VSP Vision care for life

J. Robinson Lynch
President & CEO

September 17, 2012

Kimberly Belshé
Diana S. Dooley, ex-officio
Paul Fearer
Susan Kennedy
Robert Ross, M.D.
California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, California 95814

RE: Petition to California Health Benefit Exchange Board to Agendize Action Item to Reconsider Authorization of Direct Offers of Vision Coverage by Stand-Alone Vision Plans in California

To the Members of the CHBE Board in Session:

As President and Chief Executive Officer of the nation's largest vision health care service plan, VSP Vision Care, and on behalf of our over 2,100 California employees, I urge the California Health Benefit Exchange (CHBE) Board – at its first available public proceeding - to reconsider, amend and revise its action of August 23, 2012, to exclude stand-alone vision plan health benefit offerings from the Individual purchaser exchange. The meeting record reflects that the vote to ratify staff and consultant recommendations to limit stand-alone vision plan benefit offerings to the Small-Employer Health Options Program (SHOP) exchange was, unfortunately, predicated on (a) a misreporting of purported "prohibitions" in federal law, and (b) a staff-level assumption that plans, such as VSP would be satisfied with participation solely in the small group SHOP exchange based on a poor understanding of our significant presence in the Individual and Voluntary purchaser marketplace.

VSP takes issue with the faulty premises for the staff and consultant recommendations – a position I communicated to the CHBE executive officer, and other staff, in a meeting last Thursday, September 13th. As an involved stakeholder, VSP has, both in writing and in public testimony before the Board as early as March 2012, refuted the notion that there are limitations on the CHBE including stand-alone vision plans in the Individual market exchange. In the early stages of exchange implementation around the U.S., only California has adopted this notion. States such as Massachusetts and Maryland decided exactly the opposite. That our headquarters state has reached this decision makes the Board action particularly dismaying.

Taking action to authorize direct offers of essential health benefit (EHB) pediatric vision and supplemental vision coverage in both the Individual and SHOP Exchanges in California is well within the scope and breadth of the broad discretion accorded the CHBE by the federal government to do so.

The federal Department of Health and Human Services has proposed that essential health benefits be defined by a benchmark plan selected by each State, reflecting both the scope and services offered by a "typical employer plan." As we have reported to the CHBE in writing, and in the abbreviated

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opportunities to testify before the Board, stand-alone vision coverage is not only typical, it is the predominant means in California, and nationally, by which vision services are offered in the employer-provided health benefit context. Was it this assessment, perhaps, that led to the staff assumption that VSP, and stand-alone vision plans generally, would be interested in only participating in the small-employer SHOP arena?

The current Board decision – which it has an opportunity to revisit and modify - has a particularly negative effect on the significant position in the individual purchaser marketplace earned by VSP. We are, in fact, the leading provider of vision care in the group purchaser marketplace, covering over 14.2 million Californians . That's one in every 3 in California, on top of our coverage of one in every six Americans – over 58 million lives. But, while our company is known for covering the employees of over 56 percent of Fortune 500 corporations, 87 percent of our purchasers of care are employers with under 5,000 employees, and a remarkable 56 percent of our purchasers employ fewer than 50 employees. We cover 700,000 lives – a full 80 percent of enrollees – in the Healthy Families individual purchaser program established for the working uninsured in California. And, we deliver eyecare to 73 percent of the nearly 8 million current enrollees in Medi-Cal.

VSP is a 501(c)(4), not-for-profit, managed care company. We are one of the original Knox-Keene licensees in California. We believe VSP should be regarded as exemplary of the type of plan to be included in Exchange offerings.

We recognize the Exchange has an enormous job in implementing health care reform in California. But, if expanding access to health care for those presently without care is its true mission, then actions by the California Exchange should not disenfranchise a California-headquartered health care business that (1) works through nearly 5,000 independent, California eye doctors, (2) in over 6,400 locations statewide, that, (3) as measured by Health Resources and Services Administration (HRSA) federal standards measuring access to care providers, has 99.7% of all Californians living fewer than 30 miles from one of its doctors!

Overall, the exclusion of stand-alone vision plans such as VSP will negatively impact continuity of care coverage and will generate consumer confusion. It will result in unwarranted market segmentation and coverage gaps.

The request conveyed by this petition is a matter of the highest priority for VSP. We need to know if the current exclusion will be revisited, soon, particularly in light of the pending Board action to proceed with health plan solicitations. We at VSP await a decision on this request.

Sincerely,

J. Robinson Lynch
President and CEO
VSP Global

VSP
Vision care for life

J. Robinson Lynch
President & CEO

VSP and other Stand-Alone Vision plans seek CHBE staff recommendation to the Board for action to authorize direct offers of EHB pediatric vision and supplemental vision coverage in both the Individual and SHOP Exchanges in California.

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VSP® Global Family of Companies
Impact on Economy in California

Employees
VSP Global employs nearly 5,000 employees worldwide, including more than 2,100 employees in Sacramento. Payroll in California last year totaled $133 million.

Taxes and Fees
VSP is a tax paying not-for-profit organization. In California, we average the following tax payments each year:

- Sales tax - $2.3 million
- Income taxes - $2 million
- Property taxes - $1.1 million

Knox-Keene fees (health care fees) average $3.3 million per year.

Administrative Expenses
VSP Vision Care's administrative expenses total more than $300 million annually in California.

VSP Doctors and Labs
In the last twelve months, VSP has paid 4.7 million member claims, resulting in payments to California doctors totaling more than $481 million and payments to California labs of $135 million.

Charity Outreach
To date, through VSP community outreach programs such as VSP Mobile Eyes and Sight for Students, and through relationships including those with the American Red Cross and Prevent Blindness America, VSP has invested more than $147 million in free eyecare and eyewear for close to 780,000 adults and children in need throughout the United States.

In California alone, more than 170 charitable outreach events have been held, helping over 11,000 people, and more than 167,000 gift certificates have been utilized resulting in VSP payments to doctors of more than $32 million. Partners for charity outreach have included:

Children's Health Initiative	Prevent Blindness
Hmong Women's Heritage Association	Delancey Street
Northern California Diabetic Retinopathy	CareNow
Sacramento Cancer Coalition	Salvation Army
Sacramento Community Veterans Alliance	Green Dot Schools
Asian Community Center	United Farm Workers
Sacramento County Farm Bureau	Glendale Healthy Kids
Sacramento Convey of Hope	Aerospace Museum of CA
Golden 1	Lions Clubs
UC Berkeley College of Optometry	SCCO
Western University of Health Sciences	Loaves and Fishes
Santa Clara County Optometric Society	Head Start
National Association of School Nurses	YMCA
National Council of La Raza	Boys & Girls Clubs
California Health Corp	Sacramento Kings
National Assoc. of Community Health Centers	Illumination Foundation

Charitable Donations

VSP also supports charitable organizations through a variety of ways including monetary donations and paid employee time off to volunteer in the community. In 2010 and 2011, monetary donations in California totaled $260,000.

Sacramento Kings Sponsorship

In 2011, VSP made a $1 million commitment to support the Sacramento community and to help keep the Kings in Sacramento. This significant financial contribution played a huge role in supporting Sacramento Mayor Johnson's efforts to keep the team in this city. This strategic commitment was made to support the Sacramento region and support a world-class region with world-class amenities—key components to attracting talent and other global headquarters to the Sacramento area.

Support for Small Businesses

VSP Vision Care supports small business owners by working through more than 5,000 private practice California eye doctors in more than 6,400 locations statewide.

Al Schubert
Vice President
Managed Care & Health Policy

March 9, 2012

Peter V. Lee
Executive Director
California Health Benefit Exchange
2535 Capitol Oaks Drive Suite 120
Sacramento CA 95833

RE: Recommendations to the California Health Benefit Exchange

Dear Mr. Lee:

Vision Service Plan ("VSP") appreciates the opportunity to provide comments to the California Health Benefit Exchange. VSP's comments answer a number of the requested stakeholder questions and focus on including stand-alone vision plans in the California Health Benefit Exchange ("Exchange") in order to meet the pediatric vision care component of the essential health benefits package ("EHBP").

VSP is the nation's largest provider of eye care coverage with more than 55 years of experience in the eye care field. VSP provides vision benefits on a not-for-profit basis through a national network of independent private-practice eye doctors. VSP currently covers 57 million individuals, or one in every six Americans, and it provides eye health benefits for more than 39,800 employer clients. While VSP is known for covering 56% of Fortune 500 corporations, 87% of VSP clients are employers that have less than 5,000 employees and 56% of VSP clients have less than 50 employees. VSP clients include federal, state and local government employers, as well as private employers.

VSP is a not-for-profit 501(c)4 corporation and one of the original Knox-Keene licensees in California. VSP covers 38%[1] of the State of California's population through 10,853 employer contracts. VSP's largest commercial clients in the state include Apple Computer, Google, Oracle, Cisco Systems, Facebook, Los Angeles Unified School District, The University of California and Cal State systems, CalPERS, State of California employees, CCPOA, Disney Worldwide and Northrup Grumman. VSP covers approximately 73% of all Medi-Cal participants and 80% of all participants in Healthy Families. Our network includes 4,643 eye doctors in 6,420 locations statewide. Using the HRSA definition of Medically Underserved Areas and Populations (MUA/P) and the federal standard of 1 provider in 30 miles, VSP access to the MUA/P standard in California is 99.7%[2]

[1] VSP covers 13.5 million Californians overall, which includes California residents whose employer is based outside of California. DMHC data confirms VSP covers 9.3 million residents from employer contracts domiciled in the State.
[2] VSP access to the MUA/P standard in California using a standard of two (2) providers in 30 miles is 99.5%

SUMMARY

Today, 93% of Californians with vision coverage have comprehensive coverage, including an exam and eye glasses or contact lenses, provided through a stand-alone vision plan. Preserving the ability of Californians to obtain vision services through stand-alone vision plans by allowing such plans to be offered in the California Health Benefit Exchange in order to provide required pediatric vision benefits is essential for the following reasons:

- Providing continuity of coverage and reducing consumer confusion, as the Exchange becomes effective. As referenced above, 93% of Californians with vision coverage today currently receive their comprehensive eye coverage through a stand-alone vision plan. Thus, maintaining stand-alone coverage as an option that is familiar to Californians is also likely to provide the smoothest transition to the Exchange. This will also avoid confusion as Californians transition to receiving coverage through the Exchange and get used to moving through transitory eligibility for various medical assistance programs.

- Avoiding market segmentation and gaps in coverage. The vision coverage market today is based on family coverage. Failure to allow stand-alone vision coverage in the California Health Benefit Exchange is likely to bifurcate vision coverage between adults and children, resulting in market disruption, possible loss of coverage and the reduction of coverage choices.

- Fostering wellness and the early detection of chronic diseases. Independent research has shown that individuals with stand-alone vision coverage are far more likely to obtain regular comprehensive eye exams, not only leading to better vision health but early detection of chronic diseases such as diabetes and hypertension. A comprehensive eye examination as the minimum benefit affords the ability for VSP member doctors to diagnose chronic conditions. This will save the State of California precious resources downstream.

- Satisfying the statutory requirements for the essential health benefits package (EHBP). ACA grants the Secretary of Health and Human Services the authority to determine the details of the EHBP, with the proviso that it is to be consistent with the "typical" employer plan. According to The Center for Consumer Information and Insurance Oversight's (CCIIO) Essential Health Benefits Bulletin[3] ("Bulletin"), the federal Department of Health and Human Services intends to propose that the EHB be defined by a benchmark plan selected by each State. The bulletin further refers to the selected benchmark plan reflecting both the scope and services offered by a "typical employer plan." Stand-alone vision coverage is not only typical, but the predominant method of providing vision care in the employer context. Thus, the statutory provisions relating to the EHB support allowing required pediatric vision benefits to be provided through stand-alone coverage.

[3] Center for Consumer Information and Insurance Oversight: "Essential Health Benefits Bulletin"; December, 16, 2011.

- States have the option of developing additional criteria or selectively contracting. This authority allows states such as California to go above and beyond ACA minimum essential health benefit standards in order to provide consumers with the most effective and efficient care available. Stand-alone vision plans such as VSP are uniquely qualified to meet the vision care needs of individuals in the Exchange as demonstrated above. The approximate worth of continuity of care, primary eye care prevention and reduced chronic conditions is invaluable.

- Saving valuable health care dollars through early chronic disease detection. Research[4] has indicated that persons with stand-alone vision coverage are two times as likely to utilize their benefit and obtain regular eye examinations and preventive services. This allows eye doctors to not only diagnose and prevent eye conditions, but also conditions such as type 2 diabetes and hypertension.

For the reasons stated above and discussed in further detail below, VSP strongly advocates for the inclusion of stand-alone vision plans in the California Health Benefits Exchange in order to, at a minimum, meet the pediatric vision care component of the EHBP.

DISCUSSION

The Benefits of Stand-Alone Vision Coverage Currently Received by Californians Should Be Preserved by Providing that Stand-Alone Vision Coverage Offered in the California Health Benefit Exchange Will Qualify as Meeting the Pediatric Vision Component of The Essential Health Benefits Package

Allowing stand-alone vision coverage to be offered in the Exchange will provide continuity of coverage as the Exchange becomes effective and reduce consumer confusion.

ACA seeks to enhance continuity of care through the establishment of the Exchanges. The Proposed Regulations reflect efforts to ensure that the transition to Exchanges is smooth and, in particular, include rules to "reduce potential consumer confusion, while maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market."[5] With respect to vision coverage, this goal is best met by preserving stand-alone vision benefits as a coverage option within and outside of the Exchange. As indicated above, vision coverage today and particularly in California, is overwhelmingly provided through stand-alone plans. An independent study (the "NAVCP Study")[6] found that stand-alone vision plans deliver 84% of all vision care benefits in the United States, and 87% of comprehensive vision coverage (i.e., coverage that includes materials, such as eye glasses or contact lenses, as

[4] The study was conducted by the National Association of Vision Care Plans (NAVCP). Information regarding the study (the "NAVCP Study") may be found on their website at http://navcp.org/documents/NAVCP_PressRelease_FINAL.pdf.

[5] 76 Fed Reg at 41901.

[6] See footnote 6, NAVCP Study.

well as eye exams). This is consistent with VSP's own experience, which indicates that approximately 90% of vision coverage in the US and 93% in California is provided on a stand-alone basis. These numbers alone lead to the result that "maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market" with respect to vision care means preserving stand-alone vision coverage.

Further, because stand-alone coverage is predominant today, consumers in California are very familiar with selecting vision coverage on a stand-alone basis along with major medical coverage. Over time, systems have developed that simplify enrollee choices with respect to vision coverage provided separately from a major medical plan. VSP has consistently worked with many employers and insurers to make choices simple. For example, in a typical employer context where enrollment is accomplished on-line, the employee sees an online screen that describes the available options and features by type, e.g., major medical, vision, dental, including the employee premiums based on the type of coverage (including whether self-only or family), and allows the employee to select coverage. Such programs will automatically adjust to reflect options selected, so that the consumer easily knows how different choices may affect premiums. These systems have also produced detailed pricing programs so that, for example, if an employer varies the employee premium based on the number of individuals covered by a plan, the pricing for each additional person is known. Such systems take a complex process and make it simple for beneficiaries. Consequently, we request that QHP's be required to separately price vision benefits, so as to assure simple navigation, continuity of care and easier benefits decisions for enrollees in the California Health Benefits Exchange.

A good example of how this works in a large exchange-type marketplace is the Federal Employees Dental and Vision Insurance Plan (FEDVIP) within the Federal Employee Health Benefits Plan (FEHBP, as identified in the recent HHS bulletin as a 'benchmark plan'.). Since 2006, federal employees have been able to select a vision and/or dental plan from multiple providers, and by law make that selection apart from the provider of their major medical plan. VSP has been the one stand-alone option available to FEDVIP participants, along with two major medical-based vision care plans. The BENEFEDS™ website at OPM that is used to enroll participants is a simple, straightforward process that allows participants to compare options based on price, benefit level and coverage type. In the private employer marketplace, systems are widely available that enable employers to simplify even more complex contribution, employer subsidy and tax treatment arrangements. It's our recommendation that the California Health Benefits Exchange require a similar construct in the interest of engagement with Exchange participants.

VSP already provides services to 73% of Medi-Cal beneficiaries in the State of California with several million more in Medicaid nationwide. Our wealth of experience with Medi-Cal, CHIP, Medicare, Commercial systems and populations will be invaluable in transitioning individuals between the various coverage arenas.

Allowing stand-alone vision coverage to be offered in Exchanges will avoid market segmentation and gaps in coverage.

Just as health care needs vary, vision coverage needs vary as well. Allowing stand-alone vision plans to satisfy the EHBP within the Exchange will help prevent gaps in coverage with

respect to vision care and tend to increase coverage, by providing individuals with a broader range of choices with respect to their vision coverage. For example, as a not-for-profit stand-alone plan, VSP has been able to develop the industry's broadest provider network, which expands access and choices for patients, and to develop other innovations, such as a nation-wide health information technology platform that improves efficiency and provides important clinical data for chronic disease management and prevention. Again, these innovations are a result of being a stand-alone vision plan and the unique expertise that is developed through a sole commitment to eye care.

In contrast, failure to recognize the importance of stand-alone vision plans is likely to be disruptive to the market and reduce competition. If only bundled eye coverage is permitted to satisfy the EHBP, myriad issues may ensue. A major concern is that the EHBP only calls for pediatric vision coverage. This creates quite an issue for families. If stand-alone vision coverage is not preserved, major medical plans may choose to only offer the required pediatric coverage in the Exchange. In that case, some adults who currently have stand-alone vision coverage may drop vision coverage entirely. In addition, those adults who do not have vision coverage currently may be even less likely to choose to obtain vision coverage if they must do so separately from their children. Additionally, parents will be faced with the dilemma of looking outside of the Exchange for comprehensive family vision coverage, if stand-alone coverage is not offered. In this instance, parents may be forced to seek coverage for themselves outside of the Exchange, while their children are covered under an Exchange plan, resulting in the bifurcation and segmentation of a market which has traditionally been based on family coverage. Either or both of these scenarios could result if only bundled eye coverage is permitted to satisfy the EHBP, and either or both will have the effect of disrupting what today is an innovative and expanding market, including the reduction of available plans and options, negative price impacts, and reductions in network and provider availability, competition and innovation.[7]

Stand-alone vision coverage leads not only to better vision health but also to early detection of chronic diseases compared to vision coverage that is bundled as part of a major medical plan.

The NAVCP Study[8] indicates that the value of stand-alone vision care include wellness benefits and the early recognition of chronic diseases. The study found that persons with stand-alone vision coverage (as compared to coverage bundled in a major medical plan) were twice as likely to obtain regular eye health examinations and preventive services, allowing for early diagnosis and prevention of eye conditions, as well as chronic conditions such as type 2 diabetes and hypertension.[9] This is in large part because the stand-alone vision coverage is focused on a

[7] Further complications will ensue if similar requirements do not apply both inside and outside Exchanges. ACA contemplates continued employer coverage and the ability to obtain coverage both inside and outside Exchanges. It is likely that individuals will move in and out of Exchange-based coverage from time to time, such as if the individual changes jobs, leaves or re-enters the work force, has an eligibility change/qualifying event or moves geographically. Such moves necessitate parallels between coverage inside and outside the Exchanges in order to provide options to individuals as well as consistent pricing structures. In order to provide a smooth transition from the current health care system to that contemplated by heath care reform, as well as to provide for a long-term sustainable health care system, the continued role of stand-alone vision coverage should be preserved as an option both inside and outside Exchanges.

[8] See footnote 6, NAVCP Study.

[9] *Ibid.*

particular benefit. Stand-alone plans are thus naturally encouraged to focus on providing and demonstrating value for the beneficiary and differentiating themselves from their vision plan peers. Further, the study found that children whose parents have stand-alone vision coverage are more than twice as likely to receive eye care, compared to children with parents in bundled plans.

Early diagnosis of such chronic diseases benefit the individual and the health care system in California as a whole. These benefits may be reduced if only embedded coverage is permitted. The National Association of School Nurses has recognized the importance of stand-alone vision plans in promoting primary eye care for children to aid in early learning. The California Optometric Association has also gone on record in support of Stand-Alone vision plans being able to offer vision care directly through the California Health Benefit Exchange.[10]

Meanwhile, VSP's own data has demonstrated to its clients and to its network of providers how important the company's efforts have been to require providers to check for early signs of certain chronic diseases, such as diabetic retinopathy, an early indicator of pre-diabetes and diabetes. This can be detected via a dilated retinal exam, a test that provides a unique, non-invasive view of a patient's vascular health via retinal capillaries. An eye doctor can detect diabetic retinopathy up to seven years prior to the onset of external symptoms of diabetes. Thus, it is important that adults continue to have easy access to eye care coverage and that coverage be at minimum, a comprehensive eye examination. Precluding stand-alone vision plans in the Exchange or inhibiting coverage provided outside the Exchange will be counterproductive, because the resulting bifurcation or other market and coverage disruptions will reduce the likelihood that adults will obtain comprehensive eye coverage.

The most logical reading of the statutory requirements relating to the EHBP supports allowing stand-alone vision to be offered in Exchanges.

Building upon the ACA, the authority it provides to the states and the 10 general categories it calls for within the EHBP, the CCIIO Bulletin states, "that EHB be defined by a benchmark plan selected by each State."[11] It continues, "The selected benchmark plan would serve as a reference plan, reflecting... a 'typical employer plan.'"[12] Benchmark plans that do not include coverage of all 10 categories of benefits defined by the ACA, must supplement their coverage with that of others. In the instance of pediatric vision care, the Bulletin specifically states, "For pediatric vision services we intend to propose the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment."[13] VSP has been the one stand-alone vision plan option through FEDVIP since 2006.

The NAVCP Study clearly demonstrates that stand-alone vision coverage is not merely "typical," but by far the favored means by which vision coverage is offered in the employer market today. We also note the Institute of Medicine (IOM) report on criteria to be used in determining the essential health benefits package. The IOM report focuses on the typical

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[10] See California Optometric Association (COA) press release: *California Optometric Association Pledges Support for Stand-Alone Vision Plans* - dated, February 13, 2012 at http://www.coavision.org/i4a/pages/index.cfm?pageID=3480

[11] See footnote 3, Bulletin pg 8.

[12] *Ibid.*

[13] See footnote 3, Bulletin, pg 11.

employer plan in the small employer group market. We note, however, that the IOM report indicates that both dental and vision pediatric benefits, when offered under a small employer plan, are typically offered as separate policy riders, rather than imbedded in the major medical plan.[14] Therefore, requiring QHPs to cover pediatric vision services as part of a "major medical" plan would not reflect the "typical employer plan," as called for by the statute. In fact, stand-alone vision plans initially developed here in California from an absence of or deficiencies in major medical coverage for primary vision services. As a result, stand-alone plans, led by VSP, have developed robust provider networks, care integration, chronic disease screening and diagnosis, and vision health awareness.

CONCLUSION

The federal Essential Health Benefits Bulletin and the California Health Benefit Exchange Act expressly empower the head of the Exchange with respect to various aspects of the Exchange and QHPs, including a broad grant of authority to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

VSP requests that the Executive Director exercise the authority granted under the federal Essential Health Benefits Bulletin and the California Health Benefit Exchange Act to allow stand-alone vision benefits to be offered both within and outside of the California Health Benefit Exchange if the vision plan furnishes at a minimum the required pediatric vision benefit.

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VSP appreciates the opportunity to comment. We would be happy to answer any questions you may have. Please feel free to contact me should you have any questions or comments regarding these comments and the issues raised herein.

Sincerely,

Al Schubert
Vice President, Managed Care and Health Policy
VSP Vision Care

[14] See, for example, page 5-3 of the IOM report ("Essential Health Benefits – Balancing Coverage and Cost"), prepublication copy, which is available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

VSP Vision Care, Inc
California Membership Statistics

VSP Covered Membership in California:	**14,203,621**
Number of Employers with VSP in California:	**11,111**

Employer/Membership by Size	**# Employers**	**CA Membership**
≤ 50 ees	7,175	275,681
≤ 100 ees	8,475	485,428
> 50 ees	3,936	9,796,540
> 100 ees	2,636	9,586,793
Overall Voluntary – Individual Selection Employers:	1,779	2,506,039
Healthplan Membership:	26 plans	4,127,779
Individual Plan Membership:		20,632

Specific Voluntary
- Individual Selection Plans:

MetLife/Safeguard Vision (administered by VSP)	210,000
CalPERS State Annuitants	135,577
FEDVIP	68,931

Notable Government Sponsored Plans in CA:

Medi-Cal	3,102,307
Healthy Families/CHIP	685,815
State of California Employees	402,280
Medicare	202,004

Overall CA Satisfaction with VSP (2012 YTD):

Top 3 Tiers – Excellent, Very Good, Good:	100%
Top 2 Tiers – Excellent, Very Good:	94%

Annualized Persistency (Renewal) ratio (2011 EOY): 98.3%

VSP Choice Program

VSP Promise
Committed to Eye Health & Wellness
100% Satisfaction Guaranteed
Hassle-free Experience
Privacy & Security
Industry Benchmark of Quality

Choice & Convenience
Unrestricted Benefits
Open Access to Any Eyecare Location
Choice of Any Eyewear Brand
Retail & Medical Office Locations

Service
50+ Years of Experience
Dedicated Client Account Teams
Operational Stability
World Class Call Center
IVR Available 24/7
Online Client Resources & Tools
Member Communications Support

VSP Preferred Providers
47,000 Access Points Nationwide
6.445 Access Points in CA
One-Stop Shopping
Evening & Weekend Hours
Average 21 Years in Practice

Enhanced Benefits
Eye Health Management Program®
Discounts on Lens Options
Discounts on Laser Vision Correction & Additional Glasses
Contact Lens Special Offers

Vision Plan Options for Individual & SHOP Exchanges

Plan Coverage Through a VSP Doctor		Open Access (Out of Network) Reimbursement Schedule	
WellVision Exam®	Covered in full after copay	**Eye Exam**	$45
Covered Lens		**Covered Lens**	
Single Vision Lens	Covered in full after copay	Single Vision Lens	$30
Bifocal Lens	Covered in full after copay	Bifocal Lens	$50
Trifocal Lens	Covered in full after copay	Trifocal Lens	$65
Frame	**Up to $120 or $150**	**Frame**	**$70**
	OR		**OR**
Elective Contacts	**Up to $120 or $150**	**Elective Contacts**	**$105**
Value Added Discounts Through a VSP Doctor		**Value Added Discounts (Out of network)**	
Glasses	20% off the amount over your allowance	N/A	
Lens Options	20-25% Average savings on all non-covered lens options		
Sunglasses	20% Discount		
Contacts	15% Discount off Fitting and Evaluation		
TruHearing (Hearing Aid Benefit)	25% Average Discount		
Laser Vision Care	15% Average Discount		

MOST POPULAR VISION PLAN OPTIONS AND PRICING RANGES

Copayments	Plan Frequency Exam/Lens/Frame	Allowances Frame/Contact Lens
1.) $10 Exam/$20 Material	12/12/12	$120/$120
2.) $10 Total Copayment	12/12/12	$150/$150
3.) $10 Exam/$25 Material	12/12/24	$120/$120
4.) $10 Total Copayment	12/12/24	$120/$120

Per participant pricing ranges from $2.25 to $10.50 per month depending on coverage selections and assumes less than 25% contribution toward coverage. Examination only (no hardware) coverage (every 12 months) ranges from $0.85 - $1.30 per participant.

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A vote to limit health choices

CEO of VSP Global decries state health exchange's decision to limit access to stand-alone vision plans

On August 23rd, the California Health Benefits Exchange board voted to exclude stand-alone vision plans from offering coverage in the California Health Benefits Individual exchange. The reasons given were that these plans are "not allowed" to participate and because of administrative complexity and cost.

This means that consumers who will be accessing vision care through the California exchange will be limited to vision plans associated with medical plans only - something that United Healthcare and Kaiser, who own their own vision plans, lobbied hard to achieve. This also means that our company, VSP Vision Care, a national stand-alone not-for-profit vision plan headquartered here in Sacramento, will not be able to directly compete in the California Exchange.

Needless to say, we are dismayed and disappointed that our home state did not see the importance of choice to consumers or supporting a business that was started here 57 years ago and has grown into the largest health insurer as ranked by the number of members covered – more than 58 million people.

What's even more inconceivable is that in California, VSP is also the largest insurer by membership – larger than Anthem Blue Cross, Kaiser and Blue Shield combined with 14.3 million Californian's covered by our company. Department of Managed Health Care data confirms that 93 percent of vision care coverage is provided through stand-alone plans like VSP. This was accomplished by VSP directly competing with other stand-alone vision plans as well as plans owned by medical insurers.

So, why did the health exchange board decide to exclude one of the state's largest providers? The organization's staff report to the board indicated that stand-alone vision plans are not allowed – which is simply not true. While they were left out of the Affordable Care Act, the U.S. Department of Health and Human Services issued guidance to states that specifically left open the question of including stand-alone vision plans.

As a result, other states – such as Maryland – have included stand-alone vision plans in their state exchanges. Many more are moving forward to do the same: For example, the Massachusetts Health Connector, arguably the longest running exchange program, is adding stand-alone vision and dental options. Why? Because its leaders have come to the realization that it will make their exchange more attractive and cost effective.

VSP has grown by having the ability to openly compete in the marketplace. As a not-for-profit health plan we provide coverage to Medi-Cal, Medicare, CHIP and Healthy Families participants on a cost effective and non-discriminatory basis.

Like other successful California companies, we have been heavily solicited to relocate out of state with incentives and subsidies. Choice is important in the marketplace. California has chosen not to support one of its own home-grown successful businesses, with 2,000 employees in California.

Maybe it's time for us to choose to go where we are wanted.

Rob Lynch is president and CEO of VSP Global.

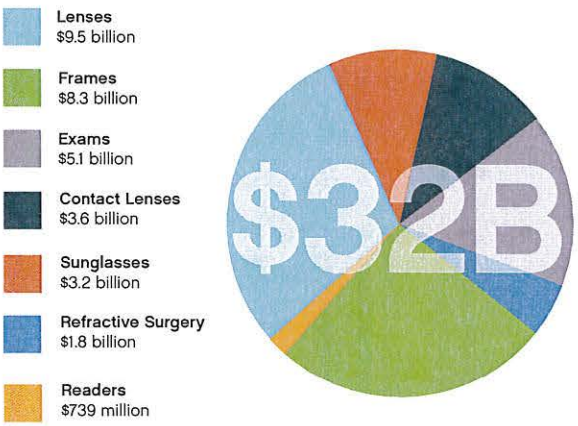
Vision Care by the Numbers

Size of the Optical Market

These charts demonstrate the size of the optical market, both from an insurance coverage and a revenue perspective.

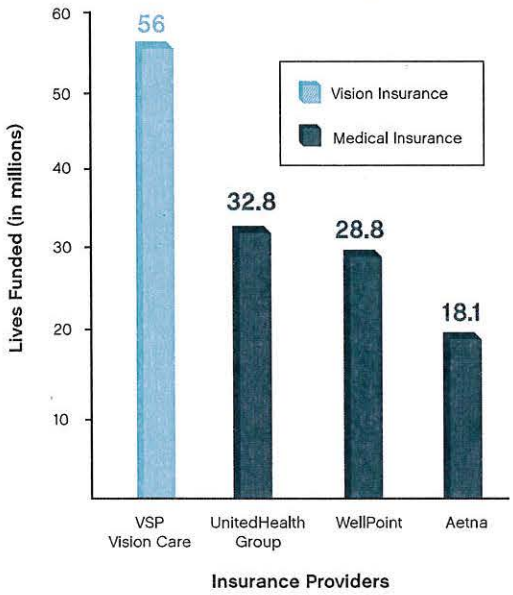
- The **Total Optical Market** breaks out the $32 billion annual revenue for the optical market by category.
- The **Vision Care vs. Medical Care Membership** compares the size of the largest vision care plan with the largest medical care plans.
- The **Vision Care Coverage Overview** shows the number of members with a vision care plan for each insurance company.

Total Optical Market[1]

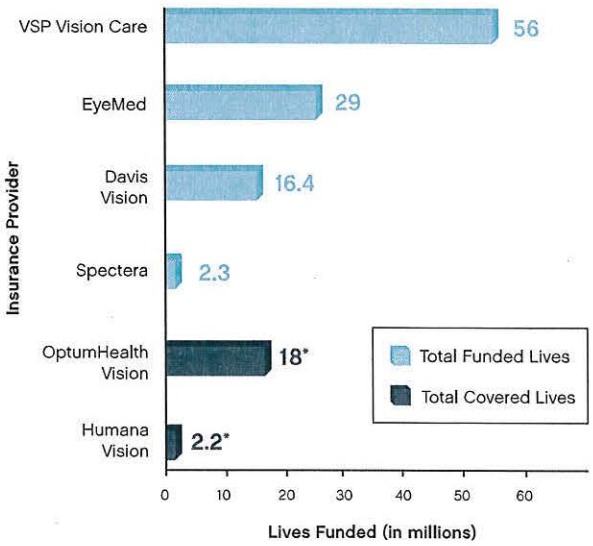


Vision care plans offer coverage for each category listed, except for over-the-counter readers.

Vision Care vs. Medical Care Membership



Vision Care Coverage Overview



*Number includes both paid members and individuals who get limited benefits through third party memberships like AAA.

Source:
[1]VisionWatch, a study conducted by The Vision Council, 12ME June 2011

Vision Care by the Numbers

Private Practices vs. Chain/Retail Providers

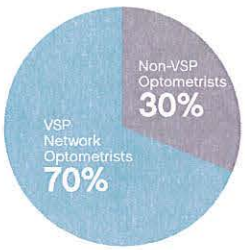
Private-practice Doctors

Private-practice doctors are small-business owners. They have a vested interest in making sure their patients get exceptional care and return for future visits. Their focus is on total eye health and wellness, not just selling glasses and contacts.

Corporate-owned Chains

Corporate-owned chains employ eye doctors and opticians. They have a higher staff turnover rate than private-practice offices, and can be accountable to shareholders for their profits.

- 28,000 VSP® private-practice eyecare providers
- 2,900 EyeMed/Luxottica-associated chains
  (LensCrafters, Pearle Vision, Target Optical, Sears Optical, JC Penney Optical, etc.)
- 540 Davis Vision chains
  (EyeMasters, Visionworks, Vision World, Empire Vision Centers, etc.)



The VSP network represents 70% of all optometrists in the U.S.

Jobs in the Optical Industry

More than 118,000 eyecare professionals work in the U.S. This group of professionals includes optometrists, ophthalmologists, and opticians.

34,800 Optometrists[2]

Optometrists are regular eyecare doctors. They examine your eyes, decide if you need eyeglasses or contacts, and make sure your eyes are healthy. They also provide medical care for your eyes.

59,800 Opticians[2]

Opticians help you decide what kind of glasses to choose and what type of corrective lenses you might need.

23,861 Ophthalmologists[3]

Ophthalmologists are doctors who specialize in surgery and advanced medical care for your eyes. An optometrist will send you to an ophthalmologist if surgery or advanced medical care is needed.

Eye Exams Decrease Medical Costs

Eye Exam Frequency

People are more likely to receive an eye exam than a preventive health exam, especially when they have vision care coverage.

- 44% – adults in U.S. with eye exam in last 12 months[4]
- 21% – adults in U.S. who get preventive health exams[5]
- 61% – adults in U.S. with vision coverage who get annual eye exams[6]

Healthcare Costs[7]

Eye exams provide a means for the early detection of chronic diseases.

- Over two years, for every $1 employers spend on eye exam services, they recoup $1.27, thanks to early disease detection.
- VSP Providers detect signs of certain chronic conditions before any other healthcare provider.
  - 65% high cholesterol
  - 20% diabetes
  - 30% hypertension
- Patients with early detection of chronic diseases enter the healthcare system with fewer complications and comorbidities, and experience lower rates of emergency room visits and hospital admissions.
- VSP clients saved $4.5 billion over a two-year period on healthcare costs due to the early detection of chronic diseases through a comprehensive eye exam.

Sources:
[2]Bureau of Labor Statistics
[3]American Academy of Opthalmology
[4]VisionWatch, a study conducted by the Vision Council, 12ME June 2011.
[5]Preventive Health Examinations and Preventive Gynecological Examinations in the United States, Archives of Internal Medicine
[6]VSP internal data.
[7]Human Capital Management Services (HCMS) Study, 2011

JOB#7630CL 10/11

Massachusetts
Connector Exchange Amendment
(Acts of 2012)

Chapter 118 of the Acts of 2012

Massachusetts law enabling stand-alone vision plans:

SECTION 39. Said section 1 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the definition of "Rating factor" the following 2 definitions:-

"Stand-alone dental plan", a nonprofit dental service plan offered by a licensed dental service corporation, as those terms are defined in section 1 of chapter 176E, offered independently of a health benefit plan offered through the connector or offered by: (i) an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; (ii) a nonprofit hospital service corporation organized under chapter 176A; or (iii) a nonprofit medical service corporation organized under chapter 176B.

"Stand-alone vision plan", a nonprofit optometric service plan offered by a licensed optometric service corporation, as those terms are defined in section 1 of chapter 176F, offered independently of a health benefit plan offered through the connector or offered by: (i) an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; (ii) a nonprofit hospital service corporation organized under chapter 176A; or (iii) a nonprofit medical service corporation organized under chapter 176B.

SECTION 45. Section 4 of said chapter 176Q, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The connector shall only offer health benefit plans or stand-alone vision or stand-alone dental plans to eligible individuals, eligible children and eligible small groups. Subconnectors may offer all health benefit plans that the connector may offer, including all health benefit plans offered through the commonwealth care health insurance program.

SECTION 46. Section 5 of said chapter 176Q, as so appearing, is hereby amended by inserting after the word "plans", in line 1, the following words:- and stand-alone vision or stand-alone dental plans.

SECTION 47. Said section 5 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the word "plan", in lines 4 and 7, each time it appears, the following words:- or stand-alone vision or stand-alone dental plans.

SECTION 47A. Said section 5 of said chapter 176Q, as so appearing, is hereby further amended by striking out, in line 11, the word "Plans" and inserting in place thereof the following words:- "Health plans".

SECTION 48. Said chapter 176Q is hereby further amended by striking out sections 10 and 11, as so appearing, and inserting in place thereof the following 2 sections:-

Section 10. The connector seal of approval shall be assigned to health benefit plans or stand-alone vision or stand-alone dental plans, as applicable, that the board determines: (i) meet the requirements of subsection (d) of section 5; (ii) provide good value to consumer; (iii) offer high quality; and (iv) are offered through the connector.

Section 11. When an eligible individual, eligible child or eligible small group is enrolled in the connector by a producer licensed in the commonwealth, the health plan or stand-alone vision or stand-alone dental plan chosen by each eligible individual, eligible child or eligible small group shall pay the producer a commission that shall be determined by

the board. In setting the commission for health plans, the board of the connector shall consider rates of commissions paid to producers for health plans issued under chapter 176J as of January 1, 2006.

SECTION 49. Section 12 of said chapter 176Q, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The connector may apply a surcharge to all health benefit plans or stand-alone vision or stand-alone dental plans which shall be used only to pay for administrative and operational expenses of the connector; provided, however, that any such surcharge shall be applied uniformly to all health benefit plans or uniformly to all stand-alone vision or stand-alone dental plans offered through the connector and subconnectors; and provided further, that a subconnector may charge an additional fee to be used only to pay for additional administrative and operational expenses of the subconnector. The surcharges shall not be used to pay any premium assistance payments under the commonwealth care health insurance program under chapter 118H.

Maryland
Health Benefit Exchange
Act of 2012

As it relates to
Stand-Alone Vision Plans

MARYLAND HEALTH BENEFIT EXCHANGE ACT OF 2012
O'MALLEY-BROWN ADMINISTRATION – HOUSE BILL 443

Maryland's Health Benefit Exchange will make health insurance affordable and accessible to thousands of Marylanders for the first time. The Exchange will be a fair, transparent marketplace that provides individuals and small businesses one-stop comparison shopping for affordable insurance options. Private insurers will offer competitive plans, allowing consumers to compare rates, benefits, and quality to find coverage that best suits their needs. The Exchange will help low-income Marylanders find out whether they are eligible for Medicaid or federal subsidies to buy private plans, and it will support small business access to affordable coverage.

2012 EXCHANGE LEGISLATION

The Maryland Health Benefit Exchange Act of 2012 takes the next important step in establishing Maryland's Exchange, which must be certified as operational by January 1, 2013. The legislation builds upon the success of the State's existing health insurance markets, and puts in place policy recommendations developed by the Exchange Board with the guidance of expert consultants and a broad-based stakeholder advisory process. It continues the State's step-by-step approach to development of the Exchange, ensuring that Maryland stays on track to meet federal deadlines and remains a national leader in bringing Marylanders the full benefit of federal health care reform through effective and deliberative implementation.

Exchange's Operating Model

- The Exchange may establish standards, like promoting wellness or ensuring continuity of care for people when they change plans, beyond minimum requirements of the Affordable Care Act (ACA).
- The Exchange will allow any plan that meets standards to be offered during the first two years of operation.
- Beginning in 2016, the Exchange may use contracting strategies like competitive bidding or negotiation with carriers to begin to achieve the critical objectives of reducing costs and enhancing the quality of health care. Prior to employing any alternative contracting strategies, the Exchange must submit its plan between December 1 and the beginning of the legislative session to the Finance and Health and Government Operations committees for 90-day review and comment.

Design of Small Business Health Options Program (SHOP) Exchange: The Exchange will serve both individual consumers and small businesses seeking to offer health insurance to their employees. The SHOP Exchange will be the market for small businesses.

- The SHOP Exchange will be separate from the Individual Exchange and will serve businesses with up to 50 employees. In 2016, it will expand to serve businesses with 50-100 employees.
- The SHOP Exchange will allow employers to offer insurance in two ways: 1) employer picks carrier and menu of plans offered by that carrier from which employees can choose; or 2) employer picks coverage level (platinum, gold, silver, and bronze), and employees choose plan from any carrier at that level (ACA-mandated option). Any changes in the options through which employers may offer insurance must be made by regulation.

Outreach and Consumer Assistance – "Navigator" Programs: The Exchange will conduct outreach and consumer assistance through its navigator programs. These programs will use workers and organizations engaged by the Exchange, or "navigators," as well as independent insurance producers, to make sure individuals and businesses learn about the Exchange and are able to take advantage of the insurance plans, financial assistance, and Medicaid enrollment services it offers. The SHOP and Individual Exchanges will have separate navigator programs.

- *SHOP Exchange*: Producers may obtain authorization and training to sell plans in the Exchange and be paid commissions by carriers as they do now; SHOP navigators will obtain a special navigator license issued by the Insurance Commissioner.

- *Individual Exchange*: Producers may obtain authorization and training to sell plans in the Exchange and be paid commissions by carriers as they do now. Navigators will obtain training and certification from the Exchange to conduct activities related directly to the enrollment of individuals in qualified health plans, subject to the regulatory authority of the Commissioner. General education, outreach, and eligibility determinations for Medicaid and premium subsidies will not require certification, and the Exchange may contract with entities to conduct the full scope or a subset of all the activities required of the navigator program.

Dental and Vision plans: The Exchange will offer adult dental and vision benefits in addition to the pediatric benefits required by the ACA, and will allow carriers to offer them as stand-alone plans, as an endorsement to, or in conjunction with medical plans. The Exchange will determine whether medical, dental, and vision plans sold in conjunction with one another must also be sold separately, and will also determine, with respect to all ways in which plans are offered and sold, the standards for disclosure of price.

Essential Health Benefits: Beginning in 2014, all health insurance plans sold inside and outside health benefit exchanges must cover "essential health benefits." For an initial 2-year transition period, the federal government will allow states to select the benefits offered by an existing "benchmark" private insurance plan to be their essential health benefits. Each state must choose its benchmark from among 10 eligible plans by September 30, 2012. Maryland's Health Care Reform Coordinating Council, with its bi-partisan legislative and executive branch membership, will conduct an inclusive, public stakeholder process and select Maryland's benchmark plan by the federal deadline.

Risk adjustment and reinsurance programs: The Exchange will implement programs in accordance with federal regulations to protect against potentially destabilizing adverse selection, where risk is spread inadequately because certain plans have a higher concentration of the healthier, lower-cost populations. It should strongly consider using the federal risk adjustment model initially, and then conduct a study to determine whether a different model would be more effective. The Exchange is directed also to study whether it should employ strategies to mitigate the impact of MHIP enrollees entering the individual market, and whether Maryland should develop its own reinsurance program after the federal program sunsets.

Fraud, waste and abuse detection and prevention program: The Exchange will establish a comprehensive program and submit it to legislative committees for review and comment.

Market rules: Any carrier above a certain market share threshold which sells health insurance in the State must also sell qualified health plans in the Exchange. The threshold is $20 million in premiums for the small group market, and $10 million for the individual market. In addition, any carrier selling a catastrophic health plan in the State must also sell one in the Exchange regardless of market share. The Insurance Commissioner may alter the amount of the premium threshold by regulation.

Exchange Financing: Maryland has received over $34 million in federal grants to fund the development of the Exchange, and it will receive another influx of federal dollars this year to support its operations through 2014. The ACA requires that it then be self-sustaining by 2015, and the Exchange has conducted an initial study of how best to achieve this goal. A joint executive-legislative committee will conduct further study of the specific financing mechanisms which would be most appropriate and effective, considering a range of options from broad-based assessments to narrower transactional fees.

Scope of Exchange's authority and interstate contracting: The Exchange may sell only qualified health, dental, and vision plans, not ancillary products like life or car insurance. The Exchange may enter into agreements with other states to promote the interests of the State and the Exchange, like facilitating consistency in plans across borders.

HOUSE BILL 443

C3 2lr0129
CF SB 238

By: **The Speaker (By Request – Administration) and Delegates Barnes, Gaines, Griffith, Hammen, Haynes, Hucker, Jones, Morhaim, Pena-Melnyk, Pendergrass, Proctor, V. Turner, ~~and Waldstreicher~~ Waldstreicher, Hubbard, Reznik, A. Kelly, Oaks, Donoghue, Nathan-Pulliam, Cullison, and Murphy**

Introduced and read first time: February 1, 2012
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted with floor amendments
Read second time: March 20, 2012

CHAPTER _____

AN ACT concerning

Maryland Health Benefit Exchange Act of 2012

FOR the purpose of requiring the Board of Trustees of the Maryland Health Benefit Exchange, subject to a certain waiver, to submit certain regulations to certain legislative committees under certain circumstances; requiring the Board to have a certain number of standing advisory committees; requiring the Maryland Health Benefit Exchange to make certain qualified dental plans and qualified vision plans available to certain individuals and employers in a certain manner and on or before a certain date; requiring the Exchange, to the extent necessary, to modify a certain format to accommodate differences in certain plan options; requiring the Exchange to establish and implement certain navigator programs; prohibiting the Exchange from making available any vision plan that is not a qualified vision plan; authorizing the Exchange to enter into certain agreements or memoranda of understanding with another state under certain circumstances; requiring the Exchange to seek to achieve a certain enrollment and ~~use a certain market impact to pursue certain objectives~~ decrease the number of State residents without health insurance coverage; authorizing the Exchange to employ certain alternative contracting options and active purchasing strategies under certain circumstances and for a certain purpose; requiring certain participation requirements for certain carriers to be suspended under certain circumstances; requiring the Exchange, before

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike-out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit–only insurance;

(vii) coverage for on–site medical clinics; or

(viii) other similar insurance coverage, specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;

(ii) benefits for long–term care, nursing home care, home health care, community–based care, or any combination of these benefits; or

(iii) such other similar limited benefits as are specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether the benefits are provided under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental insurance (as defined under § 1882(g)(1) of the Social Security Act);

(3) AUTHORIZE THE EXCHANGE TO OFFER ANY PRODUCTS OR SERVICES EXCEPT QUALIFIED HEALTH PLANS ~~OR~~, QUALIFIED DENTAL PLANS, AND QUALIFIED VISION PLANS.

31–106.

(c) **(1)** In addition to the powers set forth elsewhere in this title, the Board may:

[(1)**]** **(I)** adopt and alter an official seal;

[(2)**]** **(II)** sue, be sued, plead, and be impleaded;

[(3)**]** **(III)** adopt bylaws, rules, and policies;

[(4)**]** **(IV)** **SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION,** adopt regulations to carry out this title:

[(i)**]** **1.** in accordance with Title 10, Subtitle 1 of the State Government Article; and

[(ii)**]** **2.** without conflicting with or preventing application of regulations adopted by the Secretary under Title 1, Subtitle D of the Affordable Care Act;

[(5)**]** **(V)** maintain an office at the place designated by the Board;

[(6)**]** **(VI)** enter into any agreements or contracts and execute the instruments necessary or convenient to manage its own affairs and carry out the purposes of this title;

[(7)**]** **(VII)** apply for and receive grants, contracts, or other public or private funding; and

[(8)**]** **(VIII)** do all things necessary or convenient to carry out the powers granted by this title.

(2) UNLESS WAIVED BY THE CHAIRS OF THE COMMITTEES, AT LEAST 30 DAYS BEFORE SUBMITTING ANY PROPOSED REGULATION TO THE MARYLAND REGISTER FOR PUBLICATION, THE BOARD SHALL SUBMIT THE PROPOSED REGULATION TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE.

(g) To carry out the purposes of this title, the Board shall:

(3) ALLOW A CARRIER TO OFFER A QUALIFIED VISION PLAN THROUGH THE EXCHANGE THAT PROVIDES LIMITED SCOPE VISION BENEFITS THAT MEET THE REQUIREMENTS OF § 9832(C)(2)(A) OF THE INTERNAL REVENUE CODE, EITHER SEPARATELY, IN CONJUNCTION WITH, OR AS AN ENDORSEMENT TO A QUALIFIED HEALTH PLAN, PROVIDED THAT THE QUALIFIED HEALTH PLAN PROVIDES PEDIATRIC VISION BENEFITS THAT MEET THE REQUIREMENTS OF § 1302(B)(1)(J) OF THE AFFORDABLE CARE ACT;

~~(3)~~ (4) CONSISTENT WITH THE GUIDELINES DEVELOPED BY THE SECRETARY UNDER § 1311(C) OF THE AFFORDABLE CARE ACT, implement procedures for the certification, recertification, and decertification of:

(I) health benefit plans as qualified health plans ~~AND~~;

(II) DENTAL PLANS AS QUALIFIED DENTAL PLANS~~, consistent with guidelines developed by the Secretary under § 1311(c) of the Affordable Care Act~~; AND

(III) VISION PLANS AS QUALIFIED VISION PLANS;

~~(4)~~ (5) provide for the operation of a toll–free telephone hotline to respond to requests for assistance;

~~(5)~~ (6) provide for initial, annual, and special enrollment periods, in accordance with guidelines adopted by the Secretary under § 1311(c)(6) of the Affordable Care Act;

~~(6)~~ (7) maintain a Web site through which enrollees and prospective enrollees of qualified ~~health plans AND QUALIFIED DENTAL~~ PLANS may obtain standardized comparative information on qualified health plans ~~and~~, qualified dental plans, AND QUALIFIED VISION PLANS;

~~(7)~~ (8) with respect to each qualified ~~health PLAN AND QUALIFIED DENTAL~~ plan offered through the Exchange:

(i) assign a rating [for] TO each qualified ~~health PLAN AND QUALIFIED DENTAL~~ plan in accordance with the criteria developed by the Secretary under § 1311(c)(3) of the Affordable Care Act and any additional criteria that may be applicable under the laws of the State and regulations adopted by the Exchange under this title; and

(ii) determine each qualified health plan's [level of] coverage ~~LEVELS~~ LEVEL in accordance with regulations adopted by the Secretary under §

(2) obtain prior approval of premium rates and contract language from the Commissioner;

(3) except as provided in subsection (d) of this section, provide at least a bronze level of coverage, as defined in the Affordable Care Act and determined by the Exchange under § 31–108(b)(7)(ii) of this title;

(4) (i) ensure that its cost–sharing requirements do not exceed the limits established under § 1302(c)(1) of the Affordable Care Act; and

(ii) if the health benefit plan is offered through the SHOP Exchange, ensure that the health benefit plan's deductible does not exceed the limits established under § 1302(c)(2) of the Affordable Care Act;

(5) be offered by a carrier that:

(i) is licensed and in good standing to offer health insurance coverage in the State;

(ii) if the carrier participates in the **INDIVIDUAL** Exchange's individual market, offers at least one qualified health plan at the silver level and one at the gold level in the individual market outside the Exchange;

(iii) if the carrier participates in the SHOP Exchange, offers at least one qualified health plan at the silver level and one at the gold level in the small group market outside the SHOP Exchange;

(iv) charges the same premium rate for each qualified health plan regardless of whether the qualified health plan is offered through the Exchange, through an insurance producer outside the Exchange, or directly from a carrier;

(v) does not charge any cancellation fees or penalties in violation of § 31–108(c) of this title; and

(vi) complies with the regulations adopted by the Secretary under § 1311(d) of the Affordable Care Act and by the Exchange under § 31–106(c)(4) of this title;

(6) meet the requirements for certification established under the regulations adopted by:

(i) the Secretary under § 1311(c)(1) of the Affordable Care Act, including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health plan performance; and

(II) ESTABLISH ADDITIONAL REQUIREMENTS FOR QUALIFIED DENTAL PLANS IN CONJUNCTION WITH ITS ESTABLISHMENT OF ADDITIONAL REQUIREMENTS FOR QUALIFIED HEALTH PLANS UNDER SUBSECTION (B)(9) OF THIS SECTION.

(I) (1) EXCEPT AS PROVIDED IN PARAGRAPHS (2) THROUGH (5) OF THIS SUBSECTION, THE REQUIREMENTS APPLICABLE TO QUALIFIED HEALTH PLANS UNDER THIS TITLE ALSO SHALL APPLY TO QUALIFIED VISION PLANS TO THE EXTENT RELEVANT, WHETHER OFFERED IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO QUALIFIED HEALTH PLANS OR AS STAND–ALONE VISION PLANS.

(2) A CARRIER OFFERING A QUALIFIED VISION PLAN SHALL BE LICENSED TO OFFER VISION COVERAGE BUT NEED NOT BE LICENSED TO OFFER OTHER HEALTH BENEFITS.

(3) A QUALIFIED VISION PLAN SHALL:

(I) BE LIMITED TO VISION AND EYE HEALTH BENEFITS, WITHOUT SUBSTANTIAL DUPLICATION OF OTHER BENEFITS TYPICALLY OFFERED BY HEALTH BENEFIT PLANS WITHOUT VISION COVERAGE; AND

(II) INCLUDE AT A MINIMUM:

1. THE ESSENTIAL PEDIATRIC VISION BENEFITS REQUIRED BY THE SECRETARY UNDER § 1302(B)(1)(J) OF THE AFFORDABLE CARE ACT; AND

2. OTHER VISION BENEFITS REQUIRED BY THE SECRETARY OR THE EXCHANGE.

(4) (I) THE EXCHANGE MAY DETERMINE:

1. THE MANNER IN WHICH CARRIERS MUST DISCLOSE THE PRICE OF VISION BENEFITS AND, TO THE EXTENT RELEVANT, MEDICAL BENEFITS, WHEN OFFERED:

A. TO THE EXTENT PERMITTED BY THE EXCHANGE, IN A QUALIFIED HEALTH PLAN;

B. IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO A QUALIFIED HEALTH PLAN; OR