CONNECTICUT HEALTH INSURANCE EXCHANGE
dba
Access Health CT

AMENDMENT TO:
Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges

Original Release Date: December 13, 2012

Standard Plan Designs Release Date: March 22, 2013

Corrected Standard Plan Designs Date: March 25, 2013 – Posted March 27, 2013

QHP Amendment Release Date: March 27, 2013
This Amendment revises the document titled, “Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges” that was posted on the Connecticut Health Insurance Exchange (Exchange) website on December 13, 2012. In brief, the revisions include but are not limited to; general information, the QHP process and timetable, an increase in the number of non-standard plan designs an Issuer may offer, a replacement of the catastrophic plan design with a bronze plan design option and embedding of the pediatric dental coverage in the medical plan.

**Section I. General Information and Background:** The following sub-sections of Section I. General Information and Background have been revised as follows:

**Sub-Section D Solicitation Process and Timetable** is deleted and replaced with the following Section D Qualified Health Plan (QHP) Solicitation Process.

**REPLACEMENT:** Sub-Section D Qualified Health Plan (QHP) Solicitation Process. The following schedule represents pertinent dates necessary for the certification of a QHP(s):

<table>
<thead>
<tr>
<th>Action</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Release of Initial QHP and Stand-alone Dental Solicitation</td>
<td>December 13, 2012</td>
</tr>
<tr>
<td>Notice of Intent (NOI) Released (Non-Binding)</td>
<td>December 13, 2012</td>
</tr>
<tr>
<td>Notice of Intent (NOI) Due (Non-Binding)</td>
<td>January 4, 2013</td>
</tr>
<tr>
<td>Non-Binding Notice of Intent to Submit Qualified Health Plans Reposted to Exchange Website (revised for clarity)</td>
<td>February 15, 2013</td>
</tr>
<tr>
<td>Release of Standard Plan Summaries</td>
<td>March 22, 2013</td>
</tr>
<tr>
<td>Amendment to the Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges.</td>
<td>March 27, 2013</td>
</tr>
<tr>
<td>Inquiries from Issuers on the QHP Solicitation</td>
<td>April 1, 2013</td>
</tr>
<tr>
<td>Filings due to Connecticut Insurance Department (CID): Evidence of Coverage (EOC), Schedule of Benefits (SB), Rates*</td>
<td>April 1, 2013</td>
</tr>
<tr>
<td>Responses to Issuer Questions on the Solicitation due from Exchange</td>
<td>April 12, 2013</td>
</tr>
<tr>
<td>Draft QHP Application Sent to Responders of Non-Binding Notice of Intent</td>
<td>April 5, 2013</td>
</tr>
<tr>
<td>Draft Contract Sent to Responders of Non-Binding Notice of Intent</td>
<td>April 5, 2013</td>
</tr>
<tr>
<td>Carrier Question Period on Draft Application and Draft Contract Due to Exchange</td>
<td>April 19, 2013</td>
</tr>
<tr>
<td>Exchange Responses to Draft QHP Application and Contract</td>
<td>April 30, 2013</td>
</tr>
<tr>
<td>*Benefit form and rate filings will be reviewed by the CID in the order the filings are received at the Department.</td>
<td>First filing - in - first filing out</td>
</tr>
<tr>
<td>QHP Application Due to Exchange (commitment by Issuer to sell)</td>
<td>May 15, 2013</td>
</tr>
</tbody>
</table>

03/27/13 Amendment to the Initial Solicitation dated 12/13/12
<table>
<thead>
<tr>
<th>Action</th>
<th>Due Date</th>
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<tbody>
<tr>
<td>products on the Exchange.</td>
<td></td>
</tr>
<tr>
<td>CID Approvals Required</td>
<td>July 30, 2013</td>
</tr>
<tr>
<td>Certification of QHPs</td>
<td>July 31, 2013 – August 14, 2013</td>
</tr>
<tr>
<td>Issuer Review of Plan Data to be Published via Exchange</td>
<td>August 15, 2013</td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>October 1, 2013 – March 31, 2014</td>
</tr>
</tbody>
</table>

**REVISED: Sub-Section E. Notice of Intent (Pre-Requisite)**

Sub – Section E. Notice of Intent (Pre-Requisite) was revised to reflect the following:

Sub-Section E. Notice of Intent (Pre-Requisite). The Notice of Intent was revised to state the notice does not contractually bind an issuer to join the Exchange. The notice has been re-posted to the Exchange website.

**REVISED: Sub-Section F. Exchange Contact for Solicitation**

Please submit any questions or comments concerning this Amendment to:

- **Name:** Margo Lachowicz, Project Assistant
- **E-Mail:** CTHIX-Issuers@ct.gov
- **Mailing Address:**
  Connecticut Health Insurance Exchange
dba Access Health CT
280 Trumbull Street
Hartford, CT 06103
- **Phone:** (860) 757-5305
- **Fax:** (860) 757-5330

**REPLACEMENT: Sub-Section G. Certification, Recertification and Decertification**

Sub-Section G. Certification, Recertification and Decertification is deleted and replaced as follows:

Sub-Section G. Recertification and Decertification: The processes for recertification and decertification will be postponed until the fourth quarter of 2013 or first quarter of 2014. A specific procedure for recertification and decertification will be developed in compliance with
CGS §121 and CGS §38a-1082 and §1086, and 45 CFR 155 & 156 regarding certification and recertification standards and the decertification process for QHPs as each may be amended from time to time.

Both the recertification and decertification of a QHP will be based on the QHP certification standards or requirements. The recertification process for QHPs must be completed on or before September 15th in advance of the next plan year. For example, for plan year 2015 recertification must be complete by September 15, 2014. Details on the process will be posted on the Exchange website and sent to each individual Issuer who has been certified by the Exchange.

REPLACEMENT: Sub-Section H. Amendments to the Solicitation

Sub-Section H. Amendments to the Solicitation is deleted and rewritten as follows:

This Amendment will be posted on the Exchange website at www.accesshealthct.com as well as electronically transmitted to each Issuer who submitted a Non-Binding Notice of Intent To Submit Qualified Health Plans.

The Exchange will provide information to the Issuers on:

- the enrollment and eligibility process,
- detailed enrollment and disenrollment information,
- enrollees electronically through the 834 transactions,
- the number of plan design offerings per carrier (standard plan designs versus optional plan designs, embedded pediatric dental benefits),
- the benchmark plan selected,
- Advanced Payment Tax Credits (APTC);
- Cost Sharing Reductions (CSR), and
- NCQA accreditation requirements.

II. Application Components and Certification Requirements

REPLACEMENT Sub-Section A. Issuer General Information

This section is deleted and replaced with the following:

Issuer Information The QHP application will request the name and address of the legal entity that has obtained the Certificate of Authority to offer health insurance policies in the State of Connecticut. This information must match the information on file with the Connecticut Insurance Department (CID).

Issuer Management The QHP Application will request the contact information for the individuals in Senior Management responsible for the small group health insurance market, the individual health insurance market or both markets for which the QHP response is being submitted. The contact information for the following individuals in Senior Management is requested:
Primary Contact. The QHP Application will request the contact information of the individual or individuals assigned as the primary contact(s) to the Exchange business, including an Issuer’s QHP(s).

The following Sub-Section QHP Issuer Compliance and Oversight is added to Sub Section A. Issuer General Information

ADDED: QHP Issuer Compliance and Oversight

The Exchange will request the Issuer submit a compliance plan as part of the QHP Application. The compliance plan is intended to document the Issuer’s efforts to ensure that appropriate policies and processes are in place to maintain adherence with Federal and State law as well as to prevent fraud, waste and abuse. Further, the Issuer will provide attestation language as follows or similar to:

- Applicant attests that its compliance plan adheres to all applicable laws, regulations, and guidance and that the compliance plan is implemented or ready to be implemented.

The following sections have been deleted and replaced:

REPLACEMENT: Sub-section B. Administrative Management

The Issuer will be required to manage and resource the Exchange product portfolio and membership in the same manner as the non-Exchange product portfolio and membership. The Applicant will attest that the Issuer is capable of managing the Exchange business and will provide attestation language as follows or similar to:

- Applicant has and will maintain appropriate staffing, administrative capacity, and qualified management to effectively manage all QHPs offered by Applicant through the Exchange.

REPLACEMENT: Sub-Section C. Licensure and Financial Condition
A QHP Issuer must be licensed and in good standing to offer health insurance coverage in each state in which the Issuer offers health insurance coverage. Please refer to the citation 45 CFR Part 156.200 (b)(4) QHP Issuer Participation Requirements.

The licensing of Issuers and the determination of good standing are functions maintained, monitored and performed by the CID. The Department will continue to perform these tasks. The Applicant will be required to attest to licensure and good standing and will provide attestation language as follows or similar to:

- Applicant attests the company is licensed and in good standing to offer health insurance coverage in Connecticut.

**REPLACEMENT: Sub-Section D. Market Participation**

- An Issuer may elect to participate in either the Individual Exchange or the Small Business Health Options Program (SHOP) Exchange or both.

- Issuers who meet the certification standards will be granted a two-year certification for its QHPs. Certified Issuers will not need to reapply to be certified for 2015.

- The Exchange does not anticipate conducting a full solicitation process in 2014 for the 2015 calendar year, however, allowances will be made for newly licensed Issuers that wish to participate on the Exchange, and may be made for existing carriers that did not submit a Non-Binding Notice of Intent initially for the 2014 year. Any such certification would be strictly for one year.

- If a certified QHP Issuer ceases participation in the Exchange, the Issuer will be denied re-entry to the Exchange for a minimum two (2) years. The Exchange will develop an Issuer appeal process for an Issuer to dispute the re-entry timeframe.

- All benefit form filings and rate filings will need to be prior approved by the CID, in accordance with state and federal law.

- If an Issuer participates in the SHOP, Employers will have the option of choosing between three coverage models for their employees:
  
  - One Tier, Multiple Issuers (Employee Choice): an employer selects a benchmark plan and employees have the option to either pick the benchmark plan or use the employer’s contribution to select another QHP within the benchmark’s metal tier.
  
  - One Issuer, Multiple Plans (Employer Choice): an employer selects a benchmark plan and then offers a choice of QHP options exclusive to the Issuer of the benchmark plan.

  - One Carrier, One Plan (Sole Source): an employer will select a benchmark plan and provide the option for employees to either select or reject enrollment in the benchmark plan.
REPLACEMENT: Sub-Section E. Enrollee Materials and Marketing and Initiatives

The following sections have been deleted and replaced:

Issuers will be required to submit to the Exchange:

- **Evidence of Coverage (EOC):** the document(s) approved by the CID for each QHP product the Issuer intends to offer on the Exchange for sale (PPO, HMO, POS); and,

- **Schedule of Benefits (SOB):** the documents approved by the CID for each unique offering that depicts the cost-sharing for each metal tier.

The EOC and SOB should be combined in a portable document format (PDF) and submitted through the SERFF application. The SOB should be reported first. The reason for this requested formatted approach is to enhance the consumer shopping experience permitting the consumer to more easily review the cost sharing and contract by company and plan design.

- **Summary of Benefits and Coverage (SBC):** provide the SBC for each plan design or metal tier including each of the coverage examples defined by HHS for each QHP offered through the Exchange. The Exchange expects to access this information via a link or URL from the Issuer through the SERFF application on the Federal templates.

- **Company LOGO:** provide an electronic image of the Issuer’s logo in order to differentiate the Issuer’s products for display on the Exchange shopping screens.

REPLACEMENT: Sub Section F. - Cost-Sharing, Plan Benefits and Rates

This sub- section title has been revised to Sub-Section F. Federal Data Templates, Cost-Sharing, Plan Benefits and Rates.

ADDED The following information is added to Sub-Section F. Federal Data Templates, Cost-Sharing, Plan Benefits and Rates

The standard Federal data templates must be completed and submitted via the System for Electronic Rate and Form Filing (SERFF). The templates listed below illustrate the data requirements for an Issuer to obtain QHP Certification for each plan design intended for sale on the Exchange. The templates are located on the SERFF website and contain Issuer and Plan information required to effectively evaluate the Issuers QHP submissions.

**System for Electronic Rate and Form Filings (SERFF)** The data templates can be found on the SERFF website [http://www.serff.com/plan_management_data_templates.htm](http://www.serff.com/plan_management_data_templates.htm). The Exchange intends to extract information from these Templates to optimize the consumer shopping experience screens.

**Templates:**
• **Administrative Data** - General Company Contact Information.

• **Essential Community Providers (ECP)** - Federally Qualified Health Centers (FQHC)-Identifying information for ECP’s included in network.

• **Plans and Benefits Template & Add-In** – Plan and Benefit Data.

• **Prescription Drug Formulary Template** - Prescription drug benefit information and formulary information

• **Network Template** - Provider network information /Provides URL to company directory.

• **Service Area Template** - Geographic service area information.

• **Rates Table Template** – Premium information by Plan for each age band.

• **Business Rules Template** - Supporting business rules.

• **NCQA / URAC Template** - Accreditation Information. We will be obtaining information from NCQA for 2014.

• **Uniform Rate Review- Data for market-wide rate review** – This template is not used for Plan Management. The template includes some Issuer information to support rating development; and may be used by the CID.

**REPLACEMENT** Sub-section of **Sub-Section F, Federal Data Templates, Cost-Sharing, Plan Benefits and Rates** has been revised as follows:

• **Rates**: The rate filings must be approved prior to use by the CID. The CID is responsible for reviewing and approving any rate or rate increases. The Exchange will not duplicate the rate review process and will rely on the justifications submitted to the CID through the established rate review process. The Exchange will post on its website the Issuer’s published justification for its rate increases.

• **Essential Health Benefits**: the QHP must include at a minimum the Connecticut-specific EHB. No substitution of actuarially equivalent benefits will be allowed. (See Attachment 3 from the Initial Solicitation Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges dated December 13, 2012 for Connecticut’s Essential Health Benefits).
REPLACEMENT: Sub-Section G. Rating Factors is deleted and replaced as follows:

- **Age rating factors** will be the same for the individual and small group market and in accordance with the uniform age rating curve established by HHS.

- **Geography.** Statewide coverage is not a prerequisite to certification, but a QHP will need to cover an entire rating area as defined by the CID. See Bulletin HC-91 released March 25, 2013 by the CID.

- **Tobacco:** Issuers are prohibited from using tobacco use as a rating factor in the Small Group market in accordance with CGA§38a -567. The Exchange is also not permitted tobacco rating in the individual market for 2014.

REPLACEMENT: Sub-Section H. Wellness Incentives is deleted and replaced as follows:

- The Exchange encourages Issuers to offer both “participatory wellness programs” and health–contingent wellness programs as described in 45 CFR Parts 146 and 147. See FR Vol. 77 No 227 issued November 26, 2012/proposed rules.

REPLACEMENT: I. Sub-Section I. Number & Mix of QHPs is deleted and replaced as follows:

Please refer to Exhibits labeled #1 -8. Each Exhibit provides a complete plan design view of the cost sharing parameters for the In-Network and Out of Network portion of the plan design by metal level. These are samples only and illustrative in nature to assist Issuers with the benefit and cost-sharing parameters for each Standard plan design. Each example includes the benefits and cost-sharing to comply with federal and state law.

- To participate in the Individual Exchange, a QHP Issuer’s application must include, the following standard plans:

**Individual Exchange**

<table>
<thead>
<tr>
<th>Exhibit #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibit #1</td>
<td>Standard Plan -Silver - 72% <strong>The Standard Silver plan must be the lowest cost Silver plan in the individual market.</strong></td>
</tr>
<tr>
<td>Exhibit #2</td>
<td>Standard Plan -Silver CSR – 73.8% Plan reflects federal cost sharing reduction subsidies for individuals between 200% &amp; 250% of FPL.</td>
</tr>
<tr>
<td>Exhibit #</td>
<td>Description</td>
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<tr>
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<tr>
<td>Exhibit # 3</td>
<td>Standard Plan -Silver CSR – 87.8% Plan reflects federal cost sharing reduction subsidies for individuals between 150% &amp; 250% of FPL.</td>
</tr>
<tr>
<td>Exhibit # 4</td>
<td>Standard Plan -Silver CSR – 93.3% Plan reflects federal cost sharing reduction subsidies for individuals between 100% &amp; 150% FPL.</td>
</tr>
<tr>
<td>Exhibit # 5</td>
<td>Standard Plan - Gold – 81.6%</td>
</tr>
<tr>
<td>Exhibit # 6</td>
<td>Standard Plan -Platinum – 91.8% Please note: There is no requirement to offer a Platinum plan. If an Issuer decides to offer a non-standard Platinum plan, the Standard Platinum Plan must also be offered.</td>
</tr>
<tr>
<td>Exhibit # 7</td>
<td>Standard Plan -Bronze-1– 61.6%</td>
</tr>
<tr>
<td>Exhibit # 8</td>
<td>Standard Plan –Bronze / Catastrophic look alike</td>
</tr>
</tbody>
</table>

In addition, if an Issuer is participating in the Individual Exchange that Issuer must offer the following:

- **Child Only**: As outlined in the Federal Register Vol. 77, No.59, Tuesday March 27, 2012 Pg., 18415, CMS clarifies that a QHP issuer could satisfy the child-only plan by offering a single QHP to qualified applicants seeking child only coverage as long as the QHP includes rating for child-only coverage in accordance with applicable premium rating rules.

- **American Indians**: Two (2) zero cost-sharing alternatives for each QHP to reflect federal cost sharing reduction subsidies for American Indians. There must be one alternative that offers zero cost-sharing for American Indians under 300% of the FPL; and one alternative that offers zero cost-sharing for American Indians regardless of income for any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe,
Tribal Organization, or Urban Indian Organization or through referral under contract health services.

A QHP Issuer participating in the Individual Exchange may opt to submit non-standard individual plan designs that demonstrate meaningful difference from the standard plan design options.

- One Standard Platinum Plan an up to (2) Non-Standard Platinum Plan
- Two Gold Non-Standard Gold Plans
- Two Silver Non-Standard Silver Plans
- Two Bronze Non-Standard Plans

If an Issuer decides to offer a non-standard Platinum plan, the Issuer must also offer the Standard Platinum Plan.

**I. Sub-Section I. Number & Mix of QHP** (continued)

**Small Business Health Options Program (SHOP)** To participate in the SHOP Exchange, a QHP Issuer’s application must include the same standard plan designs indicated in Exhibits #1-#8 and the **The Standard Silver plan must be the lowest cost Silver plan in the SHOP market.**

In addition, a QHP Issuer may opt to submit non-standard plan designs that demonstrate meaningful difference from the standard plan design options.

- One Standard Platinum Plan and up to (2) Non-Standard Platinum Plan
- Two Non-Standard Gold Plans
- Two Non-Standard Silver Plans
  - For each of its non-standard silver plans, the Issuer must submit three variations of the silver plan.
- Two Non-Standard Bronze Plans

Examples of **meaningful plan design differences** include but are not limited to:

- Plan design has a different payment structure (co-payment versus co-insurance)
- Deductible and maximum out-of-pocket (OOP) differences:
  - Medical deductible difference of $50 when the two potential QHPs have otherwise identical cost sharing and nearly identical covered benefits.
  - Pharmacy deductible difference of $50 or more
  - Maximum OOP difference of $100 when the two potential QHPs have otherwise identical cost sharing and nearly identical covered benefits
  - Plans have different care management (e.g. gatekeeper model; patient centered medical home; community health teams; wellness programs.
  - Plans reflect different product offering (e.g. HMO, POS, PPO, ACO).
**REPLACEMENT: Sub-Section J. NCQA Accreditation.** This sub-section is deleted and replaced as follows:

- The Exchange will accept NCQA or URAC as the accrediting entities. The accreditation must cover the Issuer’s Connecticut operations.

- If the QHP Issuer is already NCQA accredited, the Issuer must have its Exchange product accredited within one year of the time of the application. This can include the NCQA Exchange Add-On Survey.

- There will be a one-year grace period for compliance for plans that are not accredited at the time of application. For QHPs within the grace period, an attestation that the plan has applied for accreditation and an updated application status will be required. Because of the reliance the CID will be placing on accreditation to assure adequacy of coverage offered by Issuer and QHPs, additional quality information may be required of Issuers in the grace period that have not yet obtained their accreditation.

- In future solicitations, the Exchange may inform Issuers of additional quality and Accreditation-related requirements believed to add valuable information to consumers’ enrollment process. Issuers will be given sufficient time to meet new requirements.

- By the end of 2016, a QHP Issuer’s Exchange product must have accreditation that includes performance measures.

- The QHP Applicant must authorize the release of its accreditation data from the accrediting entity to the Exchange.

- The QHP Applicant understands and acknowledges that for Issuers with an NCQA accreditation, the Exchange will convert its NCQA quality ratings to a star system with excellent represented as 4 stars; commendable represented as 3 stars; accredited represented as 2 stars; and provisional represented as 1 star.

- The QHP Applicant must authorize the release of its CAHPS accreditation data for its accredited commercial product lines when existing CAHPS data is available for the same QHP product types and adult/child populations.

**REPLACEMENT: Sub-Section K. Reporting Requirements, Quality Improvement Strategies, Transparency and Performance Information and Pharmacy Utilization.**
• Issuers will be required to report to the Exchange upon Connecticut-specific “quality information” to satisfy ACA quality reporting requirements.

• Issuers will be required to use the enrollee satisfaction survey system developed by the HHS and report results to the Exchange.

• For all data reporting requirements, the Issuers must use specific data formats, definitions, or frequency of reporting defined by HHS. If federal standards are not defined or if flexibility is left to the states to define the requirements, then the Exchange will work with the Issuers to define specific reporting requirements and standards.

• The performance information requirement of this section will be included in the attestation language of the application. The Exchange will monitor QHP reporting against this requirement.

• As part of the Issuers Application, Issuers will be required to provide the following to the Exchange:
  o CAPHS data for product most comparable to submitted QHP;
  o NCQA rating in the five core areas (i.e. “Access and Service,” “Qualified Providers,” “Staying Healthy,” “Getting Better” and “Living with Illness”) for NCQA-accredited product most comparable to submitted QHP;
  o Medical Loss Ratio (MLR) for the most recent year and projected MLR for 2014, for the individual and small-group market;
  o Quality Improvement Strategy. The Exchange expects a written narrative outlining how the Issuer will attempt to better coordinate care, control costs, improve chronic illness management, reduce medical error, promote health care delivery and payment reform for the benefit of the consumer.

The QHP Application will require the following or similar attestation language:

• The Applicant attests that the company currently has in place, a quality improvement strategy consistent with the standards of Section 1311(g) of the ACA.

• The Applicant attests that the information on health care quality and outcomes as described in Section 399JJ of the Public Health Service Act will be disclosed to the Exchange.

• The Applicant will report to HHS and the Exchange at least annually, the pediatric quality reporting measures described in Section 1139A of the Social Security Act.

• The Applicant attests that an enrollee will require satisfaction surveys consistent with the requirements of section 1311(c) of the ACA.

**REVISION Sub – Section L, Issuer and QHP Quality Rating** is revised as follows:
Sub – Section L. Issuer and QHP Quality Rating.

- The Exchange will develop a quality rating and performance metric that will relate quality of health care to price per Actuarial Value (AV) tier.
- The Exchange will use the quality and performance information requested in Section J and Section K of this Solicitation to implement and maintain a quality rating system developed by the Exchange.
- For the purpose of quality rating, the Exchange may leverage additional Issuer and/or QHP-specific information already provided through this application.
- Reporting of quality data will be in a single form and format to be determined by HHS and/or the Exchange.
- In other words, according to guidance released by CCIIO, HHS intends to propose in future rulemaking that quality reporting requirements related to all QHP issuers (other than accreditation reporting) become a condition of QHP certification beginning in 2016 based on the 2015 coverage year per ACA Sections 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h). We may collect additional quality data prior to 2016 directly from issuers or third party entities (such as accrediting entities) for use in applying the consumer interest standard of QHP certification under 45 CFR 155.1000, making QHP certification determinations, conducting QHP performance monitoring, and providing consumer education and outreach.

REVISION Sub-Section M. Service Area has been revised for clarity as follows

Sub-Section M. Service Area
The Exchange may accept QHPs that have a service area less than statewide coverage.

REPLACEMENT Sub-Section N. Network Adequacy and Provider Data requirements are as follows:

Sub-Section N. Network Adequacy and Provider Data
An Issuer must ensure that the provider network for each QHP meets the following standards:

- The provider network for each QHP meets the URAC or NCQA standards with respect to provider adequacy; and is consistent with the network adequacy provisions of §2702(c) Special Rules For Network Plans of the PHSA;
- The provider network must include a sufficient number of Essential Community Providers (ECP) to ensure reasonable and timely access for low income and medically underserved individuals in the service area;
- The provider network is sufficient in number 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;
- The network of providers for its standard plan offerings is, and continues to be, substantially the same as the network of providers available to its largest plan that represents a similar product offered outside of the Exchange.
Network Reporting Requirements

- As required by HHS, provider network reporting requirements will be developed based on a standardized format to be developed in conjunction with the Issuers.
- The Exchange will require each Issuer to provide the Exchange with the criteria used to define the adequacy of its network, including but not limited to, geographic distance standards to providers and timeliness of appointment scheduling. Such standards shall include information on variations of standards by provider specialty. All such standards shall be made readily available to the public and consumers on the Exchange.
- Issuers will be required to provide the Exchange with a list of all participating hospitals and non-hospital ECPs that is updated within 30 days of any change to the list. Issuers will use a standard template developed by the Exchange in conjunction with the Issuers.
- Issuers will be required to provide the Exchange with a link to a publicly accessible website of the Issuer’s current physician directory.
- Issuers are required to provide a URL link to the Exchange so that potential QHP enrollees can access the Issuers provider directory on-line.
- Issuers must make available a hardcopy directory to potential enrollees upon request. (45 CFR 156.230).
- The Exchange expects the Provider directory to include contact information, location, specialty and medical group and any hospital affiliations for each provider as well as an indicator of whether the provider is NOT accepting new patients. 45 CFR 156.230.

REPLACEMENT Essential Community Providers (ECP). The provision on ECPs is deleted and replaced as follows:

45 CFR 156.235 Essential Community Providers.

(c) Definition. Essential Community Providers (ECP)s are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in §340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927 (c)(1)(D)(i)(IV) of the Act as set forth by Section 221 of Public Law 111–8.

Please note that the 1927 definition broadens the definition of provider to a non-profit that would be a covered entity described in Section 340B(a)(4) of the Public Health Service Act insofar as the entity described in such section provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section.
Exchange staff has determined there is no official list of ECPs in Connecticut. Accordingly, for contracting and compliance purposes, the Exchange is developing a list of ECPs with the assistance and resources of the Office of Health Care Access, DPH as well as the DSS, Medical Operations Director. This listing will identify the ECP provider by service type, provider name and location. The Exchange will provide this listing to the carriers as soon as it is complete. The expected date for completion is following the April 18, 2013 Access Health CT Board meeting.

Exchange staff is working under the following definition of essential community providers:

- **Hospital Providers**
  - Hospitals included in the list of 340B and 1927 providers;
  - Hospitals designated annually by the State of Connecticut Department of Public Health
- **Non-Hospital Providers**
  - Covered entities on the list of 340B and 1927 providers;
  - Federally designated Tribal Health 638 Programs or Title V Urban Indian Health Programs;
  - Community clinics or health centers licensed as either a “community clinic” or “free clinic” by the State of Connecticut

Given the time deadlines for QHP certification requirements, the Exchange recognizes the difficulties that Issuers may encounter in contracting the ECP network to the standard identified by the Exchange Board at its November 29, 2012 Board meeting. (Note: QHPs to contract with 75% of ECPs located in the county in which the QHP operates and 100% of the federally qualified health centers (FQHC) or “look alike” health centers in the state.

For that reason, at the April 18, 2013 Board Meeting, the Exchange will be reconsidering its network adequacy standard of requiring QHPs to contract with 75 percent of the ECPs located in the county in which the QHP operates. The Exchange is not revising the network adequacy standard for FQHCs. Exchange staff plans to recommend an ECP network adequacy standard, more in line with the standards outlined in the Guidance on the State Partnership Exchange, released on January 3, 2013, by the Center for Consumer Information and Oversight (CCIIO). These standards can be found on page 21 of the Guidance.

**REPLACEMENT Sub–Section O. Attestations** has been deleted and replaced as follows:

Sub–Section O. Attestations. Consistent with the ACA, the Issuer must agree to comply with the minimum certification standards with respect to each QHP on an ongoing basis.

- Attestations will be required in the QHP application.
- The attestation language will cover the minimum certification standards and will include specific attestations as outlined in the other sections of this Solicitation and required by the Exchange and/or the CID.
Attestations will cover Issuer’s existing operations as well as any contractual commitments needed to meet Exchange requirements on an ongoing basis.

Applicant will attest it has in place an effective internal claims and appeals process and agrees to comply with all requirements for an external review process with respect to QHP enrollees, consistent with state and federal law. (45 CFR 147)

**REPLACEMENT Sub-Section P. User Fees** has been deleted and replaced as follows:

- **Sub-Section P. User Fees and Carrier Assessments** Attestation language will be included in the QHP application that commits the Issuer to pay user fee and /or carrier assessments, as applicable.

**NEW** The following **Sub Section Q.– Embedded Pediatric Dental Benefits** has been added:

**Sub Section Q.– Embedded Pediatric Dental Benefits**

The following benefits have been added for the Pediatric dental coverage:

<table>
<thead>
<tr>
<th>PEDIATRIC DENTAL SERVICES</th>
<th>INET</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive and Diagnostic Services</td>
<td>100% Coverage: Dental preventive and diagnostic services include:</td>
<td>No Co-pay</td>
</tr>
<tr>
<td></td>
<td>Exams, 1 every 6 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>X-rays, Bitewings 1 time/year Other types of X-rays as indicated by need</td>
<td>No Co-pay</td>
</tr>
<tr>
<td></td>
<td>Fluoride Treatments; Sealants; on premolar and molar teeth</td>
<td>No Co-pay</td>
</tr>
<tr>
<td></td>
<td>Access for Baby Care Early Dental Examination &amp; Fluoride Varnish where an oral health screen, oral health education &amp; fluoride varnish are applied to a child’s teeth during well child exams up to 4 years of age.</td>
<td>No Co-pay</td>
</tr>
<tr>
<td></td>
<td>D0145 - Oral evaluation for a patient under 4 years of age and counseling with the primary caregiver. The first oral examination, oral health instruction &amp; fluoride application may be performed on children at 6 months of age</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>Service Description</td>
<td>Fee Percentage</td>
<td>Co-pay</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>D1206 - Topical therapeutic fluoride varnish application for clients with moderate to high risk of dental decay according to the Caries Assessment Tool (CAT) developed by the American Academy of Pediatric Dentistry.</td>
<td></td>
<td>No Co-pay</td>
</tr>
<tr>
<td>Dental Orthodontia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replacement Retainer limited to one time per lifetime</td>
<td>$725 allowance per orthodontia case. Once in a lifetime</td>
<td>Balance after $725</td>
</tr>
<tr>
<td>Replacement Retainer limited to one time per lifetime</td>
<td>Replacement Retainer limited to one time per lifetime</td>
<td>100% Covered.</td>
</tr>
<tr>
<td>Amalgam Composite Restorations (Fillings)</td>
<td>80% of allowed fee</td>
<td>20% allowed fee</td>
</tr>
<tr>
<td>Fixed Prosthodontics: Crowns, Inlays &amp; Onlays/</td>
<td>67% of allowed fee</td>
<td>33% allowed fee</td>
</tr>
<tr>
<td>Recement Bridges, Crowns Inlays &amp; Space Maintainers</td>
<td>80% of allowed fee</td>
<td>20% of allowed fee</td>
</tr>
<tr>
<td>Removable Prosthodontics: Full or Partial Dentures</td>
<td>50% of allowed fee</td>
<td>50% of allowed fee</td>
</tr>
<tr>
<td>Repair, Relining &amp; Rebasing Dentures</td>
<td>80% of allowed fee</td>
<td>20% of allowed fee</td>
</tr>
<tr>
<td>Endodontic Surgery; Root Canal Treatment, Retreatment of root canal therapy; apicoectomy; apexification</td>
<td>80% of allowed fee</td>
<td>20% of allowed fee</td>
</tr>
<tr>
<td>Oral Surgery: Surgical Extraction, including impacted teeth</td>
<td>67% of allowed fee</td>
<td>33% of allowed fee</td>
</tr>
<tr>
<td>Non-surgical Extraction</td>
<td>80% of allowed fee</td>
<td>20% of allowed fee</td>
</tr>
<tr>
<td>Miscellaneous Surgical Procedures</td>
<td>80% of allowed fee</td>
<td>20% of allowed fee</td>
</tr>
<tr>
<td>Periodontal Surgery</td>
<td>50% of allowed fee</td>
<td>50% of allowed fee</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>67% of allowed fee</td>
<td>33% of allowed fee</td>
</tr>
<tr>
<td>General Anesthesia &amp; Sedation in the office</td>
<td>80% of allowed fee</td>
<td>20% of allowed fee</td>
</tr>
<tr>
<td>Miscellaneous Adjunctive Procedures</td>
<td>80% of allowed fee</td>
<td>20% of allowed fee</td>
</tr>
</tbody>
</table>

The following **Sub-Section R, Standalone Dental Benefits** has been added:

**Sub Section R, Standalone Dental Benefits**

Information with regard to Standalone dental benefits will be forthcoming.