Access Health CT Initial Solicitation to Health Plan Issuers For Participation in the

Individual and Small Business Health Options Program (SHOP) Exchanges Amendment Release Date March 27, 2013

Questions and Answers

Memo: This document represents the final version of questions submitted by Health Plan Issuers. The Issuer question period ended 5:00 pm April 5, 2013.

#	Topic	Solicitation Section	Page No.	Question	Response
1	Schedule	Section I, Sub-Section D,	2	When will we have dates on the Final QHP application	Access Health CT expects to distribute the <u>Final</u> QHP application to Issuers May
		Qualified Health Plan		distribution to Issuers and submission to Exchange?	6, 2013. Prior to that date, the <u>Draft</u> Application will be issued on April 22,
		(QHP) Solicitation			2013. An Issuer Question Period will then follow asking Issuers for responses
		Process			to our Draft by April 29, 2013. It is then that Access Health CT will send out the <i>Final</i> QHP Application on May 6, 2013. Issuers will then be instructed to
					submit their completed Applications to the Exchange by May 15, 2013.
2	QHP Issuer Compliance and	Section II, Application	5	Can you provide details on what is to be included in the	Access Health CT believes that compliance plans are an existing key part of an
-	Oversight	and Certification		compliance plan requested to document compliance with	Issuer's overall performance. Access Health CT will rely on each Issuers
		Requirements		Federal and State law?	existing compliance plan as it documents the Issuers efforts to ensure that
					appropriate processes are in place to maintain adherence with applicable
					regulations and guidance, as well as prevent fraud, waste and abuse. A
					thorough compliance plan contains specific requirements. The Exchange
					expects the Applicant has in place such a compliance program. A compliance
					plan includes but is not limited to the following elements: written policies,
					procedures and standards of conduct; a designated compliance officer and
					compliance committee; compliance training and education; well publicized disciplinary standards. Access Health CT recognizes that Exchange standards
					for certain issues (such as ECP contracting are still under development) and it
					may not be possible for the Issuer to address these issues, for that reason,
					please supply the most current compliance plan as modified to reflect the plan
					that is being submitted. The Issuer will have the opportunity to modify the
					compliance plan by amendment, once the outstanding issues are finalized.
3	QHP Issuer Compliance and	Section II, Sub-Section A,	5	Will more detail regarding the compliance plan be	Access Health CT believes that compliance plans are an existing key part of an
	Oversight	Application and		provided in the QHP Application? Our assumption is that	Issuer's overall performance and expects their compliance plan to take effect
		Certification		the compliance plan will be effective 1/1/2014.	October 1, 2013. For additional information, see response to Question 2.

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		Requirements			
4	Market Participation	Section II, Sub-Section D, Market Participation	6	Addressed in last question Coverage Models - One Tier, Multiple Issuers (Employee Choice): an employer selects a benchmark plan and employees have the option to either pick the benchmark plan or use the employer's contribution to select another QHP within the benchmark's metal tier. This delayed in year one for FFEs. Will CT follow this new guidance?	Access Health CT SHOP will have the functionality to support a limited employee choice purchasing model (i.e. one tier, multiple Issuers; or one Issuer, multiple tiers).
5	Market Participation	Section II, Sub-Section D, Market Participation	6	Please clarify: Second Bullet: 'Issuers who meet the certification standards will be granted a two-year certification for its QHPs. Certified Issuers will not need to reapply to be certified for 2015.'	The Issuer will be certified to participate in the Exchange for a two-year period. The QHP plan designs will be submitted annually and rates approved by CID. Further, the cost sharing may need to be revised in order to be validated against the Federal AV Calculator (if changed).
6	Timelines in Conflict	Section II, Sub-Section D, Market Participation	6, 12	Please clarify timelines: The following sections appear to be in direct conflict with each other about certification timelines on the QHP certification standards and completed by Sept 2014. P.6-indicates certification will be granted for 2 years and certified Issuers don't need to reapply in 2015. P.12- states a QHP already accredited has to have its Exchange product accredited within one year.	The Issuer will be certified for two years to be qualified on the Exchange. The QHP benefits and plans need to be filed and certified on an annual basis.
7	Summary of Benefits and Coverage (SBC)	Section II, Sub-Section E, Enrollee Materials and Marketing Initiatives	7	Please confirm that the requirement to provide SBCs to enrollees does not apply to stand alone dental plans.	Confirmed. SBCs are not required for stand-alone dental plans. Based on Federal Guidance "an SBC need not be provided for stand-alone dental or vision plans or health flexible savings as if they constitute excepted benefits under the Departments' regulations." (See 77 FED. REG. 8670 (Feb. 14, 2012) 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), 45 CRF 146.145(c))
8	Evidence of Coverage	Section II, Sub-Section E, Enrollee Materials and	7	If an Issuer's evidence of coverage (EOC) document has not yet been reviewed and approved by the Connecticut	No. The Exchange prefers to receive the EOC once it has been approved by the Connecticut Insurance Department (CID). The document will be available

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		Marketing Initiatives		Insurance Department (CID), should the Issuer submit the draft EOC to Access Health CT?	within the consumer shopping section of the Exchange's web portal.
9	Customer communication	Section II, Sub-Section E, Enrollee Materials and Marketing Initiatives	7	The sections noted for replacement do not appear as separate sections in the initial solicitation. Do these requirements replace only the second bullet from the original solicitation (p 14 – highlighted below)? Do the other bullets still apply? If so, we still need an answer to the following which was included in our previous comments to the initial solicitation: What is the anticipated date for defining "certain"	Yes. The section is replaced in its entirety. The bullets referred to in the question no longer apply.
10	Number and Mix of QHPs- Standard Plans	Section II, Sub-Section I, Number and Mix of QHPs	9	customer communication" by the Exchange? The standard Silver plan must be the lowest cost silver plan in the individual market." Can you confirm that this requirement applies only to non-standard Silver plans that an Issuer may choose to offer in Access Health CT's individual exchange and not to all Silver plans that an Issuer may offer in the Connecticut individual market outside Access Health CT?	Yes. The Standard Silver Plan must be the lowest Silver Plan offered by an Issuer in the individual Exchange.
11	Number and Mix of QHPs- Standard Plans	Section II, Sub-Section I, Number and Mix of QHPs	9 - 11	In looking at the Exhibits/Standard plans, regarding the OON benefit, please provide clarity in relation to the OON deductible and what applies to it. It is stated that the OON Rx is after deductible—a plan level deductible that applies to all services including Rx. Should the entire prescription drug be embedded?	For OON, it is a combined deductible, and everything unless specified otherwise will be subject to the deductible. This includes all covered prescription drugs. The Rx OON benefit is embedded, and subject to the full deductible.
12	Number and Mix of QHPs- Standard Plans	Section II, Sub-Section I, Number and Mix of QHPs	9 - 11	Regarding the OON preventive care benefit where the deductible is waived on all of the metal levels. Granted	Preventive care is an important part of the ACA. Preventive care can be acquired in or out of network. The coinsurance structure of the out-of-

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				there is coinsurance which ranges from 20-50%, please explain the rationale for waiving the OON deductible.	network benefit does encourage in-network utilization but a member does have the choice to go out of network for these services. If they go out of network they will have to pay 20-50% of an Issuer's usual and customary rate for the service and any balance above that rate. The Issuer will be responsible for 50-80% of their usual reimbursement.
13	Number and Mix of QHPs SHOP	Section II, Sub-Section I, Number and Mix of QHPs – SHOP	9 - 11	Why do Issuers participating on the SHOP Exchange have to offer all 8 standard plans which include the silver alternative plans? And why must the standard silver plan be the lowest cost? Our understanding is the silver alternatives only apply to the Individual Exchange.	To clarify, only Exhibit 1 – Standard Silver Plan, Exhibit 5 – Standard Gold Plan, Exhibit 6 – Standard Platinum Plan, and Exhibit 7 – Standard Bronze Plan 1 apply to SHOP plans. The Silver alternatives do not apply to SHOP— Correct. Standard Silver plan does not have to be the lowest cost plan.
14	Number and Mix of QHPs	Section II, Sub-Section I, Number and Mix of QHPs	9-	If plans have the same Deductible, but one is an HSA and the other is a POS, does this meet the definition of meaningful difference?	The plans must meet the definition of meaningful difference. An HSA is a savings vehicle; the POS benefit plan design associated with the HAS, must be meaningfully different from another POS plan (if it too is associated with and HSA) also being offered. In the CMS letter to Issuers on Federally-facilitated and State Partnership Exchanges, dated April 5, 2013 guidance was given regarding "meaningful difference". ii. Supporting Informed Consumer Choice "CMS will conduct a benefit package review for all QHPs offered by an Issuer. The goal of this review is to identify QHPs that are not meaningfully different from other QHPs offered by the same Issuer and with the same plan characteristics. As in other areas, CMS will use this review to target QHPs for additional review and discussion with the Issuer.

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15					based on plan type, metal level and overlapping counties/service areas. • Second, CMS will review each subgroup to determine whether the potential QHPs in that subgroup differ from each other on least any one of the following criteria: o Different network; o Different formulary; o \$50 or more difference in both individual and family in-network deductibles; o \$100 or more difference in both individual and family in-network maximum-out-of-pocket; and o Difference in covered EHB.
15	Wellness Incentives	Section II, Sub-Section H, Wellness Incentives	9	Please provide further clarification regarding wellness incentives.	As of April 10, 2013, final guidance related to wellness programs has not been released. Please refer to "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans; Proposed Rule" 77 Fed. Reg. 70620 (November 26, 2012) for examples of nondiscriminatory wellness programs. Wellness Incentive programs only apply to SHOP.
16	Number and Mix of QHPs - Child-Only Plan	Section II, Sub-Section I, Number and Mix of QHPs – Child-Only	9 - 11	Child Only – If the Issuer allows child only applicants on all offerings, does this satisfy the child only requirement?	Yes. Any Qualified Health Plan (QHP) can be sold as a child-only plan. The eligibility section of the enrollee contract must reflect child-only provisions and the plan must be appropriately rated.
17	Number and Mix of QHPs - American Indians	Section II, Sub-Section I, Number and Mix of QHPs – American Indians	9 - 11	American Indians – Are we able to offer one plan that meets the criteria for both alternatives? Will the state have a separate exchange application for the AI plans or how does the state intend to identify the American Indians over 300% of the FPL that need to receive 0 cost-sharing from IHS providers?	Per the latest release (March 1, 2013) of CMS-9964-f - Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, the Issuers must offer two separate variations for each plan they want certified on the Exchange. §156.420 (b) Submission of zero and limited cost sharing plan variations. "For each of its health plans at any level of coverage that an Issuer seeks QHP

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18	Number and Mix of QHPs-	Section II, Sub-Section I,	9 -	Will Access Health CT allow Issuers to offer a Catastrophic	certification for the individual market on an Exchange, the Issuer must submit to the Exchange for certification the health plan and two variations of the health plan, as follows:" "(1) For individuals eligible for cost-sharing reductions under § 155.350 (a) of this subchapter, [people who meet the definition of American Indian, and who have household income of less than 300 % of FPL], a variation with all cost sharing eliminated; and (2) For individuals eligible for cost-sharing reductions under § 155.350(b) [people who meet the definition of American Indian, but are not required to request an eligibility determination to qualify for this rule], a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services." Access Health CT will include Tribal status on the 834 file sent to the Issuers. Yes. But the Catastrophic plan must be lower than the Standard Bronze plans
	Standard Plans	Number and Mix of QHPs	11	plan that is not a Bronze plan, and therefore may be purchased by individuals who are under age 30 and individuals who are exempt from the individual mandate due to affordability or hardship?	based on the Actuarial Value Calculator (AVC).
19	Pediatric Dental Premium	Section II, Sub-Section I, Number and Mix of QHPs	9 - 11	Regarding pediatric dental benefits, are Issuers required to submit a separate premium for the value of the pediatric dental benefit?	No. The cost for the embedded pediatric dental benefit is to be included as part of the overall QHP premium.
20	Ü	Section II, Sub-Section G, Rating Factors	9	Does this Tobacco language mean that the Individual market is not permitted for 2014, however may change in 2015, and that SHOP is not allowed at all?	Yes. Tobacco rating factors will not be a consideration for 2014 in the Individual market, but may be in future years. Per CT state law, tobacco rating factors are not allowed and will not be permitted for SHOP.
21	Number and Mix of QHPs - American Indians	Section II, Sub-Section I, Number & Mix of QHPs	10	It states a QHP must submit a zero cost-sharing for American Indians under 300% FPL and an alternative plan	Refer to 78 Fed. Reg. 15536 (March 11, 2013) 45 CFR §156.420 titled: (b) Submission of zero and limited cost sharing plan variations.

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				that offers zero cost-sharing for American Indians regardless of income for any service that is EHB furnished directly by an Indian provider. If the cost sharing for <300% FPL is \$0, wouldn't we only need to submit a plan for the Bronze level only? If cost shares for any metal level would be zero, they would always pick the Bronze plan because the premium would be lower. For those >300% FPL they would pick an existing plan knowing if they go to Indian providers the cost share will be zero.	This section outlines the following information: For each of its health plans at any level of coverage that an Issuer seeks QHP certification for the individual market on an Exchange, the Issuer must submit to the Exchange for certification the health plan and two variations of the health plan, as follows: (1) For individuals eligible for cost-sharing reductions under §155.350(a) of this subchapter, [people who meet the definition of American Indian, and who have household income of less than 300 % of FPL], a variation with all cost sharing eliminated; and (2) For individuals eligible for cost-sharing reductions under §155.350(b) [people who meet the definition of American Indian, but are not required to request an eligibility determination to qualify for this rule], a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.
22	American Indians	Section II, Sub-Section I, Number & Mix of QHPs – American Indians	10	Can you provide a listing of Indian providers in CT that are not ECPs?	Access Health CT will not be providing a listing of Indian providers in Connecticut that are not Essential Community Providers. We recommend that Issuers refer to the document titled "Overview of the Model QHP Addendum for Indian Health Care Providers" at the following URL: http://cciio.cms.gov/programs/exchanges/qhp.html Within this document, CMS references a database of Indian Health Service (IHS), tribes and urban tribal organization (I/T/U) providers that can be used to assist Issuers in identifying these providers in their service areas.
23	Number and Mix of QHPs -	Section II, Sub-Section I,	10	Child Only – It states a QHP Issuer could satisfy the child-	Yes. Any Qualified Health Plan (QHP) can be sold as a child-only plan. The

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	Child-Only Plan	Number & Mix of QHPs		only plan by offering a single QHP as long as it includes rating for child-only coverage in accordance with premium rating rules. Is that one in total, or one per metal level?	eligibility section of the enrollee contract must reflect child-only provisions and the plan must be appropriately rated.
24	Number and Mix of QHPs SHOP	Section II, Sub-Section I, Number and Mix of QHPs - SHOP	11	The QHP Solicitation Amendment states the following: "To participate in SHOP, the Issuer must include the same standard plan designs indicated in Exhibits 1-8". These are the Individual plan designs. The SHOP has a different deductible requirement and does not have the need to have the silver variation plans to accommodate Cost Sharing Reductions. Why are these plan designs required for SHOP?	To clarify, only Exhibits 1 – Standard Silver Plan, 5 – Standard Gold Plan, 6 – Standard Platinum Plan, 7 – Standard Bronze Plan 1 apply to SHOP plans.
25	NCQA	Section II, Sub-Section J, NCQA Accreditation	12	For Issuers that do not yet have NCQA accreditation, what information will be displayed with regard to quality ratings and the star system discussed on page 12 of the amendment?	For plans that are not yet NCQA rated, no stars will be displayed. Instead, the following language will appear within the consumer shopping section of the Exchange's portal: "Not yet rated – new Issuer"
26	Reporting Requirements	Section II, Sub-Section K, Reporting Requirements, Quality Improvement Strategies, Transparency and Performance Information and Pharmacy Utilization	12 - 13	When will metrics be provided? How much time will be given to collect the data and how often will reporting be required? Will this data be displayed on the Exchange Portal and will we have the opportunity to comment prior to posting?	Processes and data for reporting has not yet been finalized by Access Health CT due to absence of data for year one. Issuers will have an opportunity to comment on data requests, posting requirements, prior to finalization of reporting policy.
27	Reporting	Section II, Sub-Section K, Reporting Requirements, Quality Improvement Strategies, Transparency and Performance	12	We previously commented on the need to confirm that the "most recent calendar year" is 2012. We plan to provide the 2012 actual MLR along with 2014 MLR estimate.	Yes. The 2012 actual MLR along with the 2014 MLR estimate is appropriate.

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		Information and Pharmacy Utilization			
28	NCQA Accreditation	Section II, Sub-Section J, NCQA Accreditation	12	Please clarify: Second Bullet: 'If the QHP Issuer is already NCQA accredited, the Issuer must have its Exchange product accredited within one year of the time of the application. This can include the NCQA Exchange Add-On Survey.'	Yes. Access Health CT expects Issuers to use the NCQA Exchange Add-On survey to become 'accredited' to sell on the Exchange.
29	Satisfaction survey	Section II, Sub-Section K, Reporting Requirements, Quality Improvement Strategies, Transparency and Performance Information and Pharmacy Utilization	13	Page 13 of the Amendment notes that "Issuers will be required to use the enrollee satisfaction survey system developed by the HHS and report results to the Exchange." Has this survey system been developed, and if so, can Access Health CT provide information or direct Issuers to a source of information on that survey?	No. The enrollee satisfaction survey system has not yet been developed by the Department of Health & Human Services (HHS).
30	Reporting	Section II, Sub-Section K, Reporting Requirements, Quality Improvement Strategies, Transparency and Performance Information and Pharmacy Utilization	13	We previously commented on concerns with meeting the reporting requirements for 2014 due to measures not currently collected or reported for commercial plans, need for medical chart reviews, programming, planning, and funding needs to implement.	Processes and data for reporting has not yet been finalized by Access Health CT due to absence of data for year one. Issuers will have an opportunity to comment on data requests, posting requirements, prior to finalization of reporting policy.
31	Network Adequacy	Section II, Sub-Section N, Network Adequacy and Provider Data	14	Can you provide additional detail concerning the following statement? 'The network of providers for its standard plan offerings is, and continues to be, substantially the same as the network of providers available to its largest plan that represents a similar product offered outside of the Exchange.'	The expectation is that the network for each of the standard plans will be equivalent in size to your largest network for your individual or small-group markets, with the addition of coverage of essential community providers.

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32		Section II, Sub- Section N. Network Adequacy and Provider Data	14	As required by HHS, provider network reporting requirements will be developed based on a standardized format to be developed in conjunction with the Issuers. Previously we commented on the need for the anticipated date for the standardized format to be finalized and available for Issuers?	HHS has not released a standardized format to the Exchange. In the consumer shopping experience, the Exchange will display Issuer network provider information through a web link to the Issuer's provider network directory.
33	ECP Network Requirements	Section II, Sub-Section L, Issuer and QHP Quality Rating - Essential Community Providers (ECP)	15 - 16	Please clarify. Issuers should be permitted to offer a contract with reasonable terms but can't force an ECP to engage in a contract or to refuse to contract unless unreasonable reimbursement is demanded.	Per 45 CFR §156.235(d) "Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer."
34	ECP Network Requirements	Section II, Sub-Section L, Issuer and QHP Quality Rating - Essential Community Providers (ECP)	15 - 16	Will the state ECP list match the Federal ECP list?	No. The ECP list for Connecticut will not match the Federal ECP list. Access Health CT is developing a Connecticut list of ECPs with the assistance and resources of the Office of Health Care Access, DPH as well as DSS, Medical Operations Director.
35	Fees	Section II, Sub-Section P, User Fees	17	Has Access Health CT determined the administrative fee that will be charged Issuers and how that fee will be structured? Has Access Health CT determined the process that Issuers must follow in remitting these fees? If not, what is the timing for these decisions?	No. The assessment fee and process is being developed and will be communicated as soon as completed.