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Connecticut's Health Insurance Marketplace

Health Plan Benefits & Qualifications and Consumer Experience & Outreach Advisory Committee Meeting

May 21, 2013

Meeting Agenda

I. Call to Order

II. Network Adequacy

III. Essential Community Providers

IV. Standard Plan Design Update

NETWORK ADEQUACY

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Network Adequacy: Affordable Care Act (ACA)

- QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards—
  - Includes ECPs in accordance with § 156.235
  - Maintains network sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services
  - Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act
- QHP issuer must make its provider directory available
  - to the Exchange for publication online in accordance with guidance from the Exchange and
  - to potential enrollees in hard copy upon request
  - Directory must include indicator for providers not accepting new patients
- QHP issuer must provide information about accreditation status

Connecticut Network Adequacy Requirements

- Sec. 38a-472f. Provider network adequacy.
  - Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or medical benefits plan, and each preferred provider network, as defined in section 38a-479aa, that contracts with a health care provider, as defined in section 38a-478, for the purposes of providing covered health care services to its enrollees, shall maintain a network of such providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards.

Network Adequacy: National Committee for Quality Assurance

- NCQA Accredited plans must develop standards for the number and geographic distribution of providers
  - Primary care, specialty care and behavioral health providers
  - Annually, must measure against standards using a statistically valid methodology
- Plans must set standards on the ability of members to get care
  - Regular appointments, urgent care appointments, after hours care and member services by phone
  - Collect data & analyze performance against standards at least annually
- Plans must assess cultural, ethnic, racial and linguistic needs of their members and adjust network if necessary.
- NCQA requires plans to ask enrollees directly whether they have adequate access to care using the CAHPS® survey
  - Addresses question of whether network providers are actually seeing patients
  - Part of a plan's overall NCQA Accreditation score is based on CAHPS® performance

Network Contracting Information

- Length of time for contracting is approximately 6 – 12 months, depending on:
  - Provider Type
  - Type of Arrangement
  - Criteria
    - Specific standards, such as hours of operation, required
    - Payment terms
- Credentialing
  - Review of information such as Educational Background, Board Certification, Professional Liability Insurance, Health Care Licensure / Registrations & Certificates
  - For providers not already credentialed, an additional 60-90 days may be needed
- ECP's Currently Contracted by Carriers
  - Under Evaluation

ESSENTIAL COMMUNITY PROVIDERS

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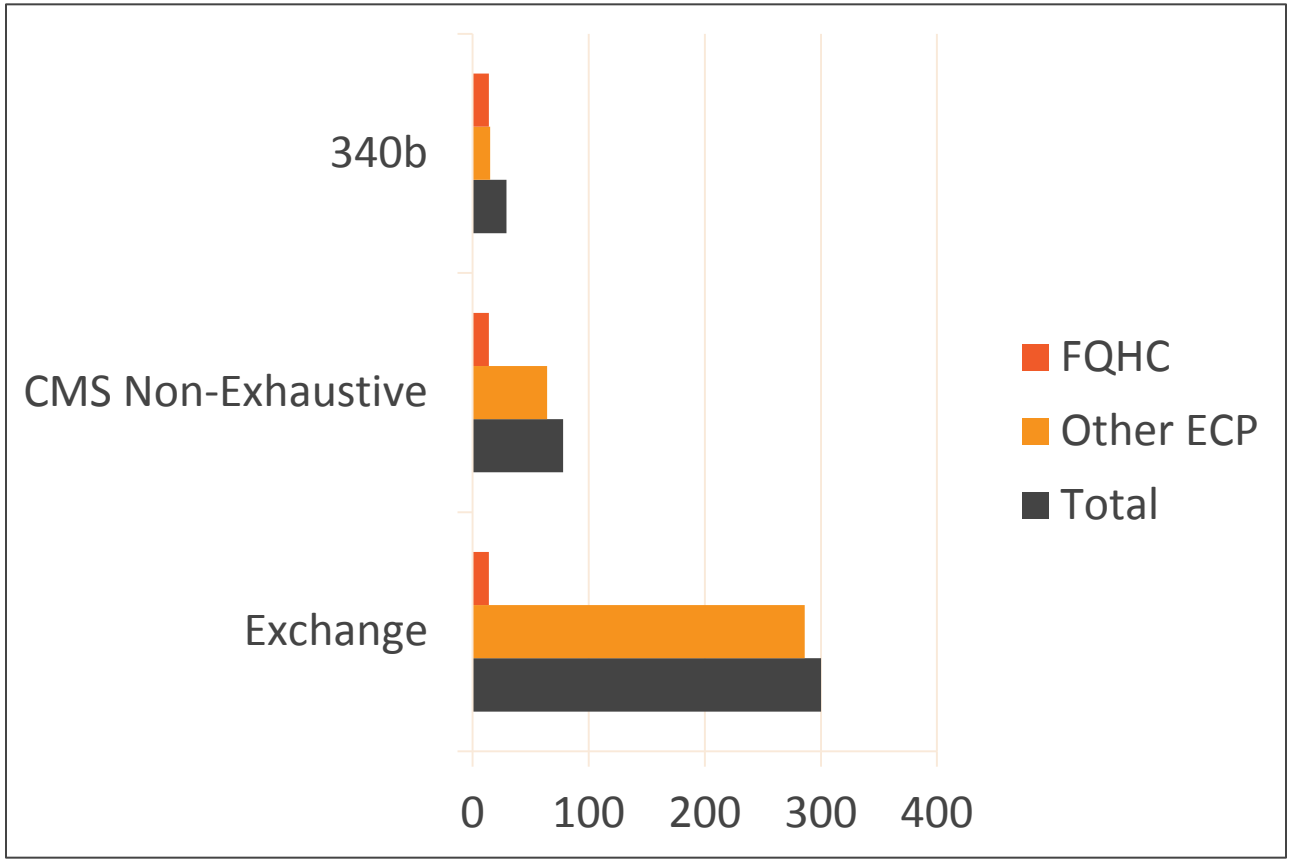
Essential Community Providers: Regulations

- Essential Community Providers: 45 CFR §156.235
  - (a) General requirement.
    - (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.
  - (c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:
    - (1) Health care providers defined in section 340B(a)(4) of the PHS Act; **AND**
    - (2) Providers described in section **1927(c)(1)(D)(i)(IV)** of the Act as set forth by section 221 of Public Law 111–8.

Essential Community Providers: Connecticut Approach

Board of Directors (November, 2012)	QHP Solicitation
With respect to ECP's, sufficiency shall be defined as carriers having contracts with: • **At least 75% of the ECP's* located in any county in Connecticut; and,** • **At least 90% of the federally qualified health centers (FQHC) or "look-alike" health centers in Connecticut.** • **The network is consistent with the network adequacy provisions of section 2702(c) of the Public Health Services Act** ***ECP's in Connecticut to include the following:** • **340b providers** • **Disproportionate Share Hospitals** • **Federally Designated Indian Health Services Facilities**	**QHP Issuer must ensure that the provider network of each of its QHPs meets these standards:** • **It includes ECP's of 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;** • **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;** • **The network is consistent with the network adequacy provisions of section 2702(c) of the Public Health Services Act**

Essential Community Providers – Unique Provider Data Lists



340b and Non-Exhaustive Lists were determined to be inadequate because they:

- ***did not include behavioral health / substance abuse facilities, dental clinics or Veteran's Home***
- ***had only a limited number of school based health centers***
- ***did not include all services included in EHBs***

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ECP: Proposed Sufficiency Standards for Connecticut

- The definition of ECP has been expanded to a larger listing of ECP entities consistent with federal requirements and state law.
- To allow carriers adequate time to get contracts in place and providers credentialed, the network sufficiency standard will span a 3 year timeframe
  - Contracting Standard Proposed (for all ECP categories not separately identified):
    - 2014 calendar year - A contracting standard of 20% of ECPs to be under contract by each carrier at the end of 2013. The provider contracting process includes a credentialing process after contracting is underway
    - 2015 calendar year - A contracting standard of 50% of ECPs to be under contract by each carrier at the end of 2014. The provider contracting process includes a credentialing process after contracting is underway
    - 2016 calendar year - A contracting standard of 75% of ECPs to be under contract by each carrier at the end of 2015. The provider contracting process includes a credentialing process after contracting is underway.

ECP: Proposed Sufficiency Standards for Connecticut

- School Based Health Centers (SBHC)
  - CGS 38a-472e requires: “Each insurer licensed to do business in this state shall, at the request of any school-based health center or group of school-based health centers, offer to contract with such center or centers to provide reimbursement for covered health care services to persons who are insured by such licensed insurer. Such offer shall be made on terms and conditions similar to contracts offered to other providers of health care services”.
  - There are presently 113 School Based Health Centers in Connecticut
  - Contracting Standard Proposed:
    - 40% for the 2014 calendar year
    - 50% for the 2015 calendar year
    - 75% for the 2016 calendar year

ECP: Proposed Sufficiency Standards for Connecticut

- Veteran's Home: CGS 381-529 requires mandatory coverage for services provided by the Veterans' Home. No group health insurance policy delivered, issued for delivery or renewed in this state on or after October 1, 1988, may exclude coverage for services provided by the Veterans' Home.
  - There is 1 Veteran Home in Connecticut
  - Contracting Standard Proposed:
    - 100% of Veteran's Home
- Exchange ECP listing for Pediatric Dental Services
  - Contracting Standard Proposed:
    - UCONN Dental Clinic at Connecticut Children's Medical Center
    - Burgdorf Dental Clinic
    - Yale New Haven Health System
    - 20% of remaining Exchange ECP Listing

ECP: Proposed Sufficiency Standards for Connecticut

- Mental Health, Behavioral Health, Substance Abuse services
  - Carriers will be required to develop a plan to comply with Mental Health parity that takes into consideration reasonable geographic access on a statewide basis as well as the full continuum of care
    - Includes the types of services required by law:
      - licensed hospital or clinics, child guidance clinics, residential treatment facility, nonprofit licensed adult psychiatric clinic and licensed alcohol treatment faculty
  - Contracting Standard Proposed:
    - 2014 calendar year – 20% statewide participation based on the revised created provider list of ECP's compiled by the Exchange
    - 2015 calendar year - 50% statewide participation based on the revised created provider list of ECP's compiled by the Exchange and;
    - 2016 calendar year - 75% statewide participation based on the revised created provider list of ECP's compiled by the Exchange
- Federally Qualified Health Centers (FQHC)
  - No changes are proposed to the recommended standard approved by the Exchange Board of Directors (carriers to contract with 90% of the FQHCs and FQHC look alike facilities)

Network Adequacy & Essential Community Providers

QUESTIONS /
OPEN DISCUSSION

STANDARD PLAN DESIGN UPDATE

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Standard Plan Designs

- Dental Plans
  - Changes to Accommodate Final Actuarial Value Determinations
    - Standard Dental Plan AV 70%: change deductible from $50 to $75
    - High Option Dental Plan AV 85%: Change OOP from $500/$1,000 to $300/$600
  - Remove Wellness Plan as a required option
    - Comply with law and regulation
- Standard Medical Plans
  - Bronze Plan 1 Home Health Care(HHC) benefit;
    - Change to member cost-sharing at 25% coinsurance after a $50 annual deductible specific to HHC
      - Revision from $0 copay after the full deductible of $3,250
  - Deletion of Bronze Plan 2
    - Bronze Plan 1 as the standard requirement for Bronze
      - All other tiers have just one standard plan requirement
  - Above two are to comply with State/Federal law