including emergency care.</p>   |

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|                             | <p>inform the enrollee if the plan makes an adverse determination, triggering appeal rights; if, however, the provider furnishes the service and without seeking prior authorization from the plan and the service is not covered, the provider cannot bill the enrollee for more than standard in-plan cost-sharing.<br/> <i>42 C.F.R. §422.105(a); Managed Care Manual, Ch. 4, § 170<sup>38</sup></i></p> <p>Emergency services obtained out-of-network are covered by plans with a limit on charges to enrollees (to amount determined by CMS annually (\$65 for 2015), or what the plan would charge the enrollee if he or she obtained the services through the MA organization, whichever is less).<br/> <i>42 C.F.R. §422.113(b)</i></p> |   |   |
| <b>Out-of-Pocket Limits</b> |   |   |   |
|                             | <p>MA plans must establish a maximum out-of-pocket liability amount (MOOP) for all Part A and B services established annually by CMS (not indexed to inflation).<br/> <i>42 C.F.R. §422.100 and .101</i></p> <ul style="list-style-type: none"> <li>- In 2015, the mandatory MOOP is \$6,700; plans that use a lower, voluntary MOOP of \$3,400 have greater flexibility in establishing cost-sharing amounts.</li> </ul> <p>There is a separate Part D catastrophic coverage maximum of \$4,700 out-of-pocket in 2015, after which out-of-pocket costs are very low (but not \$0); in other words, there is no “hard” cap on spending.</p>   | <p>The maximum out-of-pocket cost limit for any individual Marketplace plan can be no more than \$6,600 for an individual and \$13,200 for a family in 2015.<br/> <i>45 C.F.R § 156.130(a)(2) and 79 Fed. Reg. 13801</i></p> <p>For CSR silver plans in 2015, the maximum annual out-of-pocket cost limit is \$2,250 (CSR 94% and CSR 87% plans) and \$5,200 (CSR 73% plans). For family plans these amounts are doubled.</p> <ul style="list-style-type: none"> <li>- Only applies to covered, in-network benefits; no limits on cost-sharing for out-of-network care.<br/> <i>45 C.F.R § 156.230</i></li> <li>- This includes both medical services and prescription</li> </ul> | <p>As noted above, any Medicaid premiums and cost-sharing is capped at 5% of quarterly or monthly income.</p> |



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|   |  | <p>drugs. <i>Id.</i></p> <ul style="list-style-type: none"> <li>- For plan or policy years beginning after 2014, the annual limitation on out-of-pocket costs is increased by the premium adjustment percentage described under <i>Affordable Care Act § 1302(c)(4)</i>.</li> </ul> <p>In 2016, the maximum OOP limit for individuals will increase to \$6,850 for an individual/\$13,700 for a family policy.</p> <p>For CSR policies, the maximum annual OOP limit will remain the same for CSR 94% and CSR 87% plans (\$2,250 for individual, \$4,500 for family) but will increase for CSR 73% plans to \$5,450/individual and \$10,900 for families.<br/>45 C.F.R § 156.130</p> |  |
| <p><b>Network Adequacy</b></p>  | <p><i>In general, MA plans have more established network adequacy requirements than QHPs, meaning MA plans must follow more fixed guidelines as far as number, type, and access to providers. While MA plans, QHPs and Medicaid managed care all have federal network adequacy standards, they are complex. According to federal law, QHP networks must include “essential community providers”: medical care providers who serve predominantly low-income, or medically underserved patient populations. MA plans do not have such a requirement. For QHPs and Medicaid managed care, much of the detail on network adequacy is left up to the states. Ensuring adequate provider networks is one place <u>some</u> states go above and beyond federal requirements.</i></p> <p><i>Like MA plans, QHPs may use mechanisms to control utilization like network tiering and referral requirements provided they do not conflict with non-discrimination provisions. However, QHPs may not require a referral to see an OB-GYN or pediatrician. Medicaid managed care plans must provide direct access to specialists for people with special health care needs and direct access to women’s health specialists for routine and preventive health care for female enrollees. MA plans, QHPs, and Medicaid managed care plans must ensure access to out-of-network emergency care.</i></p> <p><i>While MA plans, QHPs, and Medicaid managed care plans can change their provider networks during the year, enrollees in MA plans, (non-MLTSS waiver) Medicaid managed care plans, and QHPs do not have the right to switch plans if their provider is dropped from the plan’s network mid-year (although MA enrollees will have a limited right to do so starting in 2015).</i></p> |  |  |
| <p><b>General Rules</b></p>   |  |  |  |
| <p>Coordinated care plans (e.g., HMOs) can use mechanisms to control use of services,</p> | <p>No referral necessary for OB-GYN (OB-GYN designated as PCP).</p>  | <p>Plans must implement procedures to ensure that each enrollee has an</p>   |  |

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|  | <p>such as referrals from a gatekeeper for an enrollee to receive services within the plan. <i>42 C.F.R. 422.4(a)(1)(ii)</i></p> <p>Specialist referral policies set by plans (however plans must provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to a women’s health specialist within the network for women’s routine and preventive health care services; in addition, the plan must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member’s medical needs). <i>See, e.g., Medicare Managed Care Manual, Ch. 4, §110.1</i></p> <p>PPOs have networks of contracting providers but also provide for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers (i.e., out-of-network care). <i>42 C.F.R. 422.4(a)(1)(v)</i></p> <p>Private Fee-for-Service (PFFS) plans in non-network areas<sup>39</sup> and MSAs do not need to establish networks.</p> <p>MA plans can change their provider networks any time during the year, as long as they continue to meet network adequacy standards, provide timely notice (at least 30 days advance notice to affected enrollees), and ensure continuity of care for enrollees.<sup>40</sup></p> | <p><i>45 C.F.R. §147.138</i></p> <p>No referral necessary for pediatrician. <i>45 C.F.R §147.138</i></p> <p>Access to out-of-network emergency room services: in-network cost-sharing must apply; however balance billing is not limited. <i>45 C.F.R §147.138</i></p> | <p>ongoing source of primary care appropriate to needs and a person or entity formally designated as primarily responsible for coordinating health care services. <i>42 C.F.R. § 438.210(b)</i></p> <p>State must identify people with special health care needs to plans, and plans must assess these enrollees for any ongoing special conditions that require a course of treatment or regular care monitoring; these enrollees must have direct access to specialists as appropriate. <i>42 C.F.R. § 438.210(c)(1), (4)</i></p> <p>Plans must provide female enrollees with direct access to a women’s health specialist in network for covered women’s routine and preventive health care. <i>42 C.F.R. § 438.206(b)(2)</i></p> <p>Plans must provide a second opinion from qualified professional within network or arrange for enrollee to obtain one out of network at no cost. <i>42 C.F.R. § 438.206(b)(3)</i></p> <p>Plan must adequately and timely cover services out-of-network if network is unable to provide necessary covered service and must ensure that out of network cost to enrollee is no greater than in network. <i>42 C.F.R. § 438.206(b)(4), (5)</i></p> <p>State must establish uniform provider credentialing policy that each plan must follow. <i>42 C.F.R. § 438.214(b)</i></p> <p>Plan must make good faith effort to</p> |
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|  |   |  | give written notice of termination of contracted provider within 15 days of receipt or issuance of termination notice to each enrollee who received primary care from or was seen on a regular basis by that provider.<br><i>42 C.F.R. § 438.10(f)(5)</i>  |
| <b>Rights Triggered by Provider Terminations</b>   |   |  |  |
| There is generally not a right for MA enrollees to change plans mid-year due to provider terminations, however CMS has established a limited special enrollment period right starting in 2015 when CMS has determined that a plan has engaged in “substantial mid-year provider network terminations.” <sup>41</sup>   | No right to change plans.   |  | CMS’s 2013 MLTSS waiver guidance requires states to allow beneficiaries to disenroll from their MCO “when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment.”   |
| <b>Access to and Content of Network</b>  |   |  |  |
| <p>Coordinated care plans (e.g., HMOs) contract with a network of providers; CMS is to ensure that all applicable requirements are met, including access and availability, service area, and quality.<br/><i>42 C.F.R. § 422.4(a)</i></p> <p>Medicare establishes network adequacy criteria,<sup>42</sup> which include:</p> <ol style="list-style-type: none"> <li>1. A minimum number of providers and facilities which vary by county type – population size and density parameters (large metro, metro, micro, rural and counties with extreme access considerations (CEAC), and specialty codes (e.g., primary care, cardiology, etc. for providers; acute inpatient hospitals, outpatient dialysis, etc., re: facilities).</li> <li>2. Maximum travel time and distance to providers/facilities plan enrollees cannot be “unduly burdened” in terms of travel time and distance required to access providers.</li> </ol> | <p>Plans in Marketplaces are required to provide consumers with a “sufficient choice of providers.”<br/><i>42 U.S.C § 18031</i></p> <p>Plans are required to maintain a network sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and</p> <p>Are consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act (PHS), a provision that allows network plans to limit coverage to its eligible enrollees and to limit enrollment to the network’s maximum capacity<br/><i>45 C.F.R § 156.230(a)(2)</i></p> <p>Plan networks must include “essential community providers” in accordance with <i>45 C.F.R § 156.235</i>.</p> <p>The network must have a sufficient</p> |  | <p>Plans must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all covered services; plans must consider anticipated Medicaid enrollment, expected utilization of services (taking into consideration the characteristics and health care needs of specific Medicaid populations), number and types of providers required to furnish contracted services, number of network providers who are not accepting new Medicaid patients, and the geographic location of providers and enrollees (distance, travel time, means of transportation ordinarily used by Medicaid enrollees and whether location provides physical access to people with disabilities).<br/><i>42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.206(b)(1)</i></p> <p>Plans and their network providers must meet state standards for timely access to care and services, taking into account the urgency of need for services; ensure that network providers</p> |

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|                                  |  | <p>number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals” in the area that the plan serves (the plan’s “service area”).</p> <p>Essential community providers include, but are not limited to: FQHCs, Ryan White HIV/AIDS providers, DSH hospitals, Title X Family Planning clinics &amp; hemophilia treatment centers.<br/><i>42 U.S.C 18031, 45 C.F.R. § 156.235</i></p>   | <p>offer hours of operation that are no less than hours offered to commercial enrollees or comparable to Medicaid fee-for-service if provider serves only Medicaid enrollees; make services available 24/7 when medically necessary; and participate in state efforts to promote culturally competent service delivery.<br/><i>42 C.F.R. §438.206(c)</i></p>  |
| <b>Network Adequacy (cont’d)</b> | <b>Oversight</b>   |   |   |
|                                  | <p>CMS does not review plans’ submitted data for network adequacy unless the plan is new to a service area, is expanding the service area, or there are significant changes to the network (no annual review).</p> <p>CMS uses geo mapping software program to evaluate adequacy of networks submitted by MA plan applicants (using network adequacy criteria described above).</p> <p>Largely automated process.</p> <p>Not required by statute to report claims from out-of-network providers.</p> | <p>CMS will assess provider networks using a “reasonable access” standard. For Marketplace plans in 2014, HHS relied mostly on network adequacy reviews that states or health insurance plan accreditors conducted.</p> <p>For 2015, HHS intends to more closely review network adequacy compliance among plans in the FFM looking for plans that seem to be outliers based on their inability to provide “reasonable access” before certifying plans as qualified for the Marketplace.</p> <p><i>See 2015 letter to issuers p. 17 and 18<sup>43</sup></i></p> <p>Required by statute to report claims from out-of-network providers.<br/><i>42 U.S.C.A. § 18031(e)(3); 42 U.S.C. § 300gg-15a</i></p> | <p>State Medicaid agency must ensure that all covered services are available and accessible to plan enrollees.<br/><i>42 C.F.R. § 438.206(a)</i></p> <p>State Medicaid agency also must ensure through its contracts that each plan gives assurances and provides supporting documentation that demonstrates that plan has capacity to serve expected enrollment in service area in accordance with state’s access to care standards; state must review plan documentation and certify to CMS that plan complies with state’s standards.<br/><i>42 C.F.R. § 438.207(a)-(d)</i></p> <p>CMS may request plan documentation.<br/><i>42 C.F.R. § 438.207(e)</i></p> |
|                                  | <b>Information to Consumers</b>  |   |   |
|                                  | Medicare Marketing Guidelines require MA   | <i>See Consumer Information and</i>   | <i>See Consumer Information and</i>   |

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|                                      | <p>plans to provide new and renewing enrollees with a provider directory (among other things – see “Consumer Information” below).<br/><i>Medicare Marketing Guidelines, §30.7</i></p> <p>Plans must send a Provider Directory at the time of enrollment and at least every three years after that; additionally, plans must make directories available upon beneficiary request and ensure that websites contain current directories at all times.<br/><i>Medicare Marketing Guidelines, §60.4</i></p> <p>No requirement to identify providers who speak non-English languages.</p> <p>No requirement to identify providers that are not accepting new patients.</p>   | <p><i>Assistance</i></p> <p>For 2016, QHPs must publish online (with hard copy available upon request) an up-to-date, accurate, complete, and plan-specific provider directory. Required information includes provider’s location and contact information, specialty, medical group, institutional affiliations, and whether provider is accepting new patients. Directory information must be updated at least monthly. Directory must be accessible to general public (not just enrollees) and published in a machine-readable format.</p> <p>There is no requirement to identify providers who speak non-English languages or who are accessible for patients with disabilities.<br/><i>45 C.F.R. § 156.230</i></p> | <p><i>Assistance</i></p> <p>Must identify providers who speak non-English languages.</p> <p>Must identify providers that are not accepting new patients.</p> |
| <p><b>Appeals and Grievances</b></p> | <p><i>MA plans and QHPs are <u>similar</u> in that both provide processes for appeals, initially through the plan and then by an external reviewer(s). In some cases the external reviewer for QHPs and MA is the same contracted entity (i.e., Maximus Federal Services). In Medicaid managed care, beneficiaries have access to both a plan level appeal and a state fair hearing, although unlike in MA and QHPs, states can choose whether to require beneficiaries to complete the plan level appeal first or allow beneficiaries direct access to a state fair hearing.</i></p> <p><i>Medicaid managed care requires provision of a terminated service to continue pending the outcome of an appeal, whereas MA plans do not (with some limited exceptions like discharge from institutional settings like hospitals). Also, the Medicare 5-step administrative appeals process is uniform across the country. For QHPs (and other private health plans), federal minimum standards apply to appeal rights and limit the number of levels of appeals that can be required (e.g., no more than 1 level of internal appeal can be required before external review is offered), other variation in levels/structures of QHP appeals can also be found across states. State laws that fail to meet minimum federal standards are preempted. A special rule applies to insurers in preempted states, permitting insurers the choice of using two different federally established external review systems.</i></p> <p><i>Baseline appeal rights, including plan appeals and state fair hearings, are in federal Medicaid law, although states are permitted to make some choices within that framework, such as the number of days to request a hearing.</i></p> <p><i>In addition, the MA program has a standardized, centralized complaint tracking system compared to QHP and Medicaid managed care complaint tracking, which is left to the states. There is a formalized (federal) grievance process written into regulation for MA plans while grievances against QHPs are filed with state departments of insurance and vary from state to state. The basic plan grievance process for Medicaid managed care is set out in federal law.</i></p> |  |  |

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|   | <p><b>Notice of Denial</b></p>   |  |  |
| <p>Notice of non-coverage (NONC) is a standard document developed by CMS which includes reason for service denial, information on rights to expedited and standard appeal and how to seek an appeal. MA plans must use a standardized notice of non-coverage developed by CMS.<sup>44</sup> MA notices must “use approved notice language in a readable and understandable form.”<br/><i>42 C.F.R. §422.568(e)(1)</i></p> <p>Note that denial notices and appeals correspondence are not among the documents that MA plans are required to translate into other languages<sup>45</sup>; also see Consumer Information and Assistance section below.</p> | <p>Under federal rules (states can apply enhanced standards) QHPs must provide Limited English Proficiency notices that advise enrollees of oral translation assistance by phone.<br/><i>42 USC § 300gg-19, 45 C.F.R. § 155.205(c).</i></p> <p>Written translation must also be provided upon request; however, QHPs are not required to track translation requests by LEP enrollees; enrollees must request written translation of each notice separately.</p> <p>QHPs must provide notice that includes a description of service denied, the reason for why the claim was denied, and information about appeal rights including expedited appeal rights. The notice must also include contact information for any applicable state Consumer Assistance Program (CAP) which can help consumers file an appeal.<br/><i>45 C.F.R. §147.136(E)</i></p> | <p>MCOs must provide written notices in accessible language and format that explain the action taken/to be taken, the reason(s) for the action, enrollee’s right to file an appeal, enrollee’s right to request state fair hearing (if state does not require exhaustion of plan appeal first), procedures for exercising appeal rights, circumstances under which expedited resolution is available and how to request it, and right to aid pending/how to request/circumstances under which enrollee may be required to repay.</p> |  |
|   | <p><b>Appeals Process</b></p>  |  |  |
| <p>MA organizations must provide for both an internal grievance process and a formal appeals process with external review.</p> <p>Appeals address concerns and disagreements with organization determinations (whether an item, service, or procedure is covered) and include procedures that deal with the review of adverse organization determinations; such procedures include reconsiderations by the MA organization, and if necessary, an independent review entity, hearings before administrative law judges (ALJs), review by the Medicare Appeals Council (MAC), and</p>   | <p>Right to internal review of all adverse benefit determinations and decisions. Under federal rules, right to external review only for medical necessity denials and related determinations involving clinical judgment.</p> <p>The number of appeal levels varies somewhat depending on state (though no more than one level of external review may be required before external review is offered) and may terminate in state court.<br/><i>45 C.F.R. § 147.136</i></p>  | <p>Plans must have a grievance process and an appeal process and must provide beneficiaries with access to the Medicaid state fair hearing system.<br/><i>42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. § 438.402(a).</i></p> <p>Appeals are requests for review of denials or limitations on a requested service or a reduction, suspension or termination of a previously authorized service or the failure of a plan to take timely action.<br/><i>42 C.F.R. § 438.400(b)</i></p>  |  |

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|  | <p>judicial review.<br/>See 42 C.F.R. §§422.561, .566, et seq.</p> <ul style="list-style-type: none"> <li>- Expedited appeals are available in certain scenarios</li> <li>- Amounts in controversy apply for access to ALJ and federal court</li> </ul> | <p><u>Minimum internal review standards:</u><br/>Must comply with all ERISA internal claims and appeals procedures applicable to QHP under 29 C.F.R. 2560.503.-1 and additional requirements including clarification of what constitutes an adverse benefit determination. (A) Expedited notification of benefit determinations involving urgent care; (B) Full and Fair review; (C) Avoiding conflicts of interest; (D) Notice.</p> <p><u>Minimum external review standards:</u></p> <p>State has flexibility in determining standards for external review subject to federal minimum standards, which are based on the minimum consumer protections in the NAIC Uniform Model Act.<br/>45 C.F.R. § 147.136 (c)</p> <p>State external review systems that do not meet federal minimum standards are preempted. This is currently the case for 8 states. In preempted states, the insurer is allowed to choose, on a case by case basis, to participate in one of two federally-administered external review systems. Under the HHS-administered process, the federal government selects the external reviewer. Under the DOL-administered process (which also applies to all self-insured group health plans), the plan hires the external reviewer.<sup>46</sup><br/>45 C.F.R. § 147.136</p> <p><u>Expedited Appeals:</u><br/>In the case of urgent care claims for notification of the plan's benefit determination (whether adverse or not) as soon as possible, taking into</p> | <p>Enrollees can file a plan level appeal and request a Medicaid state fair hearing.<br/>42 C.F.R. § 438.4029b)(1)(i)</p> <p>States set the number of days a beneficiary has to request an appeal (within a range of 20 to 90 days) and determine whether beneficiaries must exhaust the plan appeal process before accessing a state fair hearing.<br/>42 C.F.R. § 438.402(b)(2)</p> <p>Federal law contains the required elements of notices of plan actions and appeal resolutions and the timeframes in which plans must resolve appeals.<br/>42 C.F.R. § 438.404, 438.408</p> <p>Plans must have an expedited review process for appeals.<br/>42 C.F.R. § 438.410</p> <p>Plan appeals must provide enrollees with a reasonable opportunity to present evidence and allegations of fact and law and the opportunity to examine the enrollee's case file and any documents and records considered during the appeal.<br/>42 C.F.R. § 438.406(b)(2), (3)</p> <p>State or plan must provide information to enrollees about appeal rights.<br/>42 C.F.R. § 438.10(g)</p> |
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|                                |  | account the medical exigencies, but not later than 72 hours after receipt of the claim).<br><i>45 C.F.R. 147.136(b)</i>  |   |
| <b>Aid Paid Pending Appeal</b> |  |  |   |
|                                | Not required (other than limited continued coverage when appealing discharges from hospital, skilled nursing facilities and home health coverage).   | Required only during first internal level of appeal.<br><i>45 C.F.R. 147.136(b)(2)</i>   | Required for service terminations if timely requested by beneficiary.<br><br>Plans must provide continued benefits pending appeal, as set out in federal rules.<br><i>42 C.F.R. § 438.420</i>       |
| <b>Grievances</b>              |  |  |   |
|                                | Prescribed grievance process to express dissatisfaction about matters that are not subject to appeals, such as quality of care or failure to respect enrollee rights.<br><i>See 42 C.F.R. §§422.561, .564</i>  | QHP issuers operating in a Federally-facilitated Exchange must investigate and resolve, as appropriate, cases from the complainant forwarded to the issuer by HHS. Cases received by a QHP issuer operating in a Federally-facilitated Exchange directly from a complainant or the complainant's authorized representative will be handled by the issuer through its internal customer service process.<br><i>45 C.F.R. 156.1010(b)<sup>47</sup></i> | Grievances are expressions of dissatisfaction about matters that are not subject to appeals, such as quality of care or failure to respect enrollee rights.<br><i>42 C.F.R. § 438.400(b)</i>        |
| <b>Reporting Requirements</b>  |  |  |   |
|                                | Federal requirements for reporting complaints and grievances with the plans.<br><br>The complaint tracking module (CTM) is a centralized system for collecting plan complaint information for both plan resolution and CMS oversight of plans; CTM information is factored into plan | No federal requirements for reporting complaints and grievances with the plans nor is data collected.<br><br>However, ACA data reporting requirements, not yet implemented, mandate periodic reporting by QHPs (and other private health plans) on   | Federal requirements for reporting complaints and grievances with the plans.<br><br>Plans must maintain records of grievances and appeals which are reviewed as part of the state quality strategy. |



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|                  | quality ratings and corrective action plans.   | denied claims and claims payment practices.<br>§1311(e)(3)   | 42 C.F.R. § 438.416  |
|                  | <b>Assistance with Appeals</b>   |  |  |
|                  | No requirements for MA plan assistance with appeals, although State Health Insurance Assistance Programs (SHIPs) often serve this purpose.<br><br><i>Also see Consumer Assistance below.</i>   | Consumer assistance available for help with appeals; CAPs mandated by federal law to assist QHP enrollees with appeals.<br>45 C.F.R. § 147.36 (b)(2)(ii)(E)(5)<br><br><i>Also see Consumer Assistance below.</i>   | Medicaid MCOs must assist enrollees with appeals and provide interpreters. Plans must provide reasonable assistance to enrollees in completing forms and taking other procedural steps, including providing interpreter services.<br>42 C.F.R. § 438.406<br><br><i>Also see Consumer Assistance below.</i>   |
| <b>Marketing</b> | <i>MA plans and QHPs are similar in that oversight of agents/brokers marketing plans is performed at the state level. Similarly, the state Medicaid agency oversees Medicaid managed care plan marketing, within broad federal standards.</i>  |  |  |
|                  | <i>While the MA program has well-developed federal rules that plans and downstream entities must follow, marketing rules and regulation for QHPs are left up to individual states leading to state-based variation in this area. Like other aspects of the Medicaid program, federal law sets some baseline marketing rules and states can include further restrictions in state law or in their contracts with plans.</i>   |  |  |
|                  | The activity of MA plans is generally overseen by CMS; while states oversee/regulate licensure of agents and brokers, MA plans are ultimately responsible for the conduct of such agents/brokers and other downstream entities.<br><br>Medicare marketing rules include: <ul style="list-style-type: none"> <li>- CMS approval of marketing materials;</li> <li>- Prohibition against certain marketing practices (including marketing through unsolicited contacts and restrictions on marketing/sales events);</li> <li>- Coordination with states to address fraudulent or inappropriate marketing practices.</li> </ul> <i>See, generally, 42 USC 1395w-21(h)-(j), 42 C.F.R. § 422.4260, et seq., and Medicare Marketing</i> | QHP issuers must comply with state marketing laws and regulations. Marketing practices and benefit designs that discourage enrollment of individuals with significant health needs cannot be used.<br>45 C.F.R. § 156.225<br><br>Agents and brokers that sell QHPs are regulated by the state department of insurance and must be certified by the Marketplace to sell QHP coverage. | State must approve plan marketing materials.<br>42 U.S.C. § 1396u-2(d)(2)(A)(i); 42 C.F.R. § 438.104<br><br>Marketing materials must be distributed to plan's entire service area.<br>42 U.S.C. § 1396u-2(d)(2)(B); 42 C.F.R. § 438.104<br><br>Plans may not directly or indirectly engage in door-to-door, telephone or other cold call marketing.<br>42 U.S.C. § 1396u-2(d)(2)(E); 42 C.F.R. § 438.104<br><br>Plans must assure state that marketing plans and materials are accurate and do not mislead, confuse or defraud beneficiaries.<br>42 U.S.C. § 1396u-2(d)(2)(D); 42 C.F.R. § 438.104 |

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|   | <p style="text-align: center;"><i>Guidelines<sup>48</sup></i></p> <p>Plan marketing materials are submitted to CMS, and can be used within certain time frames after submission (from 5 to 45 days, depending upon the materials) unless CMS disapproves – “file and use”<br/> 42 C.F.R. §§422.2262 - .2266</p>  |   |  |
| <p><b>Consumer Information and Assistance</b></p> | <p><i>MA plans, QHPs, and Medicaid managed care plans are required to disclose certain information to enrollees, however MA plans must generally provide a broader range of consumer information. Medicare offers a uniform plan comparison tool that provides certain information (Plan Finder); there is no comparable tool for QHPs at the federal level, although some state marketplaces offer them. Each QHP is, however, required to offer a standardized Summary of Benefits and Coverage (SBC) for consumers to compare across plans.</i></p> <p><i>Both Medicare and the Marketplaces offer consumer assistance through publicly-funded programs (SHIPs in Medicare and navigators in the Marketplaces as well as State Consumer Assistance Programs which serve all state residents, including QHP enrollees). Under the ACA, comprehensive consumer assistance services are to be provided to all state residents through CAPs. CAPs must provide eligibility and enrollment assistance for all types of private health coverage and help state residents with post-enrollment questions and problems, including helping consumers file appeals of denied claims. In addition, CAPs are required to track and report data on consumer problems to the Secretary, who in turn, must use this information to strengthen oversight. Under the ACA, additional help is provided specifically for people who seek coverage through Marketplaces. Navigators must provide outreach and enrollment assistance to people seeking coverage through QHPs or otherwise applying for Marketplace financial assistance. For post-enrollment problems, Navigators are required to refer consumers to CAPs. However, Navigators are funded on an ongoing basis by Marketplace operating revenue, while CAPs are funded through federal grants, subject to Congressional appropriations. As a result, Marketplaces spent more than \$167 million on Navigators in 2014, while federal CAP grants that year totaled \$5 million.</i></p> <p><i>Medicare SHIPs have ongoing federal funding to perform both enrollment and general consumer assistance for all Medicare beneficiaries, including Medicare Advantage enrollees.</i></p> |   |  |
| <p><b>Plan Requirements</b></p>                   |  |   |  |
|   | <p>Disclosure Requirements (under statute) -- MA plans must disclose at the time of enrollment and at least annually thereafter certain information regarding the plan, including:</p> <ul style="list-style-type: none"> <li>- Service area;</li> <li>- Benefits offered under the plan;</li> <li>- Access – the number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option;</li> <li>- Out-of-area coverage provided by the plan;</li> </ul>  | <p>Plans are required to:</p> <p>Develop and utilization of uniform explanation of coverage documents and standardized definitions.<br/> 42 USC 300gg-15</p> <p>Enrollees must have access to a provider directory. The QHP provides this directory to the Marketplace and is responsible for keeping directory accurate and up-to-date. It must indicate providers who are not accepting new patients.</p> | <p>State must have a mechanism in place to help enrollees and potential enrollees understand the managed care program.<br/> 42 C.F.R. § 438.10(b)(2)</p> <p>Plans must have a mechanism in place to help enrollees and potential enrollees understand the plan’s requirements and benefits.<br/> 42 C.F.R. § 438.10(b)(3)</p> <p>State must provide information to potential enrollees when they first</p> |

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|  | <ul style="list-style-type: none"> <li>- Emergency coverage;</li> <li>- Supplemental benefits – including—whether the supplemental benefits are optional, the supplemental benefits covered, and any monthly supplemental beneficiary premium for the supplemental benefits;</li> <li>- Prior authorization rules or other review requirements that could result in nonpayment;</li> <li>- Plan grievance and appeals procedures</li> <li>- Quality improvement program<br/><i>42 U.S.C. §1395w-22(c)</i></li> </ul> <p>Additional information must be provided by the plan upon request of an MA eligible individual:</p> <ul style="list-style-type: none"> <li>- Certain general coverage information and general comparative plan information;</li> <li>- Information on procedures used by the organization to control utilization of services and expenditures;</li> <li>- Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters;</li> <li>- An overall summary description as to the method of compensation of participating physician</li> </ul> <p>Medicare Marketing Guidelines also require MA plans to provide to new and renewing enrollees:</p> <ul style="list-style-type: none"> <li>- An Annual Notice of Change (ANOC)/Evidence of Coverage (EOC);</li> <li>- Provider directory; (see</li> </ul> | <p><i>45 C.F.R. §156.230(b)</i></p> <p>Enrollees must have access to a plan formulary.<br/><i>45 C.F.R. § 147.200(a)(2)(i)(K)</i> (available through the Marketplace online with no log-in; offered via hard copy publication by request)</p> <p>Information must be provided in accessible language and manner for LEP and people with disabilities.<br/><i>42 C.F.R. § 155.205</i></p> <p>LEP Guidelines: For individuals who are limited English proficient, information must be provided through oral interpretation; written translations; and taglines in non-English languages indicating the availability of language services.<br/><i>42 C.F.R. § 155.205(c)</i> QHPs must make available, upon request, translated marketing materials in any non-English language that is the primary language of at least 10% of the individuals in a plan benefit package service area; note that this is also the language standard that applies for appeals notices.</p> | <p>become eligible or required to enroll in a plan and within a timeframe that allows them to use the information in choosing among plans:</p> <ul style="list-style-type: none"> <li>- General information about basic features of managed care;</li> <li>- Which populations are excluded from enrollment, required to enroll, or able to voluntarily enroll;</li> <li>- Plans’ responsibilities for care coordination;</li> <li>- Information specific to each plan including benefits covered, any cost-sharing, service area, names, locations, phone numbers and non-English languages spoken by providers and identification of providers not accepting new patients – at minimum, this includes primary care physicians, specialists, and hospitals;</li> <li>- Benefits covered under Medicaid state plan but not under managed care plan contract, including how and where to obtain, any cost-sharing and how transportation is provided<br/><i>42 C.F.R. § 438.10(e)</i></li> </ul> <p>State or plan must notify enrollees of their right to request and obtain information at least annually.<br/><i>42 C.F.R. §438.10(e)(2)</i></p> <p>State or plan must provide to enrollees the following:</p> <ul style="list-style-type: none"> <li>- Names, locations, telephone numbers and non-English languages spoken by</li> </ul> |
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|   | <p>“Network Adequacy” above);</p> <ul style="list-style-type: none"> <li>- If the plan offers Part D benefits, a comprehensive or abridged formulary and pharmacy directory<br/><i>Medicare Marketing Guidelines, §30.7</i></li> </ul> <p>Customer service call center (§80.1) and plan website (§100) requirements.<br/><i>Medicare Marketing Guidelines</i></p> <p>Limited English Proficient (LEP) guidelines: for markets with a significant non-English speaking population, provide materials in the language of these individuals. Specifically, MA organizations must translate marketing materials into any non-English language that is the primary language of at least 5% of the individuals in a plan benefit package service area.<br/><i>42 C.F.R. §422.2264(e)</i></p> <p>Plans must translate: marketing materials, application, summary of benefits, plan rating information, annual notice of change, drug list, pharmacy list, provider directory.<br/>Plan call centers must offer interpreter services.<br/><i>42 C.F.R. §422.111(h)(1)</i></p> <p>Plans must include the CMS created Multi-Language Insert with the Summary of Benefits (SB), ANOC/EOC, and the enrollment form informing individuals about free interpreter services.<br/><i>Medicare Marketing Guidelines, §§30.5, 30.5.1, 50.4</i></p> |  | <p>providers and identify providers not accepting new patients;</p> <ul style="list-style-type: none"> <li>- Any restrictions on enrollee’s free choice among network providers;</li> <li>- Enrollee rights and protections (§ 438.100)</li> <li>- Grievance and fair hearing procedures;</li> <li>- Amount, duration, scope of available benefits</li> <li>- Procedures for obtaining benefits</li> <li>- Extent to which and how enrollees may obtain benefits including family planning services from out of network providers;</li> <li>- Extent to which and how after-hours and emergency services are provided</li> <li>- Post-stabilization care services rules</li> <li>- Policy on referrals</li> <li>- Cost-sharing if any</li> <li>- How and where to access state plan benefits that are not covered under contract<br/><i>42 C.F.R. § 438.10(f)</i></li> </ul> <p>State or plan must give each enrollee 30 day advance written notice of any significant change in the above information.<br/><i>42 C.F.R. § 438.10(f)(4)</i></p> |
| <b>Shopping for and Comparing Plans</b> |  |  |   |

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|                                      | <p>Medicare offers a Plan Finder tool on the medicare.gov website allowing users to perform a personalized or generalized search of Part D and MA plans available by zip code.</p> <ul style="list-style-type: none"> <li>- Plan Finder does not include information about providers and providers networks, nor does it contain information in languages other than English and Spanish.</li> <li>- Medicare provides certain information on its website in languages other than English.<sup>49</sup></li> </ul> | <p>Healthcare.gov is an internet web-portal for comparison shopping in Spanish and English.<br/>42 C.F.R. 155.205</p> <p>Summary of Benefit and Coverage (SBC).<br/>45 C.F.R. § 147.200</p>   | <p>If Medicaid managed care enrollment is mandatory, state Medicaid agency must provide enrollees with information on plans in a comparative chart-like format, including plan service area, covered benefits, any cost-sharing, and quality and performance indicators including enrollee satisfaction, to the extent available.<br/>42 U.S.C. § 1396u-2(a)(5)(C); 42 C.F.R. § 438.10(i)</p>  |
| <b>Toll Free Call Centers</b>        |  |   |  |
|                                      | <p>Medicare offers a toll-free, 24/7 national hotline to provide information, compare plans and lodge complaints (1-800-MEDICARE).</p> <p>Spanish-speaking agents available, interpreter services for other languages.</p>   | <p>Consumer call center available through state or federal marketplace.<br/>42 C.F.R. § 155.205</p>   | <p>Plans must provide toll-free numbers for enrollees to file grievances or appeals by phone. Other telephone call center provisions may be required by state law or MCO contract.</p>   |
| <b>In Person Consumer Assistance</b> |  |   |  |
|                                      | <p>State Health Insurance Assistance Program (SHIP) - established in Section 4360 of Public Law 101-508, SHIPs provide a health insurance advisory service to assist Medicare beneficiaries with the receipt of services under Medicare, Medicaid and other health insurance programs. CMS is legislatively required to assess SHIP performance, and CMS uses data gathered by the SHIP National Performance Reporting (NPR) system.<sup>50</sup></p>  | <p>Navigator programs must be established to help consumers <u>choose and enroll</u> in a QHP or Medicaid.<br/>42 C.F.R. 155.210</p> <p>Marketplaces are authorized to perform consumer assistance and outreach (in addition to Navigator program) aka non-Navigator assistance program<br/>45 C.F.R. 155.205</p> <p>Entities Marketplaces select to be Navigators must include at least one community-based &amp; consumer-focused non-profit and at least one other type of public or private entity.</p> <p>Navigator funding: initially federal grants sometimes supplemented by states; Navigators must be funded on</p> | <p>States, plans, and enrollment brokers must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.<br/>42 U.S.C. § 1396u-2(a)(5)(A); 42 C.F.R. § 438.10(b)(1)</p> <p>State must make written material available in each prevalent non-English language spoken by a significant number or percentage of enrollees or potential enrollees.<br/>42 C.F.R. § 438.10(c)(1), (2)</p> <p>Plans must make written information available in the prevalent non-English languages in their service area.<br/>42 C.F.R. § 438.10(b)(3)</p> |

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|                                     |  | <p>an ongoing basis through Marketplace operating revenue.</p> <p>Consumer Assistance Programs are specifically authorized by the Affordable Care Act to help consumers use their health insurance (educating consumers about their health insurance rights and responsibilities, assisting with health insurance appeals, and helping resolve problems with premium tax credits) but have not been adequately federally funded. CAPs are required to collect, track, and quantify problems experienced by consumers and periodically report data to the Secretary, who is, in turn, required to use data to determine where additional enforcement actions may be necessary and who must share data with other federal and state regulators.<br/>45 C.F.R. § 155.205</p> | <p>State and plans must make free oral interpretation services in all non-English languages available to enrollees and potential enrollees.<br/>42 C.F.R. § 438.10(c)(4); state and plans must notify enrollees and potential enrollees that oral interpretation is available and how to request services.<br/>42 C.F.R. § 438.10(c)(5)</p> <p>Written material must use easily understood language and format and be available in alternative formats (e.g., visual limitations, limited reading proficiency).<br/>42 C.F.R. § 438.10(d)</p> <p>Enrollees have rights to be treated with respect and with due consideration for dignity and privacy, receive information on available treatment options and alternatives presented in manner appropriate to enrollee’s condition and ability to understand; participate in health care decisions including right to refuse treatment; be free from restraint or seclusion as a means of coercion, discipline, convenience or retaliation; and to freely exercise rights in a way that does not adversely affect how plans, providers, and state treat the enrollee.<br/>42 C.F.R. § 438.100</p> |
| <p><b>Low-Income Assistance</b></p> | <p><u>Similar</u><br/><i>In both Medicare and with QHPs, premium subsidies and cost-sharing subsidies are available. In Medicare, it is the state Medicaid program that pays the Part B premium through the Medicare Savings Program and in QHPs, the subsidy is through the federal government (the IRS). Government (Medicaid for Medicare and IRS for QHP) pays the premium directly.</i></p> <p><u>Different</u><br/><i>For MA premiums (premiums above and beyond Part B) there is no assistance above 135% FPL whereas with QHPs premium assistance is offered up to 400% FPL The Part D low-income subsidy (LIS) assistance is available for prescription drug costs to individuals up to 150% FPL.</i></p> |   |  |

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| <p><i>By definition, all Medicaid beneficiaries have low incomes, and limits on premiums and cost-sharing are included in federal law.</i></p>   |   |   |
| <p>Medicare Savings Programs:</p> <ul style="list-style-type: none"> <li>- Qualified Medicare Beneficiary (QMB) – covers premiums, deductible, coinsurance, copayments; income up to 100% federal poverty level (FPL), assets \$7,280/individual, \$10,930/couple</li> <li>- Specified Low-Income Medicare Beneficiary (SLMB) – covers Part B premium only; income between 100-120% FPL, assets \$7,280/individual, \$10,930/couple</li> <li>- Qualified Individual (QI) covers Part B premium only; income between 120-135% FPL, assets \$7,280/individual, \$10,930/couple</li> <li>- Dual eligibles who are enrolled in MA plans and who are QMBs are entitled to have their states pay MA plan copayments and are excused from liability for such payments (states can also pay MA premiums at their discretion)<sup>51</sup>; other dual eligible are entitled to have at least some copayments paid<br/><i>42 U.S.C. § 1396d(p)(3)</i></li> </ul> <p>Part D Low-Income Subsidy (LIS):</p> <ul style="list-style-type: none"> <li>- Covers most or all of Part D premium, most cost-sharing</li> <li>- Automatically eligible if have Medicaid or one of above Medicare Savings Programs</li> <li>- Also available for individuals on sliding scale up to 150% FPL, assets up to \$13,640 individual/\$27,250 couple</li> </ul> | <p>Advance Premium Tax Credits are offered; APTC can be paid in advance, directly to insurers, to reduce enrollee’s monthly premium, or can be claimed at the end of the year by consumers as a credit at tax filing. The amount of subsidy is based on a sliding scale depending upon income.<br/><i>26 C.F.R. § 1.36B</i></p> <p>Income eligibility for APTC is 100%-400% FPL. In addition, to be eligible an individual cannot be eligible for other subsidized coverage offered by an employer or through a public program, such as Medicare or Medicaid.</p> <p>APTC amount is calculated as percentage of income (for example, people between 300% and 400% FPL will pay no more than 9.5% of income on premiums for 2<sup>nd</sup> lowest cost silver plan; APTC amount is difference between benchmark plan cost and this required individual contribution amount).<br/><i>45 C.F.R. § 155.305</i></p> <p>Cost-sharing subsidies also available to individuals with incomes 100%-250% FPL.</p> <p>Cost-sharing subsidies delivered differently, through enhanced silver plans (not through plans in other metal tiers). CSR plans have higher actuarial values (and so lower cost-sharing) compared to regular silver plans. For people with income 100-150% FPL, silver plan actuarial value is increased from 70% to 94%. For</p> | <p>Medicaid eligibility is limited to people with low incomes, and federal law incorporates exemptions and limitations on premiums and cost-sharing (see above for more details).</p> |

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|                                 |   | <p>people with income 151-200% FPL, CSR plans have actuarial value of 87%. For people with income 201-250% FPL, CSR plans have actuarial value of 73%. In addition, the otherwise applicable maximum OOP limit is reduced to \$2,250 in CSR plans for individuals with income 100-200% FPL, and to \$5,200 for individuals with income 201-250% FPL.</p> <p>People eligible for CSR plans pay the same premium they would otherwise pay for a silver plan of 70% AV. The federal government separately reimburses the health plan for the value of the reduced cost-sharing.</p> <p>Enrollees have the right to appeal the termination or change in cost-sharing reductions or advance premium tax credits.<br/>45 § C.F.R. 155.1220</p> <p><u>Eligibility for APTC and CSR:</u></p> <ol style="list-style-type: none"> <li>1. Citizenship/Residency Requirements</li> <li>2. Not eligible for other “minimum essential coverage” (Minimum essential coverage includes Medicare, Medicaid and an offer of affordable employer sponsored insurance.)<br/>45 C.F.R. § 155.305</li> </ol> |  |
| <b>Medical Loss Ratio (MLR)</b> | <p><i>Both MA plans and QHPs are bound by medical loss ratio (MLR) rules that require designated percentages of revenue generated by plans to be spent on the provision of benefits (vs. administration, profit, etc.). Rebates paid by plans for failure to meet the MLR in the MA context are paid back to the Medicare program, whereas QHPs pay rebates directly to plan enrollees (except for group plans). By contrast, federal law does not require an MLR for Medicaid managed care plans, although states can opt to include an MLR in their plan contracts.</i></p> |  |  |
|                                 | <p>Effective 2014, MA plans must maintain an MLR of 85% (meaning 85% of revenue goes towards benefits).</p>   | <p>80/20; 85/15 for insurers selling to large groups (50+); rebate to individual (except group plans).</p>   | <p>Federal law does not require an MLR for Medicaid managed care plans; states may choose to require an MLR in</p> |



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|  | <ul style="list-style-type: none"> <li>- If a plan fails to meet the MLR, it must remit sums to the Medicare program.</li> <li>- The Secretary of HHS can preclude new enrollment in plans that do not meet the MLR for 3 consecutive years, and must terminate plans that fail to do so for 5 consecutive years.</li> </ul> <p><i>HCERA §1103</i></p> | <p><i>45 C.F.R. § 158.210</i></p> | <p>their contracts with plans.</p> |
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<sup>28</sup> There are different forms of Medicaid managed care from which states can choose, including capitated models and managed fee-for-service models, such as primary care case management. This brief focuses on capitated Medicaid managed care organizations.

<sup>29</sup> Regarding eligibility for Medicare without the 24-month waiting period for people with ALS, see *Benefits Improvement and Protection Act (BIPA)*, Pub. L. No. 106-554 §115, December 21, 2000.

<sup>30</sup> See, generally, “Medicaid Moving Forward,” Kaiser Commission on Medicaid and the Uninsured, June 17, 2014, available at <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/>; “The Affordable Care Act’s Impact on Medicaid Eligibility, Enrollment, and Benefits for People with Disabilities,” Kaiser Commission on Medicaid and the Uninsured, April 8, 2014, available at <http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicaid-eligibility-enrollment-and-benefits-for-people-with-disabilities/>.

<sup>31</sup> Regarding details on each state’s benchmark plan, see “Additional Information on Proposed State Essential Health Benefits Benchmark Plans, CMS: CCHIO, <http://www.cms.gov/CCHIO/Resources/Data-Resources/ehb.html>.

<sup>32</sup> See, generally, “Medicaid Enrollment and Expenditures.” The services for which a Medicaid beneficiary is eligible can depend on the benefit package associated with her coverage group.

<sup>33</sup> Regarding MA plan type and access to Part D prescription drug coverage, see 42 C.F.R. §423.30(b): an MA coordinated care plan (HMO, PPO, SNP) enrollee can obtain Part D drug coverage through that plan but not from a stand-alone Part D prescription drug plan (PDP); an enrollee of a PFFS plan that does not provide drug coverage may enroll in a stand-alone PDP; MSA plans may not offer Part D coverage so enrollees of MSAs may also enroll in a stand-alone PDP.

<sup>34</sup> For a discussion of MA payment, see, e.g., “Medicare Advantage Program Payment System,” MedPAC, revised October 17, 2014, available at <http://www.medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0>.

<sup>35</sup> MA premiums are based on plan bids relative to local CMS-established benchmark payment rate. If a plan’s bid is above the benchmark rate, plans receive a base payment rate equal to the benchmark rate and enrollees have to pay a basic premium that equals the difference between the bid and the benchmark. If a plan’s bid is below the benchmark rate, plans receive a rebate payment from Medicare that must be returned to enrollees in the form of either lower premiums or supplemental benefits. For a discussion of MA payment, see, e.g., “Medicare Advantage Program Payment System,” MedPAC.

<sup>36</sup> The 2015 CMS Call Letter states that actuarial equivalence will be applied to the following service categories in 2015: inpatient, skilled nursing facility, home health, durable medical equipment, and Part B drugs. “Note to: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties,” CMS, p. 89, April 7, 2014, available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtSpecRateStats/Downloads/Announcement2015.pdf>.

<sup>37</sup> MA cost-sharing for skilled nursing facility (SNF) care: Despite this statutory restriction on charging cost-sharing greater than that allowed in Traditional Medicare, CMS has interpreted this provision to nonetheless allow MA plans to charge cost-sharing for the first 20 days of SNF coverage, even though Traditional Medicare does not charge any cost-sharing for this period. “Note to: All Medicare Advantage Organizations,” p. 92.

<sup>38</sup> Also see “Improper Use of Advance Notices of Non-Coverage,” CMS Memo, May 5, 2014, available at [https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Improper\\_ABN\\_Us\\_e.pdf](https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Improper_ABN_Us_e.pdf).

<sup>39</sup> For purposes of determining whether a PFFS plan must establish a contracted network of providers, a “network area” generally refers to a plan service area in which at least 2 other network-based Medicare Advantage plans are offered. This usually means a coordinated care plan such as an HMO. If a PFFS plan is offered in a non-network area, plan enrollees can see any provider that is willing to accept the plan’s terms and conditions. See, e.g., *Medicare Managed Care Manual*, Ch. 16a, CMS, May 27, 2011, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16a.pdf>.

<sup>40</sup> See, generally, *Medicare Managed Care Manual*, Ch. 4 (Part II), CMS, revised August 23, 2013, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>. Also see “Medicare Marketing Guidelines,” CMS, revised June 26, 2014, available at <http://cms.hhs.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>; note that §60.4 states: “[MA] Plans must, and Part D Sponsors are expected to, make a good faith effort to provide written notice of termination of a contracted provider/pharmacy at least thirty (30) calendar days before the termination effective date to all members who regularly use the provider/pharmacy’s services. This is true whether the termination was for or without cause. When a contract termination involves a primary care professional, all members who are patients of that primary care professional must be notified.” This section goes on to note: “In instances where significant changes to the provider/pharmacy network occur, the organization must send a special mailing immediately. In general, plans can define “significant changes” when determining whether a special mailing is necessary. However, CMS may also determine if a mailing is needed and direct plans to conduct such a mailing.”

<sup>41</sup> See, e.g., *Medicare Managed Care Manual*, Ch. 2, §30.4.6 (updated 2014), available at <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY-2015-MA-Enrollment-and-Disenrollment-Guidance.pdf>.

<sup>42</sup> See “MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance,” CMS, available at <http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014-HSD-Provider-and-Facility-Specialties-Criteria-Guidancev2.pdf>.

<sup>41</sup> See, e.g., Medicare Managed Care Manual, Ch. 2, §30.4.6 (updated 2014), available at <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY-2015-MA-Enrollment-and-Disenrollment-Guidance.pdf>.

<sup>42</sup> See “MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance,” CMS, available at <http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014-HSD-Provider-and-Facility-Specialties-Criteria-Guidancev2.pdf>.

<sup>43</sup> “2015 Letter to Issuers in the Federally Facilitated Marketplaces,” CCIIO, CMS, March 14, 2014, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

<sup>44</sup> See MA required notices: “MA Denial Notices,” CMS, revised June 26, 2014, available at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html>; also see “Notices and Forms,” CMS, revised October 31, 2013, available at <http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html>.

<sup>45</sup> See, e.g., National Senior Citizens Law Center comments to DHHS Office of Civil Rights, September 30, 2013, available at <http://www.nsclc.org/wp-content/uploads/2013/10/LanguageAccessComments.pdf>. Note that CMS does provide a Spanish language Integrated Denial Notice for use by MA plans (see <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html>); also, for MA requirements re: providing Spanish language hospital discharge notices, see Medicare Managed Care Manual, Ch. 13, §150.6.1, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf>.

<sup>46</sup> Also see “Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes,” DOL, June 22, 2011, available at <http://www.dol.gov/ebsa/newsroom/tr11-02.html>.

<sup>47</sup> See Casework Guidance for Issuers in Federally-facilitated Marketplaces, including State Partnership Marketplaces, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/casework-guidance-03132014.pdf>

<sup>48</sup> “Medicare Marketing Guidelines,” CMS, revised June 26, 2014, available at <http://cms.hhs.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>.

<sup>49</sup> See “Information in other languages,” Medicare.gov, available at <http://medicare.gov/about-us/other-languages/information-in-other-languages.html>.

<sup>50</sup> Regarding the SHIP National Performance Reporting (NPR) system, see, e.g., “States,” CMS, revised January 8, 2014, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/States.html>.

<sup>51</sup> Supra at note 26.