

Connecticut Health Insurance Exchange



STATE OF CONNECTICUT

March 9, 2012

Vendor Fair: Request for Information Posted Today!

A Request for Information (RFI) will be posted today on the website for qualified vendors capable of supporting the information technology and business processes of the Exchange. This RFI seeks information from vendors with solutions that will facilitate the purchase of insurance by individuals and small employers as well as assist the Exchange in meeting its myriad responsibilities pursuant to the ACA and subsequent federal regulations, guidance and bulletins.

www.healthreform.ct.gov



Education Focus: A series on key Exchange topics

The core responsibilities of the Exchange are identified in the ACA as follows: Eligibility determination for qualified health plans; Health plan enrollment; Plan management; Consumer assistance; and Financial management.

Over the next several weeks we'll be providing summary information on these important topic areas in addition to links for more information if you'd like to dive deeper. This background information will support considerations that will take place under the Advisory Committees in the coming months as we work towards State Certification. Please see the following page for information on the first in the series, "What's involved in Plan Management".



Improving our Look and Content Delivery!

Exchange Staff were recently granted permission to make modifications to the Insurance Exchange tab on the Office of Health Reform & Innovation website. Though it remains under development, significant progress has already been made to provide for a more user-friendly web environment. We also recently underwent training on management and distribution of website e-alerts, so you should soon see these communication enhancements as well. The next step is to work with our State IT agency on overall restructuring of the layout—in order to provide an even more organized and accessible environment. Once the restructuring is complete, it would be great to hear your feedback!

Upcoming Meetings

Board meeting next Thursday 9:00-12:00 at the Capitol in Room 310

Pre-Planning Federal Review April 4th with Formal Planning Gate review re-scheduled for late April - early May

Articles of Interest

[National Academy for State Health Policy: Building A Consumer-Oriented Health Insurance Exchange: Key Issues](#)

[Kaiser Health Weekly News Brief: Update on Exchanges](#)

[National Institute for Health Care Reform: State Mandates and National Health Reform.](#)

[The Commonwealth Fund: The Small Business Health Insurance Exchanges: Opportunities and Challenges](#)

Important to Note!

- ◆ Norwalk Hospital Foundation has kindly offered to include the Exchange in their health assessment survey.
- ◆ Accounting Firm, JH Cohn, to begin work on development and design of our accounting systems.

What's Involved in "Plan Management"

Plan management is a significant responsibility of the Health Insurance Exchange (Exchange); and all of the qualified health plans (QHPs) offered through the Exchange must meet certain requirements for coverage (i.e., essential health benefits), cost sharing (i.e., actuarial value), and quality prior to being made available to consumers. The business functions of certifying, managing and renewing the QHPs offered by the Exchange are key elements of plan management. Many plan management functions are the responsibility of the Connecticut Insurance Department (CID), while certain plan management functions are particular to, and will be the primary responsibility of, the Exchange.

Certification of Qualified Health Plans

The Exchange may certify plans for participation only if it "determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the state or states in which such Exchange operates." The law also requires health insurers that seek certification as a qualified health plan to submit to the Exchange a justification for any premium increase prior to implementation of the increase, and health insurers are required to post such information on their websites.

Although the Exchange is given flexibility with regard to QHP certification and the types of QHPs offered, the ACA – as further defined by proposed regulations [<http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>] – includes a number of requirements that will minimize material differences across health plans. Most of these restrictions apply to health plans available inside and outside the Exchange. The four most significant requirements include: (1) benefits and services covered, (2) actuarial value, (3) out-of-pocket limits, and (4) maximum annual deductibles in the small group market (SHOP Exchange).

Benefits and Services Covered

All health plans sold in the individual and small group markets must cover essential health benefits. [http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf] Recent federal guidance provides the state with four health plans to choose from in defining the essential health benefits benchmark plan:

- ◆ Largest plan by enrollment for any of the three largest small group insurance plans;
- ◆ Any of the largest three state employee health benefit plans by enrollment;
- ◆ Any of the largest three national Federal Employee Health Benefit Program (FEHBP) plan options by enrollment; or
- ◆ The largest insured commercial non-Medicaid HMO operating in the state.

The Exchange plan management functions encompass the following key areas:

- ◆ Establishing and applying criteria for QHP certification
- ◆ Data Collection
- ◆ QHP oversight and account management
- ◆ QHP renewal, recertification and decertification

In carrying out these functions, the Exchange will need to establish processes to support coordination, management and governance, and establish business relationships with relevant entities, such as the Connecticut Insurance Department. While the federal law imposes new regulatory requirements on all health insurers, health plans offered through the Exchange may need to meet additional requirements, including data reporting, marketing standards, network adequacy, accreditation, and implementation of quality improvement programs.

While the state is currently weighing its options with regard to the benchmark plans, the ACA delineates ten categories and services that must be included in the essential health benefits package:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.



Actuarial Value

QHPs offered in the individual and small group markets will need to meet certain actuarial value levels. Actuarial value is a summary measure of the percentage of an average enrollee's medical claims paid by the insurer vis-à-vis the percentage of medical claims paid by the enrollee through cost sharing. As a health plan's actuarial value increases, the enrollee's point-of-service cost sharing decreases. A bulletin recently issued by HHS provides further information on the manner by which actuarial value and cost sharing reductions will be implemented [<http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>].

In the individual market, QHPs will be offered in five tiers—platinum, gold, silver, bronze, and catastrophic (High Deductible Health Plan or HDHP). The actuarial values are set at 90 percent for platinum plans, 80 percent for gold, 70 percent for silver, and 60 percent for bronze. HDHPs will only be offered to individuals under the age of 30 or those granted a certificate of exemption from the individual coverage mandate due to affordability.

Cost Sharing Limits

The ACA also requires that QHPs sold through the Exchange limit the total amount of each member's point of service cost-sharing (out-of-pocket costs, excluding premiums) for in network services. The specific limits will be based on annual maximums that apply to HSA-qualified HDHPs, which are set each year by the Internal Revenue Service. Annual out-of-pocket limits will be reduced for lower-income enrollees that purchase subsidized coverage through the Exchange.

For health plans sold in the small group market, the ACA limits the amount of annual deductibles to \$2,000 for single policies and \$4,000 for family policies. Although employers will still be able to offer employees a plan that qualifies as an HDHP, these lower limits will affect the upfront deductibles allowed in the small group market.

In total, the main requirements that apply to QHPs sold through the Exchange – essential health benefits, actuarial value standards, and cost-sharing limits – will streamline coverage options for enrollees and reduce variability across health plans.

A key consideration for the Exchange is the extent to which the structure and types of QHPs available will allow consumers to choose from a broad set of health benefits and enable consumers to make informed decisions on the basis of a clear understanding of their health coverage options. The key elements of QHP certification include:

- Developing certification criteria and an application process;
- Reviewing benefits and rates;
- Certifying QHPs; and
- Entering into agreements with QHP insurers

Data Collection

Health insurers are required to submit and make public information to the Exchange, the CID, and the Secretary of HHS. The data elements include:

- ◆ Claims payment policies and practices;
- ◆ Periodic financial disclosures;
- ◆ Enrollment and disenrollment;
- ◆ Claims denied;
- ◆ Rating practices;
- ◆ Cost-sharing and payments with respect to any out-of-network coverage;
- ◆ Enrollee and participant rights; and
- ◆ Other information as determined appropriate by the Secretary.

The Exchange, in concert with CID, will need to establish a process to collect these data, and make them publicly available.

QHP Oversight and Account Management

During the course of the year, the Exchange will have responsibility for general oversight and account management. The day-to-day interaction with the insurers will include processing enrollment and transferring data, tracking complaints and their resolution, financial transactions, and ongoing assessment of plan performance. Again, because CID has primary responsibility for many of these functions, the Exchange will need to coordinate its activities with those of the Department, as well as consumer assistance activities and responsibilities of the Office of the Healthcare Advocate and the Attorney General's Office.

QHP Renewal, Recertification and Decertification

Finally, the Exchange will need to establish a process to recertify insurers periodically. This may be an annual process or may be done every two or three years. The ACA and the federal guidance on recertification of insurers allow some flexibility in this regard. In general, the QHP recertification and decertification process and criteria will be similar to the initial certification process.

However, with regard to rate review and QHP renewals, the insurers will need to submit rates and benefits annually. Due to the nature of the small group market, in which rates can be adjusted on a quarterly basis and open enrollment is not limited the way it is in the individual market, the Exchange will need to update QHP information (i.e., rates) more frequently for the SHOP Exchange.

