

Connecticut Health Insurance Exchange:

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

DRAFT: Released November 12, 2012

Please send any questions, comments and/or concerns related to the QHP requirements included in this [Draft Solicitation](#), in writing, by 5pm on Monday, November 19, 2012, to Margo Lachowicz, Connecticut Health Insurance Exchange Project Assistant.

The Exchange intends to release additional guidance and provide assistance throughout the development of the Final Release of the Solicitation. Our website (<https://www.ct.gov/hix>) will provide up-to-date information, frequently asked questions, and notifications of interest to our stakeholders.

E-mail: cthix.inquiries@ct.gov

Please include subject line:

Comments on QHP Requirements for Initial Solicitation of Health Plan Issuers

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I. General Information and Background

A. Context

The Connecticut Health Insurance Exchange (Exchange) is soliciting applications from health insurance issuers (“Issuers”) to market and sell qualified health plans (“QHPs”) and/or stand-alone dental/vision plans through the Exchange beginning in 2013 for a January 1, 2014 effective date of coverage. The Exchange encourages Issuers to study this Initial Solicitation and its attachments carefully in preparing an application.

This Solicitation may be amended by additional addenda that describe supplemental information required of the Issuers.

This is a draft release of Exchange’s Initial Solicitation to Issuers (“the Solicitation”). This document presents proposed policies to be included in Connecticut’s QHP applications. The Exchange’s final release will take into consideration stakeholder comments and questions on any QHP requirement, including but not limited to those raised in the “Issue(s) for Review” boxes that are inserted after selected sections in this release. Comments from the public are welcome and encouraged on all sections.

The Exchange will present these comments to, and solicit additional feedback on these requirements from, two of its advisory committee—the Consumer Engagement and Outreach Advisory Committee and the Health Plan Benefits and Qualifications Advisory Committee, collectively representing consumers, advocates, providers and carriers.

The Exchange will communicate on its website the feedback received as part of the commentary period.

The Exchange intends to finalize the development of the QHP and stand-alone dental/vision plan Solicitation by December 3, 2012 and complete development of the information systems for processing applications by December 31, 2012. This Solicitation and the QHP application requirements are subject to change based on publication of additional federal rules and/or guidance from the Center for Consumer Information and Insurance Oversight (CCIIO), as well as any State legislation or other policy guidance.

The Patient Protection and Affordable Care Act of 2010 (ACA) and Connecticut’s Public Act 11-53, as amended by Public Act 12-1, provide the regulatory framework for defining the State’s QHP certification requirements and grant the authority to the Exchange for administering this Solicitation.

The Exchange reserves the right to select or reject any QHP or to cancel this Solicitation at any time. The Exchange will post any amendments to this Solicitation on its website. Nothing in this Solicitation precludes the Exchange from selectively contracting.

The process and requirements contained in this document and its various attachments are strictly related to the initial solicitation and certification of QHP and stand-alone dental/vision plan applications. The Exchange has not yet made decisions about the processes for decertification and recertification and these processes will be determined at a later date.

The Exchange will use the requirements outlined in this Solicitation to evaluate Issuers applications and agrees to offer health plans that it certifies as QHPs to any eligible consumer wanting to

purchase coverage for a term of twelve (12) months beginning January 1, 2014 and ending December 31, 2014.

B. Background

Only health plans certified as a QHP can be sold through a state or federally operated health benefit exchange. Effective January 1, 2014, these exchanges will be able to offer Issuers a state-wide distributional channel to make it easier for individuals and small businesses to compare plans and buy health insurance in the private market. QHPs are the only plans through which individuals and/or employers are eligible to qualify for any affordability subsidies, including:

- advanced premium tax credits and/or cost sharing reductions available to households purchasing QHP coverage in the individual market, and;
- affordability tax credits available to eligible employers offering QHP coverage in the small group market.

In Connecticut, the Exchange is responsible for certifying the QHPs that will be available for its two major customer groups: individuals and small employers.

To be certified as a QHP, the Issuer and its health plans must meet any and all federal and state statutory requirements, but also the Exchange specific selection criteria described in this Solicitation.

For Exchange planning purposes, Exchange staff reviewed the suggested list of QHP application elements released by CCIIO and the QHP certification requirements being considered in other states, including California, Vermont, Maryland, and Arizona. These lists of requirements were the starting point for the Exchange's development of the certification requirements defined in this Solicitation. In addition the Exchange engaged Wakely Consulting, a national actuarial and management consulting firm, to review the recommended application elements included in this Solicitation and broadly consider the potential impact of different QHP purchasing models and certification requirements.

In setting the criteria outlined in this Solicitation that the Exchange will use to certify health plans as "qualified," the Exchange was guided by its mission to increase the number of insured residents in Connecticut and reduce health disparities by improving access to the high quality health care coverage. The Exchange intends that through the development of an innovative and competitive marketplace, consumers will be empowered to choose the health plan and providers that give them the best value.

As a further preface to the requirements for this Solicitation, the Exchange wants to remind interested Issuers of its five governing principles that it expects all of its partners to reflect in their own operations:

1. Create an easy and simple consumer experience for shopping and comparison of insurance options
2. Promote innovation and new options for benefit coverage in the State
3. Provide empathetic and responsive customer service
4. Work with our health plans, brokers, and navigators to provide more affordable products and broad distribution support

5. Launch a substantive and targeted communications and outreach campaign that promotes awareness of health reform and new options for consumers and small businesses in the State

In defining these principles, the Exchange realizes that broad success can only be achieved if its reform efforts are comprehensive and performed in partnership with Issuers, providers and consumers.

By creating the necessary infrastructure, the Exchange hopes to be, in part, a catalyst for broad and thoughtfully iterative health care reform. With the enactment of the ACA and the range of insurance market reforms that are currently in the process of being implemented, the Exchange's understands Connecticut's health insurance marketplace will be transformed into a more consumer-oriented market that will reward better care management, prevention, and affordability.

Through this Solicitation the Exchange looks specifically to the Issuers to be a cooperative partner with the State in its reform agenda. The Exchange is confident that with this commitment from the Issuers, Connecticut can move closer toward the critical goal of achieving better health outcomes through better care.

C. Regulatory Filings

The Connecticut Insurance Department (CID), responsible for licensing and monitoring insurance carriers in Connecticut, will continue to exercise its regulatory oversight of the health insurance market. In accordance with Connecticut state law, all fully insured products (form and rate filings) must be approved by CID in advance of an issuer presenting the product to the market for sale. Therefore before a health plan can be sold in the individual or small group market, either inside or outside the Exchange, CID must approve the Issuer's Certificate of Coverage or Policy, (in the case of an individual plan) and the rate filing for each plan it intends to sell.

Any determinations by the Exchange to certify a health plan as "qualified" will be conditional upon CID approving the plan. Similarly, any stand-alone dental plan or stand-alone vision plan must be approved in advance by CID and certified by the Exchange.

As a result of the federal regulations effective January 1, 2014, including but not limited to QHP certification, CID anticipates there will be a large number of new health plans (form and rate filings) submitted by the Issuers to CID for review and approval for plan year 2014. To expedite CID approval and Exchange certification of the health plans, a coordinated multi-step submission process and aggressive timeline is proposed. The Exchange will partner with CID and the Issuers to establish the process and timing of all necessary regulatory filings (form and rates).

CID released a Bulletin outlining the State's filing requirements to the Issuers on November 1, 2012. Bulletin HC-90, "Filing Requirements for Individual and Small Employer Group Health Insurance Policies Subject to the Affordable Care Act" provides additional information on the process for rate and policy form filing submissions approval process for issuers submitting health products for the 2014 plan year. The Bulletin is available on the CID website, <http://www.ct.gov/cid/>, under the tab "BULLETINS."

Issuers are encouraged to adhere to CID's timetable and two-stage process for form and rate approval. To summarize the Bulletin, CID will grant conditional approval of an Issuer's form filing (e.g. Certificate of Coverage (COC) or Policy) before granting final approval of that form filing along

with rate filings and Summary of Benefits and Coverage (SBC) for each specific health plan the Issuer intends to sell in Connecticut.

Concurrent to CID's approval process, Issuers are encouraged to submit their QHP and stand-alone dental/vision plan applications in accordance with this Solicitation to the Exchange.

D. Solicitation Process and Timing

The Solicitation process shall consist of the following steps:

- Release of the Draft Solicitation
- Submission of Questions/Comments from Issuers and stakeholders
- Response to Questions from Issuers and other stakeholders (ongoing)
 - Review Comments on QHP Requirements from Joint Advisory Committee
 - Review and Approve of QHP Requirements by Exchange Board
- Release of the Final Solicitation
- Submission of Issuer's Notice of Intent to Respond to Solicitation
- 2-stage submission of Issuer plans to CID for approval
- Submission of Issuer applications to Exchange
- Evaluation and selection by Exchange of Issuer QHPs for certification
- Discussion and negotiation of final contract terms and conditions
- Execution of contracts with the selected Carriers

Following the release of this Draft Solicitation and in response to stakeholder feedback, the Exchange intends to issue additional information as part of the Final Release of the Solicitation regarding:

- Detailed standardized benefit plan designs and/or allowable benefit design parameters, if necessary
- Detailed benefit plan design for stand-alone dental plans, if necessary
- Stand-alone vision plan details
- Qualified Health Plan model contract
- Instructions to Issuers on how to submit application electronically
- Invitations to an Exchange-Issuer technical working group to define forms and formats of all required reporting documentation

This Solicitation and the Issuer's application(s) are intended to cover the Issuer's participation in the Individual Exchange (for QHPs sold in the State's Individual market) and its Small Business Health Options Program (SHOP) Exchange (for QHPs sold in the State's small group market, consisting of for employers with 1 to 50 employees). If the responses to the application requirements/questions differ based on the Issuer's individual or small group lines of business, the Issuer must indicate so such and provide separate answers to the requirements.

E. Timetable

In order for the plan design to be reviewed and certified by the Exchange in time for the initial open enrollment period, Issuers are advised of the following key dates and timeframes. Any changes to the dates will be communicated directly to the individual identified in the Issuer Notice of Intent and will be posted on the Exchange's website.

Action	Due Date <i>(all dates are subject to change)</i>
Draft Initial QHP and Stand-Alone Dental/Vision Solicitation Released	November 12, 2012
Strategy Subcommittee to the Exchange Board to review/comment on QHP requirements	November 15, 2012
Joint Advisory Committee to the Exchange to review/comment on QHP requirements	November 20, 2012
Stakeholder comments/questions on QHP requirements due to Exchange (in writing)	November 12-19, 2012
Exchange Board Review and Approval QHP requirements	November 29, 2012
Final Release of Initial QHP and Stand-Alone Dental/Vision Solicitation	December 3, 2012
Issuer Contract of Coverage Due to CID	November 2012 (ongoing)
Issuer QHP Notice of Intent Due to Exchange	December 31, 2013
Plan Rates and Summary of Benefits Due to CID	March 2013 (ongoing)
QHP, Stand-Alone Dental/Vision Applications Due to Exchange	March 29, 2013
CID Approval of Rates and Plans	July 2013 (ongoing)
Evaluation, Negotiation and Selection of Issuer QHPs for Certification by Exchange	March-July 2013
Anticipated Certification of QHP by Exchange <i>(Conditional QHP certification may be granted; however, QHP cannot be sold through Exchange without CID approving the plans' rates and forms)</i>	July 15, 2013
Carriers Attest Plan Data is Correctly Uploaded	September 1, 2013
Open Enrollment Period	October 1, 2013 – March 31, 2014
2014 Plan Year	January 1 – December 31, 2014

F. Notice of Intent (Pre-Requisite)

Following the Final Release of Initial QHP and Stand-Alone Dental/Vision Solicitation potential Issuers must submit a **Notice of Intent to Submit Qualified Health Plan** (to be included as Attachment 1 to the Final Solicitation) no later than 5:00 p.m. on December 31, 2012 to gain access to the Exchange's online application portal. The Notice of Intent is not binding; however, an Issuer cannot apply without first submitting a Notice of Intent. Only those Issuers acknowledging interest in this Solicitation by submitting a Notice of Intent will continue to receive Solicitation related correspondence from the Exchange.

Submission Instructions and Deadlines for Notice of Intent

1. Please complete the form titled: **Notice of Intent to Submit Qualified Health Plan**.

2. Issuers should submit this form via email to the Exchange’s Director of Plan Management identified in Section 1.G no later than 5PM on December 31, 2012.
3. Please make sure the email subject line reads: “Notice of Intent to Submit Qualified Health Plan.”
4. Please email questions about this Solicitation, including the **Notice of Intent**, to cthix.inquires@ct.gov no later than 5PM on December 21, 2012.
5. The Issuer will receive a response confirming your submission.

G. Exchange Contact for Solicitation

Upon the Final Release of this Solicitation, the Exchange’s single point of contact for any Issuer’s inquiries related to plan management is:

Julie Lyons
Director of Plan Management

E-Mail: julie.lyons@ct.gov
Office: (860) 418-6267

All questions should be made in writing, and submitted by email. All answers to questions, and any Addenda to this Solicitation, will be made available to all prospective applicants.

H. Recertification and Decertification

The subject matter contained in this document is strictly related to the initial application for Exchange certification of QHPs, stand-alone dental, and stand-alone vision plans.

The Exchange has not yet defined the specific criteria for recertification.

The Exchange may decertify any QHP that fails to meet the required certification standards, requirements for recertification or fails to comply with a corrective action plan. Issuers will have the right to appeal decertification decisions.

The Exchange’s preliminary decisions about the process for periodic recertification requirements and defining criteria for the decertification of either a carrier or specific QHP will be forthcoming and will be based on the QHP certification requirements included herein.

F. Definitions

For purposes of this Solicitation, the following definitions apply:

“Actuarial Value (AV)” – the percentage of total average costs for covered benefits that a plan will cover. If a plan has an actuarial value of 80 % on average you would be responsible for 20% of the costs of all covered benefits.

“Connecticut Health Insurance Exchange (Exchange)” – an independent quasi-public agency established by Public Law 111-48 for the purpose of implementing health reform in the State of Connecticut. The Exchange is governed by a fourteen member Board of Directors comprised of governmental officials and members of the public representing a range of interests and expertise

that include organized labor, employee health benefits, health policy and economics, consumers, small employers, and former health insurance executives.

“Decertification Process” – the termination by the Exchange of the certification status and offering of a QHP through the Exchange. The Exchange may decertify a QHP at any time if it finds the QHP no longer meets the QHP certification criteria.

“Essential Health Benefits (EHB)” – a set of health care service categories that must be covered by certain plans starting in 2014. The ACA ensures health plans offered in the individual and small group markets, both inside and outside of the Exchanges, offer a comprehensive package of items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

“Issuer” – an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in Connecticut and that is subject to Connecticut and federal laws regulating insurance.

“Medical Loss Ratio (MLR)” – a financial measurement used in the ACA to encourage Issuers to provide value to the enrollees. (e.g. If an insurer uses 80 cents out of every premium dollar to pay its medical claims and activities that improve the quality of care, the Issuer has a medical loss ratio of 80%.) A MLR of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions.

“Patient Protection and Affordable Care Act (ACA)” – the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

“Plan” – a specific benefits package, plan design and cost sharing being offered as a coverage option to potential enrollees.

“Product” – a line of plans that have the same benefit package and network, and differ only in the cost sharing arrangement and actuarial value.

“Qualified Health Plan (QHP)” – a Plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification or seal by each Exchange in which it is sold. Recertification - the purpose of the recertification process is to ensure that QHPs continue to meet certification requirements.

II. Application Components and Certification Requirements

This section outlines the various components that the Exchange will require in the Issuer application for this Solicitation. The actual application and any associated guidance related to its submission and the submission of any necessary (or optional) supporting documentation will be provided to the primary point of contact identified by the Issuer for the Solicitation.

Nothing in this Solicitation preempts a participating Issuer from adhering to all applicable ACA provisions and related federal regulations. Additionally, only plans approved by the CID and meeting any and all State regulatory requirements may be offered through the Exchange.

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A. Issuer General Information

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.

ACA Requirements

- This information is not specifically required by the ACA for QHP certification.

Connecticut QHP Requirements

- **Issuer Information.** The QHP Issuer will need to be identified and included on the application. The information provided on the application must match the information on file with CID and represent the legal entity that has the certificate of authority to offer health insurance policies in the State of Connecticut.
- **Issuer Management.** The application will request contact information for the individuals responsible for the market for which a response is being submitted, including the following (or equivalent thereof):
 - President or CEO
 - Chief Medical Officer
 - Senior Vice President, Individual Products (if applicable)
 - Senior Vice President, Small Group Products (if applicable)
- **Primary Contact.** The Application will request contact information for the person with primary responsibility for and authority over the Issuer's QHP(s) in the Exchange and any related business operations related to this Solicitation.
- In its application to the Exchange the Issuer will be required to attest to language similar to:

We certify and attest that we currently have and will maintain appropriate staffing and qualified management to effectively manage all QHPs offered in the Exchange.

Stand-Alone Dental Requirements

- The same general Issuer information requirements will apply to dental plans.

B. Administrative Management

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.

ACA Requirements

- This information is not required by the ACA for QHP certification.

Connecticut QHP Requirements

- As it relates to an Issuer's fully-insured individual and small group products, the Issuer will be required to manage and resource their Exchange products and membership in the same manner as their non-Exchange products and membership.
- In its application to the Exchange the Issuer will be required to attest to language similar to:

We certify that we have an appropriate administrative structure, and will add and maintain all necessary administrative capacity to effectively administer this QHP, in addition to all other QHPs that we offer on the Connecticut Health Insurance Exchange.

Stand-Alone Dental Requirements

- The same Issuer attestation will apply to dental plans.

C. Licensure and Financial Condition

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.

ACA Requirement

- 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.

Connecticut QHP Requirements

- The application will request licensure and financial condition information.
- In its application to the Exchange the Issuer will be required to attest to language similar to:

We certify that we are licensed to sell health insurance products in the state of Connecticut, and we are in good standing, and will maintain good standing and appropriate solvency levels consistent with the addition of this new business.

Stand-Alone Dental Requirements

- The same Issuer requirements and attestation will apply to dental plans.

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D. Market Participation

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.

ACA Requirements

- The Exchange must complete the certification process before the beginning of the open enrollment period.
- The Exchange has the discretion to decide to recertify QHPs annually, or on a less frequent basis, such as every other year or every three years.
- Regardless of the frequency of the certification process, the Exchange must monitor QHP issuers for ongoing compliance.

Connecticut QHP Requirements

- In its application to the Exchange the Issuer will be required to agree to the Exchange's market participation requirements.
- The initial term for Exchange participation will be granted for a two (2) year period.

Issues for Review:

1. Should failure by a QHP to participate in Exchange in 2014 inhibit participation by the Issuer until (at least) 2016? An exception to such a "lock-out" period would be considered for newly licensed Issuers.
2. If an Issuer ceases participation in the Exchange, should the Issuer be prevented from rejoining for two (or three) years?

Stand-Alone Dental Requirements

- Stand-alone dental plans may elect to participate in either the Individual Exchange or the SHOP Exchange or both.

E. Plan Benefits, Cost-Sharing and Rates

This information will be QHP-specific and will need to be included for each submitted QHP in the Issuer's application.

ACA Requirements

- Each QHP must comply with the benefit standards required by the ACA, including the cost sharing limits, actuarial value (AV) requirements, and federally approved State-specific essential health benefits.
- The Issuer must set premium rates for its QHP for the entire benefit year, or for the SHOP plan year.
- Each plan in a metal tier must meet the specified AV requirements based on the cost-sharing features of the plan:
 - The Bronze plan – AV of 60 percent;
 - Silver plan – AV of 70 percent;
 - Gold plan – AV of 80 percent;
 - Platinum plan – AV of 90 percent.

CCIIO issued a Bulletin proposing that a *de minimis* variation of +/- 2 percentage points in AV is allowable.

- The Exchange must provide information on QHP rates, covered benefits, and cost-sharing requirements, at least annually, from Issuers for each QHP in a form and manner to be specified by the HHS.
- An Issuer must submit a justification for a rate increase prior to the implementation of the increase. A QHP Issuer must prominently post the justification on its Web site.

Connecticut QHP Requirements

- **Rates.** Connecticut is a prior-approval state. CID is responsible reviewing and approving any rate or rate increases. The Exchange will not duplicate the rate review process and will rely on any justification collected through CID's rate review process. The Exchange will collaborate with CID to determine the form, manner, and timing of the submission of the rate justification and provide access to the justification on its website.

The Exchange will post on its website the Issuer's published justification for its rate increases.

- **Cost-Sharing Requirements.** Except for Catastrophic Coverage plan, the plan must be actuarial equivalent to the metal level proposed. (See Sections II. I and II.J for QHP certification requirements related to the cost sharing reductions and the need for Issuers to offer alternatives to the Silver reflecting three variations to the QHP's actuarial value.)
- **Certificate of Coverage or Policy.** A detailed "Certificate of Coverage" or Policy applicable to the Issuer's QHPs must be included in the application and will be made available by the Exchange to any consumer, upon request.
- **Summary of Benefits and Coverage (SBC).** For each QHP, the Issuer must provide the Exchange with the Rates and a SBC, including each of the coverage examples defined by HHS. Whenever possible the State will use the federal template.

- **Covered Benefits.** The QHP must include at a minimum the Connecticut-specific Essential Health Benefits approved by HHS. No substitution of actuarially equivalent benefits will be allowed. (See **Attachment 3** for Connecticut’s Essential Health Benefits)

Issues for Review:

1. Should Issuers be required to offer a standardized or more-or-less comparable benefit design for a Bronze, Silver, and/or Gold plan? If so, should the Exchange allow Issuers to submit one or more non-standard benefit design plan(s) by Metal tier?

See also Section II.H “Number and Mix of Plans”

- To avoid unnecessary duplication with CID, the Exchange will use the System for Electronic Rate and Form Filings (SERFF) to retrieve plan and benefit design information submitted to CID for approval. The Exchange will work with the Issuers to develop the form and format of a standard template for all filings.

Stand-Alone Dental Requirements

- The same Issuer general information requirements will apply to dental plans.
- An Issuer of a stand-alone dental plan must offer a child-only dental plan.
- Actuarial certification will not apply to stand-alone dental visions, unless required by federal regulations.

Issues for Review:

1. Should stand-alone dental plans be required to offer standard plan benefit designs across metal tiers?
2. Should the Exchange consider selling two benefit tiers of stand-alone dental plans: (1) preventive only; and (2) full benefits?

F. Rating Factors

This information will be QHP-specific and will need to be included for each QHP in the Issuer's submission.

ACA Requirements

- The ACA allows health plans to be rated only on the basis of age, geography and tobacco-use.

Connecticut QHP Requirements

- Household size rating factors for QHPs sold in Exchange will be: Single, Single +1, and Family.

Issue for review:

1. Should the Exchange make tobacco-use a required rating factor in the Individual Exchange?
2. Should the Exchange require Issuers to agree to standardized rating factors (for geography, age, household size, and, if applicable to the non-group market, tobacco use) across all QHPs sold through the Exchange?

- **SHOP Rating.** Small businesses that purchase coverage through the SHOP Exchange will have the option of choosing between three coverage models for their employees:
 - “Employee Choice” – One Tier, Multiple Carriers – Option allows employers to select a benchmark plan and provides employees the option to either pick the benchmark plan or use the employer’s benchmark contribution to select another QHP within the benchmark’s metal tier.
 - “Employer Choice” – One Carrier, Multiple Plans – Option allows an employer to select a benchmark plan and then offer a choice of QHP options exclusive to the benchmark plan’s carrier.
 - “Sole Source” – One Carrier, One Plan –An employer can select a benchmark plan and provide the option for employees to either select or reject enrollment in the benchmark plan.

Stand-Alone Dental Requirements

- At this time, HHS has not further defined specific information related to dental plan rating factors.

G. Wellness Incentives

This information will be QHP-specific and will need to be included for each QHP in the Issuer's submission.

ACA Requirements

- The ACA expands Health Insurance Portability and Accountability Act of 1996 (HIPAA) wellness program exemption to allow employers to offer employees incentives of up to 30%, and could be expanded to 50% (with a federal waiver) of the cost of their coverage for meeting employer-defined health targets. "Participation only" programs do not have to meet additional requirements, but programs that are "standard-based" have to certain requirements.

Examples of "participation-based" wellness programs:

- Incentives to participate in a health fair
- Waiver of co-payment/deductible for well-baby visits
- Reimbursement for gym membership
- Reimbursement for smoking cessation programs (regardless of outcome)

Examples of "standards-based" wellness programs:

- Providing a premium discount to employees who have an annual cholesterol test and achieve cholesterol levels below 200.
- Waiving the annual deductible for employees who have a body mass index (BMI) within a specified range.
- Imposing a surcharge on employees who don't provide an annual certification that they have not used tobacco products within the last 12 months.

Connecticut QHP Requirements

- The Exchange will encourage Issuers to offer both "participation-based" and "standard-based" wellness incentives to employers and their employees purchasing coverage in the SHOP Exchange.
- The Exchange will allow Issuers to offer both "participation-based" and "standard-based" wellness incentives for QHPs sold in the non-group market. (If there is Issuer interest, the Exchange will need to coordinate with Issuers to apply for a federal waiver)

Stand-Alone Dental Requirements

- No wellness incentive information will be required for the dental application.
- An Issuer may offer enhanced dental benefits or a reduction in the costs thereof as part of their Wellness Incentive program.

H. Number and Mix of QHPs

This information will be Issuer and QHP-specific and refers to the entirety of the Issuer's submission.

ACA Requirements

- An Issuer must submit at least one (1) Silver plan and one (1) Gold plan to participate in an Exchange.
- For at least one Silver plan, the Issuer must submit three variations to the plan reflecting reduced cost sharing on the essential health benefits according to standards promulgated by HHS (see Section J).

Connecticut QHP Requirements

- For each Issuer's application the number of QHPs cannot exceed the following:
 - One (1) Gold Plan
 - Two (2) Silver Plans
 - Each plan must have meaningful differences (to be determined) with respect to cost-sharing arrangements (deductible, co-payments, co-insurance) and/or prior authorization
 - For at least one Silver plan offered for sale by the Issuer in the individual/family market, the Issuer must provide three alternative plan designs reflecting the cost sharing reduction (CSR) required by the ACA. The network and benefits in each alternative must be identical to the reference Silver plan. The alternative Silver plans will only be available to enrollees eligible for appropriate level of cost sharing reductions.
 - Two (2) Bronze Plans
 - Each plan must have meaningful differences with respect to cost-sharing arrangements (deductible, co-payments, co-insurance) and/or prior authorization
 - One (1) Catastrophic Coverage Plan. These plans can only be sold in the Exchange's individual/family market to people under 30 at the start of the plan year, people for whom coverage is considered "unaffordable" under 5000A(e)(1) of the Internal Revenue Code (IRC), and people with a "hardship" under 5000A(e)(5) of the IRC. These plans must have a network as the lowest-costing Silver plan offered by the Issuer. For any essential health benefit provided in-network, the enrollee will be billed the Issuer's lowest negotiated rate (except where no cost sharing is allowed as defined by the ACA).
 - One (1) child-only QHP for each metal tier for which an Issuer submits a plan (applies to Individual Exchange only)

Issues for Review:

1. Should Issuers be required, prevented, or given the option of offering Platinum QHPs?

- **Examples of Meaningful Plan Design Differences**

- Plan design has a different payment structure (co-payment versus co-insurance versus deductible versus high-deductible health plan (HDHP))

- Deductible and maximum out-of-pocket (OOP) differences:
 - Medical deductible difference
 - Pharmacy deductible difference of \$50 or more
 - Maximum OOP difference greater than \$1000
- Changes in Cost Sharing for key service categories:
 - Inpatient/Outpatient Visit: at least 10% difference or if applicability of deductible is changed
 - PCP/Specialist Visit: at least \$10 or 10% difference or if applicability of deductible is changed
 - Generic Drugs: at least a \$5 average difference or if applicability of deductible is changed
 - Brand Drugs: at least a \$10 average difference or if applicability of deductible is changed
- Change from Coinsurance to Copay on Inpatient/Outpatient/PCP/Specialist Visits
- Plan designs have difference care management (e.g. gatekeeper model; patient centered medical home; community health teams; wellness programs)
- Plan design features payment reform (e.g. pay-for-performance, tiered networks)

Stand-Alone Dental Requirements

- The Exchange will set requirements on the maximum number of stand alone dental plans that an Issuer may offer through the Exchange.

Issues for Review:
1. Should Issuers be required to issue stand-alone dental plans across all, any, or specific metal tiers?

I. Cost-Sharing Reduction Subsidy

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related Initial QHP application submissions.

ACA Requirements

- Section 1402(a)-(c) of the ACA directs issuers to reduce cost sharing on essential health benefits (EHB) for an individual with a household income of 400 percent of the Federal Poverty Level (FPL) or below who enrolls in a silver-level qualified health plan (QHP) through an Exchange.
- Section 1402(d) of the ACA directs an issuer to eliminate cost sharing for an Indian (as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income of 300 percent of the FPL or below who is enrolled through the Exchange in a QHP at any level of coverage.
- CCIIO has released an “Actuarial Value and Cost-Sharing Reductions Bulletin” on February 24, 2012. The Bulletin outlines CCIIO’s intended three-step approach to implementing cost-sharing reductions for eligible individuals and to making payments to issuers for these reductions. The cost-sharing reductions will apply only to households with income at or below 250% of the federal poverty line. **Table J.1** reflects the proposed reduction in maximum out-of-pocket (OOP) limit and increased actuarial value requirements for the alternative plans options.

Table J.1. Proposed reductions in Maximum Out-of-Pocket (OOP) Limit and Actuarial Value (AV) Requirements, by Household Income

Household Income	Proposed Reduction in Maximum OOP Limit	Plan AV Requirement
100-150% of FPL	2/3	94%
150-200% of FPL	2/3	87%
200-250%	1/2	73%

- It is expected that further federal guidelines, and or state laws or regulation, may be released prior to the execution of a contract

Connecticut Requirements

- With their application, Issuers must submit three alternative plan design options for at least one of its Silver plans. The alternative AV design options must be defined for the standardized Silver plan, if applicable.
- Pending additional federal guidance suggesting otherwise, the premium charged must be held constant across the alternative Silver plans and be the same as the premium for the reference Silver QHP (controlling for allowable rating factors)

Stand-Alone Dental Requirements

- This information will not be required for the dental application.

J. Accreditation

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related Initial QHP application submissions.

ACA Requirements

- At a minimum, the Issuer must be accredited by an entity recognized by HHS, and provide the Exchange with a copy of its most recent accreditation survey. Accreditation must include:
 - local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS);
 - patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and;
 - consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.
- If not accredited, the Issuer must receive such accreditation within a period established by the Exchange for such accreditation that is applicable to all QHPs.

Connecticut QHP Requirements

- The Exchange will accept all HHS accrediting entities, as long as they cover the basic ACA requirements. Accreditation must cover the Issuer's Connecticut operations.
- Specific accreditation modules may be required by the Exchange (for later Solicitations); but the Issuer will be given sufficient time to meet new requirements.
- The Exchange will inform Issuers of additional accreditations modules recommended by the Exchange and believed to add valuable information to consumer's enrollment process.
- 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 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.

Stand-Alone Dental Requirements

- This information will not be required for the dental application.
- Additional quality information will be required of Issuers of stand-alone plans to assure adequacy of offered coverage.

K. Reporting: Quality Improvement Strategies, Quality Reporting, and Enrollee Satisfaction

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related Initial QHP application submissions.

ACA Requirements

- Consistent with ACA all Issuers must disclose and report on:
 - Health care quality and outcomes measures
 - Implement and report on quality improvement strategy(s)
 - Enrollee satisfaction surveys

Specific measures related to health care quality and outcomes have yet to be further defined by HHS.

Connecticut QHP Requirements

- Issuers will be required to report to the Exchange upon Connecticut-specific “quality information” (as defined by HHS) to satisfy ACA quality reporting requirements. In an effort to ensure equal comparison of data between QHPs and to minimize administrative burden to the Exchange, health care quality and outcome measures should be reported in a consistent format as defined by HHS and/or approved by the Issuers.
- Accredited Issuers will not be required to provide a “quality improvement strategy” (as defined by HHS) in the application; but an attestation that the Issuer has addressed this ACA required element would be included. For plans that have not been accredited, a written quality improvement strategy must be submitted.
- Issuer will be asked to provide any additional quality reporting required of federal law, including HEDIS and CAHPS information.
- Issuers will be required to use the enrollee satisfaction survey system developed by the HHS and report results to the Exchange.

Stand-Alone Dental Requirements

- Quality reporting will not be required for the dental application.

L. Reporting: Transparency and Performance Information

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related Initial QHP application submissions.

ACA Requirements

- The Issuer must provide the following information to the Exchange, consistent with *45 CFR Part 156.220(a)*:
 - Claims payment policies and practices;
 - Periodic financial disclosures;
 - Data on enrollment;
 - Data on disenrollment;
 - Data on the number of claims that are denied;
 - Data on rating practices;
 - Information on cost-sharing and payments with respect to any out-of-network coverage, and;
 - Information on enrollee rights under Title I of the Affordable Care Act.

Connecticut QHP Requirements

- The performance information requirements of this section will be included in the attestation language. The Exchange will monitor QHP reporting against this requirement.
- For all data reporting requirements, the Issuers must use specific data formats, definitions, or frequency of reporting defined by HHS. If no federal standards are 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.
- As part of their application for this Initial Solicitation (to be made available to consumers enrolling in coverage for 2014 plan year), the Issuers will be required to provide the following to the Exchange:
 - CAPHS data;
 - NCQA star ranking;
 - Medical Loss Ratio (“MLR”) for the most recent year and projected MLR for 2014, for non-group/small-group.

Stand-Alone Dental Requirements

- Performance information will be required for the stand-alone dental application.

M. Reporting: Pharmacy Utilization Management Program

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related Initial QHP application submissions.

ACA Requirements

- A QHP Issuer must provide to HHS the following information defined by Section 156.295(a) of ACA, including:
 - The percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type;
 - The aggregate amount, and the type of rebates, discounts or price concessions, and;
 - The aggregate amount of the difference between the amounts the QHP Issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

Connecticut QHP Requirements

- The pharmacy utilization management program reporting requirements of this section will be included in the attestation language.
- The Exchange will monitor QHP reporting against this requirement.

Stand-Alone Dental Requirements

- Attestation will **not** be required for the dental application.

N. Issuer and QHP Quality Rating

The rating will be QHP-specific. Some required information will be QHP-specific and will need to be provided in relationship to each QHP in the Issuer's submission. Other data will be Issuer-specific and only needed to be provided once.

ACA Requirements

- HHS will develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4) (*Section 1311(c)(3) of the ACA*).

Connecticut QHP Requirements

- The Exchange will use the quality and performance information requested in Sections J through M of this Solicitation to implement and maintain a quality rating system developed by either the Exchange and/or HHS.
- 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 the Exchange.
- The Exchange will develop a quality rating and performance metric that will relate quality of health care to price per AV tier.

Stand-Alone Dental Requirements

- Quality rating information will be required for the stand-alone dental application.

O. Service Area

This information will be QHP-specific and will need to be included for each QHP in the Issuer's submission.

ACA Requirements

- The Exchange must have a process to establish or evaluate the service areas of QHPs to determine whether the following minimum criteria are met:
 - The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.
 - The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

Connecticut QHP Requirements

- Service area information will be included in the application.
- The Exchange may accept QHPs that provide less than statewide coverage.

Stand-Alone Dental Requirements

- Service area information will be included in the dental application.

P. Network Adequacy and Provider Data

This information may be Issuer or QHP-specific. If the provider network is consistent across all products and plans sold by the Issuer, the Issuer's provider data will need to be provided only once. If there is any variation in the provider networks across QHPs then the specific provider networks will need to be included for each product and/or plan in the Issuer's response to this Solicitation.

ACA Requirements

- Issuers must ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.
- Issuers must include a sufficient number and geographic distribution of Essential Community Providers (ECPs) that serve low-income and medically underserved individuals, such as those ECPs defined in section 340B(a)(4) of the Public Health Service Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. This is not a requirement for any QHP to provide coverage for any specific medical procedure at an ECP, however.

Connecticut QHP Requirements

- The Exchange will enforce the minimum network adequacy and essential provider requirements under ACA. Carriers will be required to attest that their network ensures a sufficient choice of providers and meets Connecticut's ECP requirements.

Issues for Review:

1. What should the Exchange's network adequacy standard be as it relates to Essential Community Providers? Short of meeting such standards, should an issuer be allowed to evidence a good faith effort to contract with ECPs by, for example, providing contract terms accepted by some providers, and offered to, but rejected by, ECPs?

Example 1: Should sufficiency of ECP be defined as Issuers having contracts with a minimum of 50% of the essential community providers across the State as well as 75% of the ECPs located in any city or town that contains one or more of the 20 zip codes with the greatest number of uninsured individuals in Connecticut?

Example 2: Should sufficiency of ECP also be defined as Issuers having contracts with at least two-thirds of the federally qualified health centers (FQHC) or "look-alike" health center in the State?

See **Attachment 4** for directory of ECPs in Connecticut.

- Issuers will be required to provide the Exchange with a list of all participating hospitals and non-hospital ECPs that is updated within 7 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 that is updated at least every 15 days.
- Provider network reporting requirements will be developed based on a standardized format to be developed in conjunction with the Issuers.

- Issuers are encouraged to cooperate with the Exchange to develop a standardized template for an Issuer physician directory for the purpose of creating and maintaining a comprehensive physician directory for Connecticut. This directory will be to allow potential QHP enrollees to filter the QHP selection (directly in the Exchange portal) according to certain demographics of, and specialties practiced by, the providers and whether or not the providers are accepting new patients. If appropriate, the Exchange will coordinate its efforts with Connecticut's Health Information Exchange.

Stand-Alone Dental Requirements

- Provider network information should also be required for the stand-alone dental application.
- Stand-alone dental plans are not required to contract with any ECP but are encouraged to do so.

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Q. Attestations

This information may be Issuer or QHP-specific and will need to be included for in the carrier's application for this Solicitation.

ACA Requirements

- Comply with the minimum certification standards set forth in 45 CFR Subpart C of Part 156, with respect to each QHP on an ongoing basis

Connecticut QHP Requirements

- Attestations will be included on the application.
- The attestation language will cover the ACA requirements listed above, and will include specific attestations as outlined in the other sections of this Solicitation and required of the Exchange and/or CID.
- Attestations will cover Issuer's existing operations as well as any contractual commitments needed to meet Exchange requirements on an on-going basis.

Stand-Alone Dental Requirements

- Some of the same attestation language will apply to dental plans, but there may also be attestations that are unique to QHPs or stand-alone dental/vision plans

S. User Fees

This information will may be Issuer- or QHP-specific and will need to be included as appropriate for the Issuer's submission.

ACA Requirements

- Issuer must pay pay any applicable user fees assessed by the Exchange.

Connecticut QHP Requirements

- Attestation language will be included in application that commits the Issuer to pay any applicable user fee in a form and manner to be determined.

Stand-Alone Dental Requirements

- Risk adjustment and transitional reinsurance requirements will not apply to dental plans

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III. Attachments

1. Notice of Intent to Submit Qualified Health Plans
2. Connecticut's Essential Health Benefits
3. Listing of Connecticut's Essential Community Providers
4. References: Federal statutory requirements, regulations, and guidance
5. Required Attestations

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1. Notice of Intent to Submit Qualified Health Plans

The Notice of Intent to Submit Qualified Health Plans will be made available on the Exchange website with the Final Release of this Solicitation on December 3, 2012 at: <http://www.ct.gov/hix/>.

When form is complete, e-mail it to Julie Lyons, Director of Plan Management, at julie.lyons@ct.gov. Notice is due by 5:00 p.m. on December 31, 2012.

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2. Connecticut's Essential Health Benefits

The State has selected a benchmark plan that is pending approval by HHS and will set the essential health benefits package for 2014 and 2015. All plans in the individual and small employer group markets both inside and outside of the exchange are required to provide at minimum coverage for the essential health benefits. A QHP's essential health benefits will form the basis for calculating the actuarial value of the QHP.

SERVICE	LIMIT
Outpatient Services	
PCP Office Visits (non-preventive)	
Specialist Office Visits	
Outpatient Surgery Physician/Surgical Services	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Home Health Care Services	100 visits/year
Emergency Services	
Emergency Room	
Emergency Transportation/Ambulance	per state mandate*
Walk-in/Urgent Care Centers	
Hospitalization	
Inpatient Hospital (Facility & Provider Services)	
Skilled Nursing/Rehabilitation Facility	90 days/year
Hospice	life expectancy of 6 months or less
Residential Treatment Facilities	
Mental Health and Substance Use Disorder Services	
Mental/Nervous and Substance Abuse Services	same as any other illness
Rehabilitative and Habilitative Services and Devices	
Outpatient Rehabilitation Services (PT/OT/ST)	40 visits (combined)/year
Cardiac Rehabilitation	
Chiropractic Visits	20 visits/year
Durable Medical Equipment	
Prosthetics	
Ostomy Appliances and Supplies	per state mandate*
Diabetic Equipment and Supplies	
Wound care supplies	per state mandate*
Disposable Medical Supplies	
Hearing Aids	for children under 12; 1/every 24 months
Surgically Implanted Hearing Devices	
Wigs	per state mandate*
Birth to Three	per state mandate*
Prescription Drugs	
Laboratory and Imaging Services	
Laboratory Services	
Non-advanced Radiology	
Advanced Imaging (includes MRI, PET, CAT, Nuclear Cardiology)	
Preventive and Wellness Services and Chronic Disease	
Adult Physical Exam	every 1-3 years for ages 22-49; 1/year for age 50+ as recommended by physician
Preventive Services	based on USPSTF A and B recommendation
Prenatal and Postnatal Care	
Infant/Pediatric Physical Exam	in accordance with national guidelines
Routine Immunizations	in accordance with national guidelines
Routine Gynecological Exam	1/year
Screening for Gestational Diabetes	for pregnant women between 24 and 28 weeks of gestation and at first prenatal visit for high risk of diabetes
Human Papillomavirus Testing	for women aged 30+; 1/every 3 years
Counseling for Sexually Transmitted Infections	for women 1/year
Counseling and Screening for HIV	for women 1/year

Note:

*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

SERVICE	LIMIT
Contraceptive Methods and Counseling	for women
Breastfeeding Support, Supplies and Counseling	for women
Screening and Counseling for Interpersonal and Domestic Violence	for women 1/year
Preventive Lab Services	complete blood count & urinalysis, 1/year
Baseline Routine Mammography	1 between ages 35-39 ; 1/year for age 40+
Adult Routine Vision Exam	1/year
Routine Cancer Screenings	in accordance with national guidelines
Blood Lead Screening and Risk Assessment	per state mandate*
Bone Sensity	1/every 23 months
Pediatric Hearing Screening	under age 19 as part of physical
Other Services	
Craniofacial Disorders	per state mandate*
Oral Surgery for Treatment of Tumors, Cysts, Injuries, Treatments of Fractures Including TMJ and TMD	TMJ for demonstrable joint disease only
Dental Anesthesia	per state mandate*
Reconstructive Surgery	to correct serious disfigurement or deformity resulting from illness or injury, surgical removal of tumor, or treatment of leukemia; for correction of congenital anomaly restoring physical or mechanical function
Maternity Coverage	
Mastectomy	per state mandate*
Breast Reconstructive Surgery after Mastectomy Including on Non-diseased Breast to Produce a Symmetrical Appearance	per state mandate*
Breast prosthetics	per state mandate*
Breast Implant Removal	per state mandate*
Autism Coverage	per state mandate*
Clinical Trials	per state mandate*
Solid Organ and Bone Marrow Transplants	
Medically Necessary Donor Expenses and Tests	
Transportation, Lodging and Meal Expense for Transplants	up to \$10,000 per episode (initial evaluation until sooner of discharge or cleared to return home)
Lyme Disease Treatment	per state mandate*
Allergy Testing	up to \$315 every 2 years
Diabetes Education	per state mandate*
Sterilization	
Casts and Dressings	
Renal Dialysis	
Sleep Studies	1 complete study/lifetime
Pain Management	per state mandate*
Neuropsychological Testing	per state mandate*
Accidental Ingestion of a Controlled Drug	per state mandate*
Diseases and Abnormalities of the Eye	annual retina exams for members with glaucoma or diabetic retinopathy
Corneal Pachymetry	1 complete test/lifetime
Infertility	per state mandate*
Genetic Testing	for members who have or are suspected of having a clinical genetic disorder
Specialized Formula	per state mandate*
Nutritional Counseling	2 visits/year
Enteral or Intravenous Nutritional Therapy	
Modified Food Products for Inherited Metabolic Disease	per state mandate*
Pediatric Vision Care	
Routine Eye Exam	1 exam/year
Lenses	1 pair/year
Frames	1 frame/year
Contact lenses	1 fitting and set of lenses/year
Pediatric Oral Care	
Exams	1 every 6 months
Bitewings	1 time/year

Note:

*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

SERVICE	LIMIT
Other X-rays	
Sealants	on premolar and molar teeth
Fluoride treatments including topical therapeutic fluoride varnish application	for clients with moderate to high risk of dental decay
Access for Baby Care Early Dental Examination and Fluoride Varnish where an oral health screen, oral health education and fluoride varnish are applied to children's teeth during well child examinations	up to 4 years of age
Dental Orthodontia (under age of 19)	
Replacement Retainer	limited to 1 replacement/lifetime
Amalgam and Composite Restorations (Fillings)	
Fixed Prosthodontics: Crowns, Inlays and Onlays	
Re-cementing Bridges, Crowns Inlays & Space Maintainers	
Removable Prosthodontics: Full or Partial Dentures	
Repair, Relining and Rebasing Dentures	
Intermediate Endodontic Services	
Major Endodontic Services: Root Canal Treatment, Retreatment of root canal therapy; apicoectomy; apexification	
Oral Surgery: Surgical Extraction, including Impacted Teeth	
Non-surgical Extraction	
Periodontal Surgery and Services	
Space Maintainers	
General Anesthesia and Sedation	
Miscellaneous Adjunctive Procedures	

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Note:

*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

3. Listing of Connecticut Essential Community Providers

For purposes of this Solicitation, the **ECPs** in Connecticut include:

1. **340B Essential Community Providers:**

Non-hospital and hospital entities in located Connecticut and listed in HRSA’s 340B non-hospital and hospital entities list are 340B Essential Community Providers for purposes of this solicitation.

To generate a statewide listing of 340B providers in the form of a worksheet go to:

<http://openet.hrsa.gov/OPA/CESearch.aspx>.

Under **Entity Type**: select “All”

Under **340B Number**: leave blank

Under **Entity Name**: leave blank

Under **Entity City**: leave blank

Under **State**: select “Connecticut”

Under **Zip and Grant/Provider Number**: leave blank

Under **Participating**: select “Yes”

For the purposes of this solicitation, 340B entities that do not appear in this list as of December 31, 2012, are not considered Essential Community Providers.

2. **Disproportionate Share Hospitals**

3. **Federally-designated Indian Health Service facilities**

4. References: Federal Statutory Requirements, Regulations, and Guidance

The ACA requires the Exchange to establish procedures for the certification of QHPs (ACA § 311(d)(4)(A)). In determining whether a health plan should be certified as a QHP, the Exchange is required and permitted to consider certain criteria regarding the Issuer and regarding the health plan. In general, the Issuer must provide evidence that it complies with the minimum certification requirements, and the Exchange must make a determination that the issuer is acting in accordance with the ACA and Exchange standards and that making the health plan available is in the interest of qualified individuals and qualified employers (45 CFR §155.1000(c)(2)).

The Exchange intends to include in its Final Release, references to all statutory requirements and all current federal regulations—final and proposed.

Solicitation Section	Requirement Category	Federal Requirement	Reference
C	Licensing	<i>State Licensure</i>	45 CFR §156.200(b)(4)
D	QHP Certification Process	<i>Timing of QHP Certification</i>	45 CFR §155.1010(a)
		<i>Frequency of QHP Certification</i>	45 CFR §155.1075
	Continued Compliance with Criteria	<i>Exchange monitoring of QHP for compliance</i>	45 CFR §155.1010(d)
F	Actuarial Value	<i>Actuarial Value Standards</i>	Federal guidance not yet final
	Abortion Services	<i>Compliance with State Abortion Laws</i>	45 CFR §156.280(a)
		<i>Abortion Funds Segregation</i>	45 CFR §156.280
		<i>Rate Plan Year</i>	45 CFR §156.210(a)
	Premium Rate and Benefit Information	<i>Rate submission</i>	45 CFR §156.210 (b)
		<i>Rate Increase Justification</i>	45 CFR §156.210(c), 45 CFR §155.1020(a)
		<i>Rate Increase Consideration</i>	45 CFR §155.1020 (b)
		<i>Benefit and Rate Information</i>	45 CFR §155.1020(c)
	Plan Benefits	<i>Minimum Coverage</i>	45 CFR §156.200(b)(3)
		State-Specific Essential Health Benefits	Federal guidance not yet final
Stand-Alone Dental		§9832(c)(2)(A) of the Internal Revenue Code, §2791(c)(2)(A) of the Public Health Service Act, 42 U.S.C. 18031(d).	
G	Rating variations	<i>Product Pricing</i>	45 CFR §156.255(b)
		<i>Allowable Variability</i>	45 CFR §156.255(a)
I	Plan Offering Requirements	<i>Actuarial Value Tiers</i>	45 CFR §156.200(c)(1)
		<i>Child-only plan.</i>	45 CFR §156.200(c)(2)
J	Cost Sharing Reduction	<i>Cost Sharing Reductions</i>	§1402(a)-(d) of the ACA
K	Accreditation	<i>General requirement</i>	45 CFR §156.275(a)
		<i>Timeframe for Accreditation:</i>	45 CFR §156.275(b)
L	Health care quality requirements	<i>Quality Improvement Initiative</i>	45 CFR §156.200(b)(5), Section 1311(g) of the ACA

Solicitation Section	Requirement Category	Federal Requirement	Reference
		<i>Quality and Outcomes Reporting</i>	45 CFR §156.200(b)(5), Section 1311(c)(1)(I) of the ACA
		<i>Enrollee Satisfaction Surveys</i>	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
M	Transparency in Coverage	<i>Required Information Related to Coverage Transparency</i>	45 CFR §156.220(a)
		<i>Reporting Requirement</i>	45 CFR §156.220(b), 45 CFR §156.220(c)
		<i>Enrollee Cost Sharing</i>	45 CFR §156.220(d)
P	Service Area	<i>Minimum Service Area</i>	45 CFR §155.1050(a)
		<i>Non-Discriminatory Service Area</i>	45 CFR §155.1050(b)
	Network Adequacy	<i>Network Adequacy Standards</i>	45 CFR §156.230
		<i>Provider Directory</i>	45 CFR §156.230(b)
		<i>Essential Community Providers</i>	45 CFR §156.235
S	User Fees	<i>Issuer Payment of Fees</i>	45 CFR §156.200(b)(6)
Other	Marketing	<i>Marketing Rule Compliance</i>	45 CFR §156.225(a)
		<i>Non-discrimination</i>	45 CFR §156.225(b)
	Enrollment Processes and Periods	<i>Enrollment Periods and Processes</i>	45 CFR §156.260, §156.265 (small employer: 45 CFR §155.725)
		<i>Termination</i>	45 CFR §156.270
	Risk Adjustment	<i>Participation in Risk Adjustment Programs</i>	45 CFR §156.200(b)(7)
	Non-discrimination	<i>Non-Discrimination</i>	45 CFR §156.200(e)

5. Required Attestations

Any required attestations will be included in the Final Release of this Solicitation on December 3, 2012.

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