



Connecticut's Health Insurance Marketplace

Memorandum

Date: April 25, 2014

From: Julie Lyons

To: Access Health CT Board of Directors

Re: **Plan Management – Qualified Health Plan Requirements in 2015**

Introduction

Access Health CT (AHCT) released a Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace ("Solicitation") on March 17, 2014. Qualified Health Plan (QHP) Issuers that did not participate in the AHCT Marketplace in 2014 or Issuers that wish to extend their participation to a new market (Individual or Small Group) were required to submit a Non-Binding Notice of Intent (NOI) in order to be considered for certification for the 2015 plan year. Although the QHP Issuers that are currently participating in the AHCT Marketplace did not have to submit a NOI, they were encouraged to review the requirements provided in the Solicitation.

AHCT granted QHP Issuers participating in the AHCT Marketplace certification for a two year period. However, certification of the QHPs offered by such Issuers must be conducted annually. Consequently, QHP Issuers that participate in the AHCT Marketplace in 2014 will have to meet the requirements pertaining to QHP certification that will be provided in the 2015 QHP Application ("Application") consistent with the provisions in the 2015 Solicitation.

A number of QHP certification requirements have been expanded to reflect current policies as well as AHCT's ongoing efforts to monitor QHP Issuers' compliance with AHCT's requirements. These requirements will be included in the 2015 QHP Application and will apply to the currently participating QHP Issuers and new entrants:

- **Compliance and Performance Oversight Requirements:** in 2014 AHCT required QHP Issuers to submit a compliance plan and an attestation that an Issuer's compliance plan adheres to all applicable laws, regulations, and guidance and is implemented or ready to be implemented. The 2015 Solicitation provides that in addition to the submission of a compliance plan and the attestation, AHCT will utilize complaint data, Issuer self-reported problems, information related to consumer service and satisfaction, health care quality and outcomes, QHP Issuer operations, and network adequacy in its assessment of Issuers' performance in the Marketplace. This provision is consistent with AHCT's current practices of the Issuers' compliance monitoring. Additionally, as part of compliance and performance monitoring, AHCT

intends to require the Issuers to provide complaints reports at a frequency established by AHCT. This measure will allow for a more comprehensive compliance oversight by AHCT.

- **Marketing Guidelines:** in 2014, AHCT advised QHP Issuers that co-branding is not permitted. Consistent with this guidance, in 2015 AHCT will continue to prohibit co-branding. Specifically, Issuers will not be allowed to use AHCT's name or logo in any of their marketing materials. In addition, Issuers' marketing material cannot include a reference to the "Exchange" or "Connecticut Exchange" without express approval from AHCT. AHCT will require Issuers to provide AHCT with an opportunity to review and provide feedback on any marketing materials specific to QHPs offered on the AHCT's Marketplace. Another requirement in this section pertains to AHCT's expectation that QHP Issuers' Plan Marketing Names will be easy to understand for the consumers. Specifically, AHCT will prohibit inclusion of an Issuer's internal coding in the Plan Marketing Names.
- **Consumer Information:** AHCT will continue to require the submission of the enrollee materials such as Schedule of Benefits, Evidence of Coverage and the Summary of Benefits and Coverage and will post such materials on the AHCT's consumer shopping portal. AHCT will require QHP Issuers to submit these materials in English and Spanish. AHCT required Issuers to provide URLs to the Issuers' online provider directory and prescription drug formulary specific to each QHP. The Solicitation provisions which will be incorporated in the Application reflect and provide detail on this requirement. Additionally, consistent with 45 C.F.R. 156.230(b) which provides that "[i]n the provider directory, a QHP issuer must identify providers that are not accepting new patients," the Solicitation provision requires QHP Issuers to identify those providers that are not accepting new patients and allow consumers the ability to perform a search by those providers that are accepting new patients and those that are not. AHCT will issue guidance to the Issuers on implementing this requirement.
- **Wellness Incentives:** In 2014, AHCT encouraged QHP Issuers to offer wellness programs as described in 45 C.F.R 146 and 147. The 2015 provision continues to state AHCT's encouragement for Issuers to offer such program but requires Issuers that wish to offer a wellness program in the Small Group market to provide AHCT with detailed information about the proposed program and an Issuer's prior experience with offering wellness programs outside of the AHCT Marketplace. AHCT will review the proposed wellness program(s) to determine whether it should be offered in the Marketplace.
- **Accreditation:** CMS has recently recognized a new accrediting entity, Accreditation Association for Ambulatory Health Care (AAAHC) for 2015 plan year. Accordingly, AHCT has added AAAHC to the list of recognized accrediting agencies in the Solicitation. Additionally, AHCT added a provision that requires QHP Issuers to authorize the accrediting entity to release to AHCT a copy of its most recent accreditation survey, together with any survey-related information, such as corrective action plans and summaries of findings.
- **Reporting:** in addition to requiring QHP Issuers to submit a narrative outlining how an Issuer 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 through the Issuer's Quality Improvement Strategy, AHCT will require Issuers to submit metrics they intend to use to demonstrate program success.

- **Patient Safety Standards:** AHCT intends to adopt the Patient Safety Standard proposed by CMS for the 2015 plan year. Proposed regulatory requirements at §156.1110 in the CMS 2015 Payment Notice outline how QHP issuers can demonstrate compliance with these standards, on a transitional basis, for 2 years beginning January 1, 2015 or until further regulations are issued, whichever is later. Specifically, the proposal requires QHP issuers that contract with a hospital with greater than 50 beds to verify that the hospital, as defined in section 1861(e) of the SSA, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:
 - (1) A quality assessment and performance improvement program as specified in 42 C.F.R. § 482.21; and
 - (2) Discharge planning as specified in 42 C.F.R. § 482.43.

In addition, QHP issuers would be required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the certification for the 2015 benefit year, AHCT anticipates requiring QHP issuers to demonstrate compliance with these patient safety standards as part of the QHP Application with an attestation that they have collected and are maintaining the required documentation from their network hospitals. AHCT intends to develop a standard form for Issuers to demonstrate compliance with Patient Safety Standards.

The Solicitation included other, more substantial changes in QHP certification requirements that AHCT will propose to the Board of Directors. Upon the Board's approval of these requirements, AHCT will include them in the Application and require all QHP Issuers participating in the AHCT Marketplace to comply with QHP certification requirements. The list provided below outlines the provisions that have been substantially changed and will require the Board's approval to be implemented for QHP certification in 2015:

- Network Adequacy
- Pediatric Dental Benefits
- Plan Options
- Prescription Drug Formulary

The exhibits provide additional information on changes to these requirements.

1. Exhibit 1 – Informational Memorandum: Network Adequacy Requirements for the 2015 Plan Year
2. Exhibit 2 – Informational Memorandum: Plan Options Requirements for the 2015 Plan Year
3. Exhibit 3 – Informational Memorandum: Pediatric Dental Benefits Requirements for the 2015 Plan Year
4. Exhibit 3 – Informational Memorandum: Prescription Drug Formulary Requirements for the 2015 Plan Year

Exhibit 1

INFORMATIONAL MEMORANDUM**Network Adequacy Requirements for the 2015 Plan Year**

Reasoning/Background: Access Health CT (AHCT) is seeking to amend Network Adequacy requirements for Qualified Health Plan (QHP) Issuers for the 2015 plan year. The proposed amendment changes the current “substantially similar” requirement for Issuers’ provider networks for standard plans to a more comprehensive requirement in 2015.

Additionally, Issuers’ networks for all plans will need to adhere to AHCT’s “reasonable access” standards which AHCT is currently developing and will propose to the Board of Directors at a later date. The purpose of the amendment is to implement meaningful and comprehensive network adequacy standards and enable AHCT to thoroughly assess Issuers’ compliance with such standards.

The language was amended in the 2015 Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace (“2015 QHP Solicitation”) and if the change is adopted, AHCT will include the language in the 2015 QHP Issuer Application and extend the requirement to the Issuer(s) joining the Marketplace in 2015 as well as the currently participating Issuers which will be offering QHPs in 2015.

AHCT is not proposing to change the QHP Issuer contracting standards with Essential Community Providers for 2015 which the Board had previously approved.

Proposed 2015 Plan Year Requirement: AHCT proposes to require that an Issuer’s provider network for the Standard Plan designs offered for sale in the Marketplace must include at least 85% of those unique providers and unique entities that are in the Issuer’s network for its largest plan (representing a similar product) that is marketed, sold and has active enrollees outside of the Marketplace (“the benchmark plan.”)

If an Issuer has an affiliated company that is active outside of the Marketplace, but in the State of Connecticut, AHCT will look to the larger of the Issuer’s network for its largest plan or the network of the Issuer’s affiliated company’s largest plan (representing a similar product) that is marketed, sold and has active enrollees outside of the Marketplace, but in the State of Connecticut, as the “benchmark plan” for the purposes of such network adequacy calculation.

In order to determine whether the Issuer’s provider network(s) meet the 85% requirement, AHCT will periodically require an Issuer to provide current network information for both its standard plan designs’ network and for the benchmark plan network.

Issuers’ networks for all QHPs will need to adhere to AHCT’s reasonable access standards. AHCT is currently evaluating the requirements for the 2015 benefit year. AHCT’s intention is to develop reasonable access standards based on membership distribution by Issuer throughout the State and implement specific geographical access standards by provider type. Issuers will be required to submit provider network information in a format specified by AHCT.

2014 Plan Year Requirement: AHCT currently requires an Issuer’s provider network for standard plans to be substantially similar to the provider network available to the Issuer’s largest plan (representing a

Exhibit 1

similar product) offered outside of the Marketplace. AHCT determines whether an Issuer meets the “substantially similar” requirement, by applying the following criteria:

- Provider network for each QHP must include at least 85% of the hospitals that are in the Issuer’s provider network outside of the Marketplace
- If the Issuer’s provider network outside of the Marketplace includes fewer than 750 unique facilities, the Issuer’s provider network for each QHP must include at least 85% of those facilities
- If the Issuer’s provider network outside of the Marketplace includes greater than 750 unique facilities, the Issuer’s provider network for each QHP must include at least 80% of those facilities
- If the Issuer’s provider network outside of the Marketplace includes fewer than 10,000 unique providers, the Issuer’s provider network for each QHP must include at least 85% of those providers
- If the Issuer’s provider network outside of the Marketplace includes greater than 10,000 unique providers, the Issuer’s provider network for each QHP must include at least 80% of those provider

Exhibit 2

INFORMATIONAL MEMORANDUM**Plan Options Requirements for 2015 Plan Year**

Reasoning/Background: Access Health CT (AHCT) is seeking to amend the number of standard and non-standard Qualified Health Plans (QHPs) that could be offered by the Issuers for the 2015 plan year. AHCT proposes adding a Health Savings Account (HSA) compatible Standard Bronze Plan that Issuers must offer in 2015 and expanding the previous limit on the number of non-standard Plans an Issuer may offer in the Marketplace from two (2014 limit) to three. The proposal applies to both the Individual and Small Group markets. The purpose of these changes is to augment the number of options that consumers can choose from in the Marketplace.

The language was amended in the 2015 Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace (“2015 QHP Solicitation”) and if the change is adopted, AHCT will include the amended language in the 2015 QHP Issuer Application and extend the requirement to the Issuer(s) joining the Marketplace in 2015 as well as the currently participating Issuers which will be offering QHPs in 2015.

2014 Requirements: AHCT currently requires QHP Issuers to offer at least one Standard Gold Plan, one Standard Silver Plan, and one Standard Bronze Plan.

A QHP Issuer may opt to submit non-standard individual 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 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.

Proposed 2015 Requirements: AHCT proposes amending the current requirements as follows:

An Issuer must submit at least one Standard Gold Plan, one Standard Silver Plan, and two Standard Bronze Plans (one Standard Bronze Plan and one Standard HSA compatible Bronze Plan).

Issuers are also encouraged to submit any combination of QHP plan designs:

- The Issuer may opt to offer a catastrophic coverage plan in the Individual market. Any Issuer offering the catastrophic coverage plan option must comply with Federal law including Section 1302 (e) of the ACA and 45 C.F.R. § 156.155; and any applicable State law.
- One Standard Platinum Plan and up to two Non-Standard Platinum Plans
- Up to three Non-Standard Gold Plans
- Up to three Non-Standard Silver Plans with the corresponding cost-sharing reduction plans
- Up to three Non-Standard Bronze Plans

INFORMATIONAL MEMORANDUM

Pediatric Dental Benefits Requirements for the 2015 Plan Year

Reasoning/Background: In accord with federal and state law, Access Health CT (AHCT) recognizes a Qualified Health Plan (QHP) Issuer's choice whether to embed or not embed the pediatric dental benefits in the Non-Standard Plans. However, Issuers must embed pediatric dental benefits in AHCT's Standard Plan designs.

Specifically, 45 C.F.R. § 155.1065(d) provides that if a limited scope dental benefits plan is available through the Exchange, "another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act." To allow consumers to continue to have a fully comparative shopping experience among QHP Issuers, AHCT will continue to require pediatric dental benefits to be embedded in the Standard Plan designs which all participating QHP Issuers must offer.

Conn. Gen. Stat. § 38a-1086 provides that "[h]ealth carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by a health carrier through a qualified dental plan and health benefits are provided by another health carrier through a qualified health plan, provided the plans are priced separately and are also made available for purchase separately at the same such prices."

AHCT has solicited Stand-Alone Dental Plan Issuers to offer stand-alone dental plans through the Marketplace in 2015.

Exhibit 3

INFORMATIONAL MEMORANDUM**Prescription Drug Formulary Requirements for the 2015 Plan Year**

Reasoning/Background: Access Health CT is seeking to require Issuers to provide a prescription drug formulary for the Standard Plan designs in accord with the greater of either 45 C.F.R. § 156.122(a)¹, or equal in number and type to the formulary in the Issuer's plan with the highest enrollment (representing a similar product) offered outside of the Marketplace.

In 2014 QHP Issuers were required to meet the standards set forth in 45 C.F.R. § 156.122.

The language was amended in the 2015 Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace ("2015 QHP Solicitation") and if the change is adopted, AHCT will include the amended language in the 2015 QHP Issuer Application and extend the requirement to the Issuer(s) joining the Marketplace in 2015 as well as the currently participating Issuers which will be offering QHPs in 2015.

QHP Requirements for 2015 Plan Year

¹45 C.F.R. §156.122(a) provides that in order for a health plan to comply with the requirement to provide Essential Health Benefits (EHB), health plan must cover "at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan."