Connecticut
Health Insurance
Exchange

DRAFT FOR REVIEW AND VOTE

To: Members of the Joint Advisory Committee Meeting

From: Connecticut Health Insurance Exchange Staff

Re: Revisions to staff recommendations for "Issues for Review" identified in draft of "Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges"

Date: November 26, 2012

No.	Issue for Review	Staff Recommendation
1	**Initial Certification Period**	
1.a	Should the initial QHP certification be for a two-year period? Should failure of an issuer to apply for certification in 2014 inhibit participation by the carrier until (at least) 2016? *Amended to reflect a desire to be more flexible with granting a one-year certification for 2015.	Staff recommends that the Exchange's initial QHP solicitation be for a two-year QHP certification.[1] This would provide carriers with both a level of predictability and incentive to participate in the Initial Solicitation. Rates will need to be approved annually by CID according to state regulation. The Exchange would solicit applications for QHP certification again for plan year 2016, but will consider admitting newly licensed carriers and existing carriers for special circumstances (e.g., an issuer tries but fails to meet certification criteria in 2014, and succeeds in doing so for 2015) in 2015 that the Exchange decides would be in the interest of consumers. Any QHP certification granted for 2015 would only be for one-year certification.
1.b	If a QHP carrier ceases participation in the Exchange, should the carrier be prevented from rejoining for two (or three) years?	Staff recommends that if a certified QHP carrier ceases participation in the Exchange, the carrier be denied re-entry for a minimum two (2) years until the next solicitation. The Exchange will consider appeals to this general exclusion during the next general QHP solicitation after conducting a thorough review of the carrier's new application.
2	**Mix and Number of Plans**	
2.a	How many health plans should a carrier be required and/or allowed to offer through the Exchange? *Amended to reflect a desire for fewer requirements with respect to the mix and number of plans (with the addition of requirement for a Bronze plan, the requirement will reflect the minimum requirement)	Staff recommends that for both the Individual Exchange and SHOP Exchange (although a carrier does not need to participate in both exchanges), a QHP carrier **must** submit at a minimum the following mix of plans: • One (1) Gold Plan • One (1) Silver Plan • One (1) Bronze Plan But no more than: • One (1) Platinum Plan • Two (2) Gold Plans • Two (2) Silver Plans • Two (2) Bronze Plans For the Individual Exchange only, a QHP carrier **must** submit: • Three (3) required actuarial value ("AV") variations for **at least** one (1) Silver Plan • One (1) child-only QHP for each metal tier for which a carrier submits a plan And may submit: • One (1) Catastrophic Coverage Plan **An Issuer's proposed QHP offerings must exhibit **meaningful differences** after controlling for plan's metal level* *^The AV alternatives reflect the "Cost Sharing Reductions" available to eligible individuals/families with household income below 250% of FPL. If these alternative Silver are offered for only one (1) Silver plan, it must be for the carrier's lowest-costing Silver.*

2.b	Should carriers be required, prevented, or given the option of offering Platinum QHPs?	Staff recommends the Exchange allow, but not require, carriers to submit one (1) Platinum plan in each of the Individual Exchange and SHOP Exchange.
2.c	Should QHP carriers be required to submit one or more standardized plan designs for one or more metal tiers as a part of their application to participate in the Exchange?	Staff believes one standardized plan design per tier promotes transparency, ease, and simplicity for comparison shopping by enrollees. Staff recommends that the Exchange define one standard plan design for each of the Bronze, Silver and Gold tiers. The standard plan would define the QHP's deductible, co-payment and/or co-insurance mix for the essential health benefits offered in-network. The standard plan designs will be developed in partnership with the carriers and be based upon the most popular plans sold in the small group market in 2012. The plan would be subject to adjustment after release of the federal actuarial value calculator. Staff recommends that a QHP carrier be required to submit this Exchange-defined standard plan for each the Bronze, Silver, and Gold tiers. Staff recommends that for each metal tier (except Platinum) the carriers be encouraged to submit one other, non-standard, plan of their choosing.
3	**Pediatric and Stand-Alone Dental**	
3.a	Should pediatric dental services be priced separately? (Alternative is to allow QHP carriers to bundle services.)	Staff recommends that the Exchange require QHP carriers to separately rate their pediatric dental benefit. If a QHP includes pediatric dental services, potential enrollees will be automatically assigned to the carrier's dental benefit, but the enrollee will retain the option of selecting another carrier's dental plan if desired.
3.b	For stand-alone dental plans, should carriers be required to offer plans across all, any, or specific metal tiers?	Staff recommends that actuarial certification to the metal tiers not apply to stand-alone dental visions, unless required by federal regulations.
3.c	For stand-alone dental plans, should the Exchange consider selling two benefit tiers of stand-alone dental plans: (1) preventive only; and (2) full benefits? *Amended to reflect the concern that "Access-only Plans" (a paid membership to a network of dentists that have agreed to a maximum payment schedule for services) should not be part of the QHP Solicitation.	Staff recommends that all stand-alone dental plans must provide coverage for the full dental benefits, as included in the "essential health benefits" for pediatric dental services. Staff recommends against offering a limited preventative-only dental plan. Instead, the Exchange will explore the value of offering "access-only" dental plans. However, these plans are not insurance and would not be part of the Initial QHP solicitation.
4	**Rating Factors**	
4.a	Should the Exchange make tobacco-use a required rating factor in the Individual Exchange?	Staff recommends that the Exchange prohibit QHP carriers to include tobacco use as a rating factor in the Individual Exchange.
4.b	Should the Exchange require carriers to agree to standardized rating factors (for geography, age, household size) across all QHPs sold through the Exchange?	**Family.** Staff recommends that the Exchange standardize family composition structure, but allow carriers to determine tier ratios. **Age.** Per ACA reforms QHPs will be subject to a 3:1 age factor rating. Staff recommends that the Exchange allow carriers to determine tier ratios. **Geography**. Staff recommends that the Exchange allow carriers to determine tier ratios.

<table>
<tr><th colspan="3">5 Network Adequacy</th></tr>
<tr><td>5.1</td><td>What should be a carrier's network adequacy standard?</td><td>A QHP carrier must ensure that the provider network of each of its QHPs meets these standards:
1) Include essential community providers ("ECP");
2) Maintain a network that is 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;
3) Is consistent with the network adequacy provisions of section 2702(c) of the PHSA.[2]
Consistent with Sec. 38a-472f of the Connecticut General Statutes, carriers in Connecticut must be URAC or NCQA accredited with respect to provider network adequacy. Other than how it relates to the inclusion of ECPs, the staff recommends that the Exchange not impose any additional requirements (beyond those necessary to meet accreditation) on a carrier's provider network.
However, staff recommends that the carriers be required to provide the Exchange with the criteria used to define the adequacy of its network, including but not limited to, geographic distance standards to providers and timeliness of appointment scheduling. Such standards shall include information on variation of standards by provider specialty.
Staff recommends that the Exchange consider proposals for tiered or narrow networks for non-standard QHPs in its Initial Solicitation. The Exchange will need to develop separate standards for these types of networks</td></tr>
<tr><td>5</td><td>What should the Exchange's network adequacy standard be as it relates to Essential Community Providers?

*Amended to reflect to reflect county-level geography to better assure statewide access. Included a list of town/cities (16) in the state that have the highest number of uninsured.</td><td>With respect to ECPs, staff recommends that sufficiency be defined as carriers having contracts with:
1) At least 50% of the essential community providers in every county across Connecticut; and,
2) At least 75% of the ECPs located in any city or town that contains one or more of the 20 zip codes with the greatest number of uninsured individuals in Connecticut, with a minimum of one city per county:
<table>
<tr><th>County</th><th colspan="2">Cities</th></tr>
<tr><td>Hartford</td><td>• Hartford
• Bridgeport
• Stamford
• Bristol</td><td>• Danbury
• East Hartford
• New Britain</td></tr>
<tr><td>Litchfield</td><td>• Torrington</td><td></td></tr>
<tr><td>Middlesex</td><td>• Middletown</td><td></td></tr>
<tr><td>New Haven</td><td>• New Haven
• Waterbury</td><td>• West Haven
• Meriden</td></tr>
<tr><td>New London</td><td>• Norwich</td><td></td></tr>
<tr><td>Tolland</td><td>• Vernon-Rockville</td><td></td></tr>
<tr><td>Windham</td><td>• Willimantic</td><td></td></tr>
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and,
3) At least 80% of the federally qualified health centers ("FQHC") or "look-alike" health center in Connecticut.
Short of meeting such standards for ECPs, staff recommends that carrier be allowed to evidence a good faith effort to contract with ECPs by, for example, providing contract terms accepted by some providers, and offered to, but rejected by, an ECP.</td></tr>
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6	Purchasing Model	
6	What should be the Exchange's purchasing model? Should the Exchange actively negotiate rates in 2014?	1. The Exchange's purchasing model will reflect its principles for QHP certification. For its Initial Solicitation and to promote member choice and carrier competition, staff recommends that the Exchange selectively contract with any carrier that meets the standards for QHP certification defined in its QHP Solicitation. 2. Staff recommends that the Exchange not directly negotiate rates and deny a carrier QHP certification on the basis of its approved rates; but the Exchange reserves the right to not offer for sale an otherwise certified QHP that is an outlier with respect to the submitted rates. 3. The Connecticut Insurance Department must approve all forms and rates before a plan may be certified by the Exchange. 4. Staff recommends that that the Exchange require carriers to submit a narrative outlining how they will attempt to better coordinate care and control costs, improve chronic illness management, reduce medical error, or otherwise promote health care delivery and payment reform for the benefit of the consumer.[3]

[1] There was some consideration by advisory committee members that subsequent QHP solicitations be for a one-year certification period. Staff recommends not defining the certification length for subsequent solicitations. That decision could be better determined by the Board when the subsequent QHP certification requirements and solicitation process are being developed.

[2] From **Public Health Services Act** (see 42 U.S.C. 300gg–1):
Sec. 2702. Guaranteed Availability of Coverage.
(c) SPECIAL RULES FOR NETWORK PLANS.—
(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—
(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and
(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—
(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and
(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

[3] Staff cautions against actively promoting a particular model of delivery/payment reform in its initial year. Such promotion could become arbitrary and put certain carriers at a competitive disadvantage without a rational basis for giving this preferential treatment to one type of plan design over another, particularly as it relates to best serving this previously underserved population. Instead, staff recommends that the Exchange actively engage with carriers to guarantee adherence to the ACA requirement that the carriers "implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act" (45 CFR § 156.200(a)(5))