MEMORANDUM

To: Health Plan Benefits & Qualifications (HPB&Q) Advisory Committee

From: Connecticut Health Insurance Exchange

Re: Plan Management Overview

The purpose of this memorandum is to provide the HPB&Q Advisory Committee information pertaining to plan management activities and illustrate the minimum certification standards required for certification, recertification and decertification as required by the ACA. This is the second version of the plan management process and is yet to be finalized. It is anticipated additional comments will be forthcoming from CCIIO.

The Connecticut Health Insurance Exchange (CT HIX) is a quasi-public agency established to implement certain provisions of the Patient Protection and Affordable Care Act, Pub.L111-48 as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA). The Exchange is charged with implementing Connecticut's Health Insurance Exchange (CT HIX) for individual and small employers effective January 1, 2014. As part of the implementation CT HIX is the responsible entity for coordinating and administering the Qualified Health Plan (QHP) certification, recertification and decertification process.

PLAN MANAGEMENT PROCESS OVERVIEW

CT HIX will initiate the Qualified Health Plan (QHP) certification process with the health insurance carrier electronically utilizing the System for Electronic Rate and Form Filing (SERFF) (if operational), email or the U.S Postal service. For the 2014 calendar year the CT HIX will electronically submit to the health insurers an invitation, "Request to Participate" that will accompany a 2013-2014 Initial Solicitation For Individual and Small Business and application. The solicitation will include the QHP certification requirements and appropriate plan management detail with regard to carrier responsibilities and an application which the carrier may return with appropriate responses. Each interested health insurer will return the initial application supplemented with necessary documentation and/or attestations to the CT HIX. Once the documentation is reviewed and approved by CT HIX; the request for proposal process commences. The CT HIX will collect from the health insurance carrier information relative to the certification process, validate the information for accuracy, negotiate to finalize the QHP certification process, as appropriate and establish a health insurance carrier account in the CT HIX plan management system. The QHP certification or recertification application review, and approval process will essentially be a manual process of checks and balances completed by the CT HIX. All interactions related to the QHP certification, recertification or decertification process whether in person, telephone or electronic will be documented and retained in accordance with state and federal law.

Any necessary correspondence between the carrier and CT HIX may be delivered via SERFF, email or U.S Postal service.

The review and QHP approval process will be complete in advance of the initial open enrollment period commencing on October 1, 2013 and ending on March 31, 2014. The CT HIX anticipates the QHP certification process will take approximately six months from the initial notification through the approval process. The process is estimated to begin in March or April of 2013. Although these timeframes are estimates, it is necessary for the CT HIX to allot sufficient time for carriers to plan for and develop their QHP offerings and for the CT HIX to have ample time for review to meet effective date of January 1, 2014 and the open enrollment deadline of October 1, 2013. Therefore, it is expected the CT HIX will begin accepting QHP certification applications as early as March 2013.

The CT HIX will evaluate the application and once complete, the carrier will be notified of the QHP acceptance or declination. If the QHP application is declined, the CT HIX will assist the carrier in resolving any outstanding matters, as appropriate.

QHP CERTIFICATION STRATEGY

The CT HIX has opted to utilize an "any qualified plan" approach for the QHP certification process. For the initial 2014 year the QHP minimum certification standards will be required. This option will provide flexibility to the CT HIX and carriers in terms of plan design options and account for any administration or operational development requirements. For calendar years 2015 and later, CT HIX may opt for a competitive bidding process and develop a selective contracting agreement that will require specific selection criteria over and above the minimum standards.

A decision has yet to be made with regard to the number of plan designs or metal levels required to be offered per carrier for the individual exchange, as well with regard to employer versus employee choice in the Small Business Health Options Programs (SHOP) exchange. Please note discussions are ongoing and decisions are expected during the fourth quarter 2012 or early first quarter 2013. The CT HIX is seeking guidance from a variety of stakeholders including but not limited to the CT HIX Board of Directors, the advisory committees (Health Plan Benefits & Qualifications, Consumer Experience and Outreach, SHOP and Broker and Navigator), the Connecticut Insurance Department (CID), health insurance carriers, the Connecticut Health Plan Association, AHIP and non-profit community minded organizations. As appropriate decisions made will be consistent for the individual and SHOP exchange.

QHP issuers must not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

INTEGRATION BETWEEN CT HIX AND THE STATE INSURANCE DEPARTMENT

The CT HIX has leveraged existing established processes from other state agencies and

intends to continue to do so. An example is illustrated through the day to day interactions with the CID. The CT HIX and CID have developed a strong partnership memorialized earlier this year by executing a Memorandum of Understanding (MOU). Both teams work in close contact developing policies and procedures to ensure compliance with the QHP certification requirements, federal and CT state law. As stated in the MOU the CID is responsible for a myriad of regulatory activities including review and approval of the rate filings and benefit form filings, licensing of health insurers and healthcare centers, monitoring compliance with regulations and statutes. The QHP certification requirements and regulatory activities performed by CID may be done in conjunction with, or prior to the QHP certification process is complete.

As previously mentioned CT HIX regularly meets with CID to discuss issues and jointly work together on matters related to exchange business. The CT HIX relies on CID for technical expertise with regard to risk adjustment, reinsurance, actuarial value, group participation criteria and levels, solicitation of data from carriers, and offers technical advice with regard to discriminatory health benefits. The CID is responsible for ensuring a carrier meets the statutory requirements to comply with state and federal law.

In terms of specific tasks related to the certification of a QHP, the CID is the entity responsible for an annual review and approval of the policy forms and rate filings. It is the CT HIX intention to leverage the current regulatory processes established in Connecticut. To ensure the policy forms comply with Connecticut law (including but not limited to the state mandates) the review will validate that the policy forms comply with federal law (including but not limited to assuring each of the ten EHB categories of benefits are included and the cost sharing provisions comply with § 1302 (c) of the ACA). As previously mentioned the exchange of information between CID and the CTHIX will be handled via the SERFF application if operational otherwise by email or US postal service.

With respect to the rate filings, CID will work with carriers to ensure the rate filings meet actuarial standards and are in compliance with federal and state law. Both the policy forms and rate filings must be approved prior to marketing for sale.

The CT HIX and CID have met with the insurance carriers on at least eight to ten occasions over the past year to develop rapport and ensure open communication to ease administrative burden and/or bring resolution to matters in a swift and timely manner for all parties. There are five domestic health insurance carriers (Anthem, Aetna, ConnectiCare, United Healthcare / Oxford and CIGNA) in the state of Connecticut. (There are two new potential companies entering the Connecticut health insurance market. A CO-OP and the other an out of state insurer are both are going through the regulatory licensure process with CID.)

As stated previously, an MOU is in effect between CT HIX and CID. Many of the minimum certification standards are outlined in the MOU and are the responsibility of CID. The CT HIX will not require the carriers to duplicate these requirements in an effort to avoid administrative burden.

CERTIFICATION STANDARDS:

A carrier must comply with Subpart C, Qualified Health Plan Minimum Certification Standards, comply with CT HIX processes, procedures and requirements of subpart K of part 155 and §155.705
The CTHIX:

- will only offer health plans that are certified as qualified health plans and;
- determined making the plan available through the exchange is in the interest of qualified individuals and qualified employers in Connecticut**.** The CTHIX will strive to ensure plans offered have meaningful difference - difference of practical importance. Examples of such include the CT HIX requiring a QHP to offer a portfolio to discourage look alike plans that do not provide substantively difference coverage to enrollees, will encourage carriers to compete on factors that matter to consumer such as on price, cost sharing, benefits, and provider networks, the CT HIX will encourage streamlining plan choices without placing stringent limits on choices available to consumers reducing potential disruption to insured individuals eligible for a subsidy. One noteworthy difficulty encountered with regard to determining meaningful difference is that a defined standard has yet to be established in context of the ACA.

The CTHIX will not refuse to certify a plan because:

- it is a fee-for-service plan, or;
- the health plan provides treatments necessary to prevent deaths' in circumstances the exchange determines are inappropriate or too costly; or
- granting the certification was on the condition of the imposition of premium price controls.

The following are technical specifications or minimum requirements necessary to obtain QHP certification:

The CT HIX will utilize the Federal Risk Adjustment program in lieu of developing a separate program for the state of Connecticut.

Carrier General Information- This information will be carrier specific and will need to be included initially per submission by the licensed entity, for all related QHP applications and upon recertification (annually) of the QHP. Each licensed entity with the Certificate of Authority (COA) is permitted to offer a QHP through the CTHIX. The information provided must match the information on file with the Connecticut Insurance Department (CID) and represent the legal entity that holds the COA permitting the carrier to offer health insurance policies in the state of Connecticut. Required information: Company name, U.S. postal address, e-mail address, telephone number of main office responsible for carrier's QHP.

The dental carrier will need to be identified on the return submission. Required information includes: Company name, U.S. postal address, e-mail address, telephone number of main office responsible for carrier's dental plan.

CT HIX will be responsible to verify the data (licensure) with CID, it is expected to be a manual process tracked and documented. The CT HIX will require this information for the **recertification** process.

Carrier Key Management Personnel This information will be health insurance carrier specific. It will need to be included initially per submission by the licensed entity, for all related QHP applications and upon **recertification** (annually) of the QHP. In order to be a QHP with CTHIX the application will require contact information for the person with responsibility for CTHIX business. Information will include: name, title, mailing address, e-mail address and telephone number.

In addition, the carrier will be required to provide attestation language similar to,

> "We certify and attest that we currently have and will maintain appropriate staffing and qualified management to effectively manage this QHP, and all other that are offered."

Contact information and attestation language will be required for the dental carrier.

CT HIX will be responsible for acquiring this data, and will be a required entry in the initial solicitation. The information will be documented and retained.

The CT HIX will require this information for the **recertification** process.

Administrative Management – The carrier will be required to provide attestation language similar to the following:

> **"**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."

The dental application will require similar attestation language.

The CT HIX will require this information for the **recertification** process.

CT HIX will be responsible for acquiring this data. Should an issue arise the preventing the carrier to provide administrative support to enable effective performance of carrier functions; the carrier is responsible for notifying the CT HIX to avoid the enrollees being adversely affected. This may be cause for decertification. In efforts to avoid enrollee

disruption CT HIX will work with the carrier to correct the issue or ensure transition to another QHP. The information will be documented and retained. The CT HIX will require this information for the recertification process.

Carrier Experience & Market Conduct The carrier will be required to submit attestation language similar to:

> "We have no corrective action plans in the state of Connecticut that will not be addressed by December 31, 2013." A carrier with a corrective action plan will be required to provide copies and necessary explanation. CID has a Consumer Affairs area in compliance with C.G.S. § 38a-9.

CID has a Market Conduct area (C.G.S. § 38a-15) that monitors health insurers and other insurers' performance in complying with statutes and meeting all contract requirements and treating policyholders and certificate holders fairly and in accordance with state insurance laws.

The dental application will also require an attestation language similar to "We have no corrective action plans in the State of Connecticut that will not be addressed by December 31, 2013."

The CT HIX will verify such information with CID. The verification is expected to be a manual process. The information will be documented and retained.

Should an issue arise resulting from an adverse market exam performed by the CID the carrier is responsible for notifying the CT HIX. This may be cause for decertification. In efforts to avoid enrollee disruption CT HIX will work with the carrier to correct the issue or ensure transition to another QHP.
The CT HIX will consider this information during the **recertification** process.

Licensed in Good Standing: This information will be health insurance carrier specific and will need to be submitted to attain certification and upon recertification for all related initial QHP applications. The application will request the carrier to certify it is in good standing with all appropriate local, state, and federal licensing authorities. Good standing means that the carrier has not had any fines, penalties, citations or ongoing disputes with the licensing authorities that would disrupt the normal flow of daily business or in any way prohibit the carrier from performing duties.

A carrier will be required to provide attestation language similar to the following: "We certify that we are licensed to sell health insurance in the state of Connecticut, and are in good standing, and will maintain good standing and appropriate solvency levels consistent with the addition of this new business."

If the carrier is unable to attest to being licensed in good standing the carrier will no longer be considered eligible for a QHP certification. In efforts to avoid enrollee disruption CT HIX will work with the carrier to correct the issue or ensure transition to another QHP.

The dental application will require an attestation similar to the language stated above. Should the dental carrier be unable to attest to being licensed in good standing.

Ensuring licensure, solvency and good standing are the responsibility of CID. The CT HIX will verify with CID that all carriers obtaining QHP certification are licensed, solvent and in good standing. The verification is expected to be a manual process. The information will be documented and retained. The CT HIX will require this information for the **recertification** process.

Plan Benefit Design – Policy form review and approval is the responsibility of CID. To be certified as a QHP the carrier must have an approved form filing, including plan designs meeting an actuarial certification of benefit level (e.g., the plan is actuarially equivalent to the metal level proposed). A carrier must submit benefit information to the Exchange at least annually, for each QHP in a form and manner to be specified by HHS information is to include (1) Rates; (2) Covered benefits; (3) Cost-sharing requirements.

The carrier must offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level. A QHP offering a non-catastrophic health plan must offer the identical plan at the same level of coverage as a child only plan to individuals to age 21.

The CT HIX will verify approval by accessing SERFF to obtain the SERFF Submission Numbers and CID file numbers and approval dates. In the event SERFF is not operational the CT HIX will contact CID and obtain the appropriate information in writing. This information will be QHP specific and will need to be included for each QHP in the carrier's submission. The CT HIX is responsible for the verification. It is expected to be a manual process. The information will be documented and retained. The filed and approved Evidence of Coverage (EOC) must be included in the certification application.

Identical requirements will be necessary for the dental carrier.

The QHP certification process will cease if the carrier does not have an approved policy form filing prior to the effective date of the benefit year. The CT HIX will require this information for the **recertification** process.

Rate filing – Rate filing review and approval is the responsibility of CID. All rates must be approved by CID prior to use. To be certified as a QHP, the carrier must agree to submit a justification for any premium increase before implementation of the increase. The carrier shall prominently post the justification and any information related to such justification on its Internet web-site.

At least annually a QHP must have an approved rate filing by the CID in order to obtain QHP certification, complete an actuarial certification of benefit level (e.g., the plan is actuarially equivalent to the metal level proposed) and include plan benefit design information in a form and manner to be specified by HHS.

In addition each QHP issuer must offer a QHP at the same premium rate without regard to whether the plan is offered through the CT HIX or whether it is offered directly through an agent or from an agent. A QHP's rates must be applicable for an entire benefit year and or in the case of SHOP for the entire plan year.

The CT HIX will leverage the state review process and verify approval by accessing SERFF to obtain the SERFF Submission Numbers, CID approval dates and CID file number or in the event SERFF is not operational the CTHIX will **contact** CID via email for this information. This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

Rate filing review and approval will be required for the dental carrier.

The QHP certification process will cease if the carrier does not have an approved rate filing prior to the effective date of the benefit year. This applies to both the medical and dental plan. The CT HIX will require this information for the **recertification** process.

Network Adequacy Requirements C.G.S §38a-472f stipulates that a health carrier must meet the NCQA or URAC standards on network adequacy. CID requires managed care organizations to certify they meet NCQA or URAC standards for this requirement in their submission. The CT HIX will need to confirm there are an adequate number of essential community providers (ECP).

Rules require a QHP to include within its network a sufficient number and geographic distribution of ECPs, where available, that serve predominantly low income, medically underserved individuals. Providers meeting this definition deliver significant care to the uninsured and enrollees in public programs.

The health plan will be required to afford a sufficient distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals in its service area.

The QHP will ensure access to a provider directory either through an on –line means or upon request of a hard copy. The provider directory must note if providers are no longer accepting new patients.

In part to satisfy this requirement the CT HIX will need to establish a process for the provider directory requirements. CT HIX will utilize a link to the carriers on line provider directory. As for the information gathered by CID, the CT HIX will either access SERFF for this information or contact CID directly to obtain the information. The verification is expected to be a manual process. The information will be documented and retained. The CT HIX may consider this information for recertification purposes.

Any healthplan network deemed insufficient will be required to contract as necessary to fulfill the obligations set forth in the requirements. CT HIX will rely on accreditation

standards set forth by NCQA or URAC. The decertification process will be triggered should a network lack sufficient number of providers (e.g. the loss of a hospital in a remote area.) The CT HIX will work with the carrier to resolve such issues timely. An example would be requiring claim payment for any utilization until contract negotiations are agreed upon or providing written notice and a grace period to all affected enrollees so they may transition to another carrier.

Service Area Currently the service area as applicable to Connecticut health insurance carriers is the entire state of Connecticut. All hospitals participate in each carrier's network.

In the event a carrier proposes service area changes including limited networks or multiple networks; carriers must seek the counsel and approval from CID. CID has approved service areas smaller than the entire state in the past and has also approved a network within a network allowing tiered cost-sharing provisions. To date CID has not approved a carrier to offer multiple networks with some overlapping providers. Essentially the concern relates to provider and the member confusion that ultimately results in claims that are not covered. Both parties would not only need to know if the provider is participating with the carrier but if the provider was in the specific network that applied to a specific plan. Should a limited network be pursued by the carriers, a formal filing to the CID would be necessary. CID will review multiple network filings and will require the carrier to describe how they limit confusion around the various networks. CT HIX would verify the status of a limited network through SERFF or with direct contact with CID to obtain the information. The verification is expected to be a manual process. The information will be documented and retained. The CT HIX may consider this information for recertification purposes.

Quality Information The CT HIX will provide consumers an opportunity for equal comparison of data between various QHPs health care quality and outcome measures should be reported in a consistent format as defined by HHS or the state of Connecticut. QHPs will be required to report Connecticut specific quality information (*as "quality information" will be defined by HHS)* to satisfy ACA quality reporting requirements.

Quality reporting will be required for the dental application.
The CT HIX will require this information for the **recertification** process.

Quality Strategy - Quality improvement information will *not* be requested on application but an attestation will be required. The attestation language will be similar to

"We certify and attest that we currently have a quality strategy to comply with §1311(g)(1) of the ACA – a strategy that improves health outcomes through the implementation of activities such as quality reporting, case management, care coordination, chronic disease management, compliance initiatives, activities to reduce or prevent hospital readmissions, enhance patient education, and we will maintain appropriate staffing and qualified management to effectively manage this QHP."

Quality Rating Data To comply with paragraph (4) (§1311(c)(3) of the ACA, the CT HIX shall include a quality rating in the information provided to individuals and employers through the internet portal. HHS shall 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. Once the rating system has been developed and information has been made available a process will be established.

Currently the Connecticut health insurance carriers have received NCQA accreditation. Any new entrants in the Connecticut market will need to be NCQA or URAC accredited.

The quality function will be the responsibility of the CTHIX, who will request the quality rating data from the accreditation authority and the the carriers. It will be necessary to implement and maintain the quality rating system that will be developed by HHS. The CT HIX application will be the mechanism by which the quality rating information will be communicated to the CT HIX. This information is not currently captured at the CID nor is it a requirement stated in the MOU.

The CT HIX will verify the information with the carriers and accreditation authority. The verification is expected to be a manual process. The information will be documented and retained. The CT HIX will not require detailed information with regard to quality programs until 2015 and may consider this information during recertification process.

Quality rating information will be required for the dental application only if HHS requires it. Reporting of quality data will be in a single form and format (to be determined).

The CT HIX will require this information for the **recertification** process.

Performance Information To comply with §1311(c)(4) of the ACA the CT HIX shall include results of enrollee satisfaction surveys in the information provided to individuals and employers through the internet portal. The data will be available in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans. The SI vendor will develop the internet portal which contains this information. In addition CT HIX will require CAHPS reporting in year two and HEDIS in year three.

The HHS Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange. The CT HIX will utilize this mechanism prepared by the Secretary.

This information will be QHP specific and will need to be included for each QHP in the carrier's submission. The CT HIX is responsible for the verification. It is expected to be a manual process. The information will be documented and retained for **recertification** purposes. Detailed information with regard to enrollee satisfaction will not be required until 2015

Transparency To be a certified QHP the carrier must provide the following information

to the public, CT HIX, CID and the Department of Health and Human Services (HHS) :

- claims payment policies and practices,
- periodic financial disclosures,
- enrollment data,
- disenrollment data,
- data relative to the number of denied claims,
- data on rating practices, and,
- information on enrollee rights,

QHP issuers must make available, in a timely fashion through a website or other means to the enrollee information on the cost sharing responsibilities for a specific service by a participating provider under the enrollee's plan.

Carriers must comply with use of plain language as defined in §155.20 which states plain language is defined as language that the intended audience including individuals with limited English proficiency can readily understand and use because that language is concise, well organized and follows best practices of plan language writing.

This information will be QHP specific and will need to be included for each QHP in the carrier's submission. The CT HIX is responsible for the verification. It is expected to be a manual process. The information will be documented and retained for recertification purposes.

Marketing of QHPs Carriers may not employ marketing strategies to discourage enrollment of individuals with significant health needs and must comply with State laws and regulations regarding marketing health insurance carriers. Typically, the CID only becomes involved with marketing review if there is a problem or issue that needs attention.

Therefore the CT HIX will require attestation language similar to **"**We certify that our marketing practices will discourage enrollment of individuals with significant health needs and will comply with State laws and regulations regarding marketing health insurance carriers."

The dental application will require similar attestation language if a stand alone dental plan.

This information will be QHP specific and will need to be included for each QHP in the carrier's submission. The CT HIX will be responsible for obtaining this information, and verify such information with the carrier and where appropriate CID. The verification is expected to be a manual process. The information will be documented and retained and may be considered for **recertification** purposes.

Note: The QHP application requirements are subject to change based on publication of additional federal rules and/or guidance from CCIIO, as well as any State legislation,

Connecticut Insurance Department (CID) requirements or guidance or other policy guidance (e.g., adoption of new or an amendment to existing administrative rules).

In addition, the CTHIX may determine additional certification requirements are necessary and review such criteria on an annual basis. Any revisions will be communicated during the recertification process. For calendar years 2015 and beyond the CTHIX may opt for a more complicated competitive bidding or a selective contracting process and limit QHP participation to those health insurance carriers who rank highest in terms of CT HIX criteria as well as to promote competition amongst the carriers.

UTILIZING STATE AGENCIES & EXISTING PROCESSES

The CT HIX will ensure ongoing QHP compliance with the certification requirements through primarily a manual process of checks and balances. The CT HIX will develop a compliance plan to establish regular monitoring of each certification requirement. The QHP application and solicitation will outline each requirement necessary for the carrier to obtain certification. Each submission sent to CT HIX by the carrier will be reviewed for compliance prior to the QHP certification or seal being awarded. Compliance will be ascertained in conjunction with the aid of the CID who performs many of the QHP certification tasks required of a carrier. If operational CT HIX will obtain the information through SERFF or through established weekly in person meetings or conference calls throughout the QHP certification process. The CT HIX is responsible for the verification. It is expected to be a manual process. The information will be documented and retained for **recertification** purposes.

The CTHIX will develop a process to resolve enrollee complaints received at the exchange. Currently there are two state agencies that review and resolve to health insurance consumer complaints, appeals and grievances. Such matters are resolved by direct communication with CID or the Office of the Healthcare Advocate (OHA). It is not the intent or in the interest of the CT HIX to duplicate effective processes currently established within the state. The CID has a consumer affairs area that complies with C.G.S. 38a-9 to assist with consumer inquiries and complaints on health insurance.

The CT HIX will soon enter into an MOU agreement defining roles and the types of matters and issues that will be forwarded to the OHA. It is expected health care complaints with regard to medical appeals or grievances that will be received at the CT HIX will be sent directly to the OHA or CID. Both of these teams have many years of experience resolving member complaints associated with the health insurance carriers. The OHA team is responsible for communicating with managed care consumers; assists consumers with the filing of complaints and appeals, including filing appeals and circumventing the process with a managed care plan's internal appeal or grievance process and provides information about the external appeal process established under Connecticut law; the OHA is responsible for tracking complaints from the public and quantifying these complaints in order to initiate legislative and regulatory

recommendations on behalf of consumers. The OHA is responsible for educating the general population on their managed care rights and responsibilities.

It is anticipated the types of complaints or appeals which will be resolved by the CT HIX are those matters related to administrative error such as enrollment in the incorrect plan offering, company or type of plan as well as cost sharing reductions and advance premium tax credits. The CT HIX will be working in tandem with the CID and OHA to establish an effective process benefiting the residents of Connecticut enrolled in a health plan through the CT HIX.

CT HIX will develop a tracking mechanism to ensure resolution and deadlines for responses are maintained.

Technical Assistance and Support Activities –AN example of technical assistance that is being developed is directly related to the benefit form filing process. CT HIX and CID are developing a Bulletin which will communicate filing requirements for the carriers. The anticipated publish date of the Bulletin by CID mid- October 2012. The Bulletin information will coincide with the proposed policy form filing schedule outlined and tentatively agreed to with the carriers. It will provide direction outlining the requirements necessary to achieve a timely approval. Required elements of the rate and form filing will include such elements as product type, benefits and cost sharing information and the specified format of each, HIX unique and distinct form numbers, demonstration of compliance to federal and state law. A meeting with the Connecticut Health Plan Association and the carriers will be held to formally introduce and communicate the requirements. The Bulletin outlining such will be posted on the CID website and a website link will be posted on the CT HIX website.

RECERTIFICATION

Recertification Process – The purpose of the recertification process is to ensure that QHPs continue to meet certification requirements. The CT HIX recertification process will be completed on an annual basis in order to comply with CID requirements. All CID requirements (e.g.annual form approval and rate approval) must be adhererd to, however to ease administrative complexity the CT HIX may permit the carrier to submit an attestation certifying they continue to comply with the other certification requirements and that there has been no change. This partial recertification process is intended to alleviate potential administrative burden that may be experienced in replicating unchanged from the previous year and additionally would allow for focus on any new certification requirements.

The recertification process will commence 150 days prior to the next calendar year. Therefore in August of 2014 the CT HIX will commence the recertification process with a “Request to Participate” letter, a 2014-2015 Renewal Proposal For Individual and Small Business and application will be sent to each carrier. The recertification process must be complete by September 15th of any applicable year so that enrollees have a full range of options from which to choose during the open enrollment process.

The minimum standards will be required to attain certification as well as other recertification measures for the renewal calendar year.

Additional measures may include but are not limited to the following:

- Mechanisms to promote better prevention and wellness services, strategies and programs:

    - Health assessment at enrollment, availability of health education and chronic disease management programs including industry standard requirements, Centers of Excellence availability and participation from providers and enrollees;
    - Pharmaceutical management – steering use to generics in lieu of brand name drugs
    - Programs that foster primary care, wellness health coaching, weight loss, smoking cessation which may include financial incentives offered through the SHOP exchange;
    - HEDIS & CAHPS patient experience ratings; consumer access; complaints and appeals (reporting enrollee satisfaction and evaluation of medical screen preventive services offered to enrollees and utilization of such (colorectal screening, mammography screening, GYN and pap tests, diabetic testing, blood pressure)
    - Call center reporting may be required on performance metrics on carrier customer service calls, percentage of callers who reach a live person and how many calls are answered within 30 seconds, abandonment rate essentially requirement s and standards related to satisfactory outcomes and percentages of calls where the issue is resolved during the first contact,
    - Disease management reports,
    - Patient experience measures may be required, access to specialty care evaluated, over satisfaction of plan, ease of obtaining an appointment.
    - Targeted goals for chronic disease management and adherence to such programs,
    - Steering mechanisms direct enrollees to better performing physicians and efforts to promote enrollee selection of higher performing providers.
    - Future QHP standards may encourage development of innovative access models (telemedicine & retail clinics) to meet patient needs especially in areas where provider availability are constrained or establishing requirements for office wait times (e.g. survey enrollees about their experience with appointment wait times as a component in evaluating access requirements.

DECERTIFICATION

Decertification Process: Decertification means the termination by the CT HIX of the certification status and offering of a QHP. The CT HIX may decertify a QHP at any time

if it finds the QHP no longer meets the QHP certification criteria. The CT HIX will provide the QHP with an appeal process to appeal such decision. The carrier must notify the CT HIX within 30 days of determining they are noncompliant of any QHP certification standard or in the event of change in circumstances that would adversely impact processes of the enrollees and CT HIX. An example of an instance that would warrant decertification includes but are not limited to any reportable HIPAA Privacy or Security matter, a change in medical management processes, a claims systems problem or an issue with ID cards or Explanation of Benefits (EOBs).

Prior to a carrier becoming decertified all efforts will be made to correct the issue to avoid enrollee disruption however a carrier may not terminate coverage until the CT HIX has provided notice to the enrollees, HHS and CID. The enrollee notification will include detailed information regarding special enrollment periods permitting the enrollees a transition plan to another QHP:

The following are examples of the the necessary procedural steps which the CT HIX will utilize to transition the enrollees:

1. The CT HIX will run a report of all affected enrollees and request the same from the carrier to ensure accuracy and that no enrollees are missed.
2. The CT HIX will provide a 30 day advance notice to each enrollee apprising of the need to select another QHP.
3. An election form outlining the potential plan options will be included in the notification letter which will include Customer Service contact information and potential plan options for enrollment in another plan. The election form will also include a CT HIX website for enrollees to re-enroll.
4. Enrollee records will be reviewed to determine re-enrollment response of enrollees and CT HIX customer service will commence campaign whether via telephone calls, email or mail to follow up with enrollees who have not responded.
5. It is not expected that plans will become de certified for non-compliance of QHP certification requirements, especially since the requirements mirror the functions already being performed with the oversight of CID. Should a carrier become non-compliant with these requirements it is likely other aspects of their business would be affected. A more likely scenario triggering the decertification may be a carrier who decides to not renew its QHP offering must notify the CT HIX of its decision prior to commencement of the recertification process. A QHP who wishes to terminate its partnership with the CT HIX must fulfill its obligation to provide benefits through the end of the plan year and notify enrollees with a notice of QHP non-renewal participation in the CT HIX (either the individual or small group market or both) is no longer an advantageous business prospect and that the benefits of withdrawing from that market segment outweigh the benefits of remaining in the market.

   Regardless of the reason for decertifying a plan, the CT HIX will ensure to the extent possible that any enrollees who wish to remain enrolled through the

exchange will be transitioned to another plan to avoid adverse effect due to these circumstances beyond their control.