

# Connecticut Health Insurance Exchange

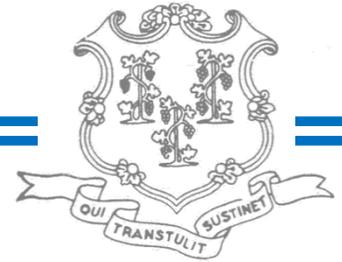
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Health Plan Benefits & Qualifications  
Advisory Committee

*October 15, 2012*

# Agenda

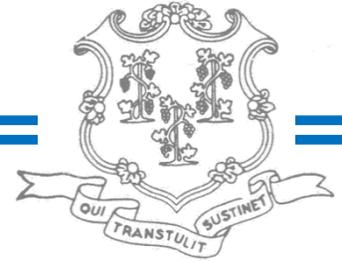
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- 1) Call to order and Introductions
- 2) Review and approval of minutes:  
July 11, 2012 Meeting
- 3) Plan management overview:  
Certification, decertification, recertification
- 4) Potential plan design options review/comment
- 5) Public comment
- 6) Adjournment

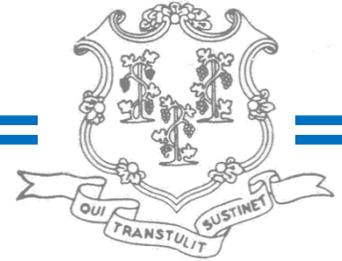
# Plan Management Overview

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- The Connecticut Health Insurance Exchange (HIX) has developed detailed strategy for the certification, recertification and decertification of Qualified Health Plans (QHPs). The following is an overview of this strategy.

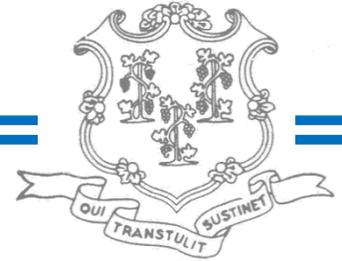
# Plan Management Strategy: HIX



- Will utilize an “any qualified plan” approach for 2014:
  - Encourage participation in the Exchange
  - Promote flexibility for plan design options
  - Exchange does not currently have its own data for certification of QHPs
  - Carriers need to meet minimum standards to be a certified
  - Will not exclude:
    - Fee for service plans
    - Plans by imposition of price controls
    - Plans providing treatment to prevent death which may be considered too expensive.



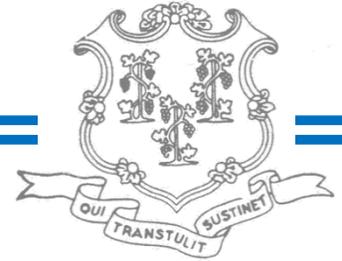
# Plan Management Strategy: HIX



- Plan certification complete prior to 10/01/2013
- Review rate increase and cost sharing justifications prior to implementation
  - Confirm rates are posted on web.
- Ensure plans have an adequate network and include essential community providers in their networks.
- Ensure all plans accredited by NCQA/URAC
- Ensure essential pediatric dental and vision benefits are available to participants
- Continually monitor Health Plans for:
  - Ongoing compliance.
  - Plan benefits designs
  - Use of “plain language” in communications.

# Plan Management Strategy: Carriers

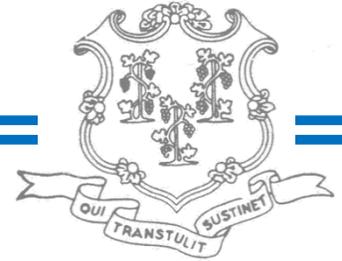
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- 1) All Plans must be certified by the Exchange and comply with standards of the Affordable Care Act
- 2) Must be licensed and not have outstanding sanctions from the Connecticut Insurance Department
- 3) Follow all current and future ACA requirements, such as user fees and risk adjustment.
- 4) Offer one silver and one gold coverage level, catastrophic coverage for under age 21, child only, and MAGI eligible.
- 5) Rates to be locked in for benefit or plan year.
- 6) Follow state requirements for marketing practices
- 7) Maintain adequate networks including essential community providers

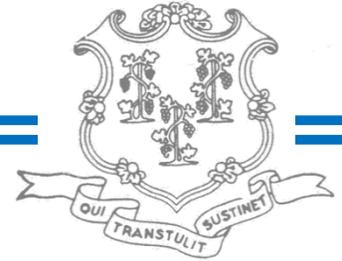
# Plan Management Strategy: Carriers

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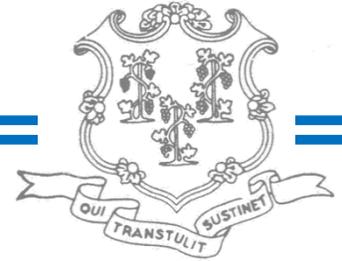
- 8) Accept eligible enrollees during an established initial open enrollment and during annual open enrollment.
- 9) Abide by premium payment procedures established by the Exchange
- 10) Follow all established marketing and communication guidelines
- 11) Adhere to all future HHS reporting guidelines and timetables

# Plan Management Strategy: Recertification



- The purpose of the recertification process is to ensure that QHPs continue to meet the certification process on an annual basis.
- At year two renewal, CT HIX will accept an attestation for any requirement met in the previous year to avoid administrative burden on the carrier.
  - This will allow HIX and carrier to focus on new criteria such as HEDIS measures, disease management programs etc.
- Recertification process to begin 150 days prior to next calendar year or by September 15<sup>th</sup>, allowing enrollees full range of choice during Open Enrollment.

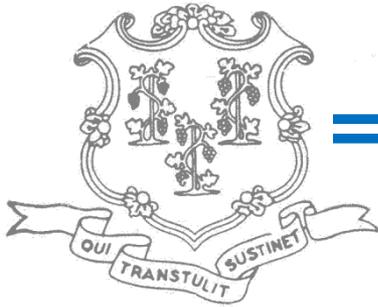
# Plan Management Strategy: Decertification



- Decertification is the process by which HIX will terminate the certification of status of a QHP and thus the offering of a plan through the Exchange.

▪ **Note:** all efforts will be made by HIX to prevent or correct a carrier's certification status so that decertification will not occur.

- HIX will notify Carrier, HHS and CID of decertification status
- Enrollee transition plan will be put into place for effected participants. This may include an off cycle special enrollment
- Transition plan will contain notifications, enrollment forms, other plan features, as well as deadlines and default options.



# QHP Solicitation

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# QHP Solicitation

## Minimal Requirements – Mix and Number of Plans



The Exchange should not require QHPs to offer a standardized plan design. Below are plan design options for discussion:

Suggested Mix and Number of Plans
Issuers should be encouraged to offer: <ul style="list-style-type: none"><li>• 1 Gold</li><li>• 2 Silver: High/Low<ul style="list-style-type: none"><li>*at least 1 HSA-compatible</li></ul></li><li>• 2 Bronze: High/Low<ul style="list-style-type: none"><li>*both 1 HSA-compatible</li></ul></li><li>• 3 “child-only” QHP (1 per tier)</li></ul>
Issuers should be discouraged from offering Platinum plans
Issuers will be encouraged to offer Catastrophic QHPs

Except for Catastrophic Coverage plans, the same QHPs plan options will be available in both Individual and SHOP Exchange, if issuer is participating in both.

# QHP Solicitation

## *Other Requirements and Recommendation*



### Other QHP Requirements

Standardize family tiers (i.e. Single, Single +Spouse, Single +1, Couple +1, Couple +Family), not family rating ratios

Use of Consumer Assessment of Healthcare Providers and Systems (CAHPS) on Exchange

### QHP Recommendation – Wellness Incentives

Permit wellness incentives in SHOP

If there is issuer interest, the Exchange should apply for the “10-State Wellness Program Demonstration Project.” If permitted by HHS, Exchange will allow wellness incentives in Individual Exchange