



To: Members of the Joint Advisory Committee Meeting  
 From: Connecticut Health Insurance Exchange Staff and Joint Advisory Committee Meeting  
 Re: Joint Advisory Committees' Recommendations for "Issues for Review" identified in draft of "Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges"  
 Date: November 27, 2012

No.	Issue for Review	Advisory Committee Recommendation
<b>1 Initial Certification Period</b>		
<b>1.a</b>	Should the initial QHP certification be for a two-year period? Should failure of an issuer to apply for certification in 2014 inhibit participation by the carrier until (at least) 2016?	<p>The Exchange's initial QHP Solicitation should be for a two-year QHP certification. This would provide carriers with both a level of predictability and incentive to participate in the Initial Solicitation.</p> <p>Rates will need to be approved annually by CID according to state regulation.</p> <p>The Exchange would solicit applications for QHP certification again for plan year 2016, but will consider admitting newly licensed carriers and existing carriers for special circumstances (e.g., an issuer tries but fails to meet certification criteria in 2014, and succeeds in doing so for 2015) in 2015 that the Exchange decides would be in the interest of consumers. Any QHP certification granted for 2015 would only be for one-year certification.</p>
<b>1.b</b>	If a QHP carrier ceases participation in the Exchange, should the carrier be prevented from rejoining for two (or three) years?	<p>If a certified QHP carrier ceases participation in the Exchange, the carrier should be denied re-entry for a minimum two (2) years until the next solicitation.</p> <p>The Exchange will consider appeals to this general exclusion during the next general QHP solicitation after conducting a thorough review of the carrier's new application.</p>
<b>2 Mix and Number of Plans</b>		
<b>2.a</b>	How many health plans should a carrier be required and/or allowed to offer through the Exchange?	<p>For both the Individual Exchange and SHOP Exchange (although a carrier does not need to participate in both exchanges), a QHP carrier must submit at a minimum the following mix of plans:</p> <ul style="list-style-type: none"> <li>• One (1) Gold Plan</li> <li>• One (1) Silver Plan</li> <li>• One (1) Bronze Plan</li> </ul> <p>But no more than:</p> <ul style="list-style-type: none"> <li>• One (1) Platinum Plan</li> <li>• Two (2) Gold Plans</li> <li>• Two (2) Silver Plans</li> <li>• Two (2) Bronze Plans</li> </ul> <p>For the Individual Exchange only, a QHP carrier must submit:</p> <ul style="list-style-type: none"> <li>• Three (3) required actuarial value ("AV") variations for <b>at least</b> one (1) Silver Plan</li> <li>• One (1) Catastrophic Coverage Plan</li> </ul> <p>And may submit:</p> <ul style="list-style-type: none"> <li>• One (1) child-only QHP for each metal tier for which a carrier submits a plan</li> </ul>
<b>2.b</b>	Should carriers be required, prevented, or given the option of offering Platinum QHPs?	The Exchange should allow, but not require, carriers to submit one (1) Platinum Plan in each of the Individual Exchange and SHOP Exchange.

2.c	Should QHP carriers be required to submit one or more standardized plan designs for one or more metal tiers as a part of their application to participate in the Exchange?	<p>A standardized plan design per tier promotes transparency, ease, and simplicity for comparison shopping by enrollees.</p> <p>As such, the Exchange should define one standard plan design for each of the Bronze, Silver and Gold tiers. The standard plan would define the QHP’s deductible, co-payment and/or co-insurance mix for the essential health benefits offered in-network. The standard plan designs will be developed in partnership with the carriers and be based upon the most popular plans sold in the small group market in 2012. The plan would be subject to adjustment after release of the federal actuarial value calculator.</p> <p>A QHP carrier should be required to submit this Exchange-defined standard plan for each the Bronze, Silver, and Gold tiers.</p> <p>For each metal tier (except Platinum) the carriers will be encouraged to submit one other, non-standard, plan of their choosing.</p>
<b>3 Stand-Alone Dental</b>		
3.a	Should pediatric dental services be priced separately? (Alternative is to allow QHP carriers to bundle services.)	The Exchange should require QHP carriers to separately rate their pediatric dental benefit. If a QHP includes pediatric dental services, potential enrollees will be automatically assigned to the carrier’s dental benefit, but the enrollee will retain the option of selecting another carrier’s dental plan if desired.
3.b	For stand-alone dental plans, should carriers be required to offer plans across all, any, or specific metal tiers?	Actuarial certification to the metal tiers should not apply to stand-alone dental visions, unless required by federal regulations.
3.c	For stand-alone dental plans, should the Exchange consider selling two benefit tiers of stand-alone dental plans: (1) preventive only; and (2) full benefits?	<p>All stand-alone dental plans must provide coverage for the full dental benefits, as included in the “essential health benefits” for pediatric dental services.</p> <p>The Exchange should not offer a limited preventative-only dental plan. Instead, the Exchange could explore the value of offering “access-only” dental plans. However, these plans are not insurance and would not be part of the Initial QHP solicitation.</p>
<b>4 Rating Factors</b>		
4.a	Should the Exchange make tobacco-use a required rating factor in the Individual Exchange?	The Exchange should prohibit QHP carriers to include tobacco use as a rating factor in the Individual Exchange.
4.b	Should the Exchange require carriers to agree to standardized rating factors (for geography, age, household size) across all QHPs sold through the Exchange?	<p><b>Family.</b> The Exchange should standardize family composition structure, but allow carriers to determine tier ratios.</p> <p><b>Age.</b> Per ACA reforms QHPs will be subject to a 3:1 age factor rating. The Exchange should allow carriers to determine tier ratios.</p> <p><b>Geography.</b> The Exchange should allow carriers to determine tier ratios.</p>

5 Network Adequacy		
5.a	What should be a carrier's network adequacy standard?	<p>A QHP carrier must ensure that the provider network of each of its QHPs meets these standards:</p> <ol style="list-style-type: none"> <li>1) The network for each of its plans is URAC or NCQA accredited with respect to provider adequacy;</li> <li>2) It includes essential community providers ("ECP") of a sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the service area;</li> <li>3) The network is, and continues to be, 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;</li> <li>4) The network is consistent with the network adequacy provisions of section 2702(c) of the PHSA;<sup>1</sup> and,</li> <li>5) The network of providers for its standard plan offerings is, and continues to be, substantially the same as the network of providers it offers to its largest plan offered outside of the exchange.</li> </ol> <p>The Exchange will monitor network adequacy by:</p> <ol style="list-style-type: none"> <li>1) Requiring each carrier to provide the Exchange 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 variation of standards by provider specialty. All such standards shall be made readily available to the public and consumers on the Exchange;</li> <li>2) Contracting for an ongoing independent secret shopper review and ongoing independent monitoring process to validate sufficiency of the network and to assure that all services will be accessible without unreasonable delay. All data and reports of the independent review and monitoring entity shall be made readily available to the public and consumers on the Exchange.</li> </ol>
5.b	What should the Exchange's network adequacy standard be as it relates to Essential Community Providers?	<p>With respect to ECPs, sufficiency shall be defined as carriers having contracts with:</p> <ol style="list-style-type: none"> <li>1) At least 75% of the ECPs located in each county in which the QHP operates.</li> <li>2) 100% of the federally qualified health centers ("FQHC") or "look-alike" health center in each county in which the QHP operates. A QHP is not required to contract with an FQHC or "look-alike" health center that refuses to accept the relevant Medicaid PPS rate.</li> </ol> <p>The ECPs in Connecticut include:</p> <ol style="list-style-type: none"> <li>1) 340B Essential Community Providers: Non-hospital and hospital entities located in Connecticut and listed in HRSA's 340B non-hospital and hospital entities list.</li> <li>2) Disproportionate Share Hospitals</li> <li>3) Federally Designated Indian Health Services Facilities</li> </ol>

6 Purchasing Model	
6	<p>What should be the Exchange’s purchasing model? Should the Exchange actively negotiate rates in 2014?</p>

1. The Exchange’s purchasing model will reflect its principles for QHP certification. For its Initial Solicitation and to provide consumers transparent choice and carrier competition, the Exchange should contract with any carrier that meets the standards for QHP certification for the standard plan design defined in its QHP Solicitation, except as provided in 2 below.
2. In the event that there is an adequate number of Qualified Health Plans available to allow for sufficient consumer choice, at the time of the initial Solicitation or at any time thereafter, the Exchange should consider not offering for sale one or more otherwise certified QHPs on the basis of price.
3. After its initial Solicitation, the Exchange should develop a plan to move along a continuum from “any willing carrier” toward “active purchaser” starting with the next solicitation.
4. The Connecticut Insurance Department must approve all forms and rates before a plan may be certified by the Exchange.
5. The Exchange will require carriers to submit a narrative outlining how they will attempt to better coordinate care and control costs, improve chronic illness management, reduce medical error, or otherwise promote health care delivery and payment reform for the benefit of the consumer.

<sup>1</sup> From **Public Health Services Act** (see 42 U.S.C. 300gg-1):

**Sec. 2702. Guaranteed Availability of Coverage.**

(c) SPECIAL RULES FOR NETWORK PLANS.—

- (1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—
- (A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and
  - (B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—
    - (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and
    - (ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.