

***Connecticut Health Insurance Exchange:***

**Initial Solicitation to Health Plan Issuers for Participation in the  
Individual and Small Business Health Options Program (SHOP)  
Exchanges**

**Release Date: December 13, 2012**

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## I. General Information and Background

### A. Context

The Connecticut Health Insurance Exchange (Exchange) is soliciting applications from health insurance issuers (“Issuers”) to market and sell qualified health plans (“QHPs”) and/or stand-alone dental plans through the Exchange beginning in 2013 for a January 1, 2014 effective date of coverage. This Solicitation defines the requirements an Issuer must comply with to participate in the Individual Exchange and its Small Business Health Options Program (SHOP) Exchange. The Exchange encourages Issuers to study this Initial Solicitation and its attachments carefully in preparing an application.

The Patient Protection and Affordable Care Act of 2010 (ACA) and Connecticut’s Public Act 11-53, as amended by Public Act 12-1, provide the regulatory framework for defining the state’s QHP certification requirements and grant the authority to the Exchange for administering this Solicitation.

*To provide consumers transparent choice and carrier competition, the Exchange will contract with any carrier that meets the standards for QHP certification; however, nothing in this Solicitation precludes the Exchange from selectively contracting and not offering for sale one or more otherwise certified QHPs on the basis of price if there is an adequate number of Qualified Health Plans available to allow for sufficient consumer choice.*

*This Solicitation may be amended by additional addenda that describe supplemental information required of the Issuers. The Exchange will post any amendments to this Solicitation on its website.*

The process and requirements contained in this document and its various attachments are strictly related to the initial solicitation and certification of QHP and stand-alone dental plan applications. The Exchange has not yet made decisions about the processes for decertification and recertification and these processes will be determined at a later date.

The Exchange will use the requirements outlined in this Solicitation to evaluate Issuers’ applications and certify QHPs. Issuers must agree to offer health plans certified as QHPs to any eligible consumer wanting to purchase coverage for a term of twelve (12) months beginning January 1, 2014 and ending December 31, 2014. The Issuer will also agree to offer its QHPs during special enrollment periods to eligible enrollees who experience a valid change in circumstances as defined in the ACA.

### B. Background

Only health plans certified as a QHP can be sold through a state or federally operated health benefit exchange. Effective January 1, 2014, these exchanges will offer Issuers a state-wide marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance.

The exchanges are the only distributional channel through which individuals and small employers will be able to purchase coverage that will be eligible for certain affordability subsidies, including:

- advanced premium tax credits and/or cost sharing reductions available to households purchasing coverage in the individual market, and;

- affordability tax credits available to eligible employers offering coverage in the small group market.

To be certified as a QHP, the Issuer and its health plans must meet any and all federal and state statutory requirements, but also the Connecticut-specific selection criteria set by the Exchange and described in this Solicitation. The Exchange is the entity responsible for certifying health plans and ensuring that plans remain compliant with the state's QHP certification requirements.

For Exchange planning purposes, Exchange staff reviewed the suggested list of QHP application elements released by the Center for Consumer Information and Insurance Oversight ("CCIIO") and the QHP certification requirements being considered in other states, including California, Vermont, Maryland, and Arizona. These lists of requirements were the starting point for the Exchange's development of the certification requirements defined in this Solicitation. In addition, the Exchange engaged Wakely Consulting, a national actuarial and management consulting firm, to review the recommended application elements included in the draft of this Solicitation and broadly consider the potential impact of different QHP purchasing models and certification requirements.

Exchange staff reviewed its recommended QHP certification requirements with its advisory committees and made available the Solicitation and the staff's recommendations for public comment. Exchange staff subsequently presented to its Board of Directors the stakeholder feedback received and the recommended criteria for certification. This Solicitation reflects the criteria approved by the Board and that it deems are in the best interest of individuals and employers.

The Exchange contracted with Gorman Actuarial, LLC to define proposed standard plan designs. These plan designs are based on popular plans sold in the Connecticut individual and small group markets. Gorman Actuarial used the proposed Actuarial Value calculator released by the CCIIO to evaluate the plans. The Exchange presents these plans as preliminary and intends to engage Issuers and its stakeholders and adjust the plans as necessary.

In setting the criteria outlined in this Solicitation that the Exchange will use to certify health plans as "qualified," the Exchange was guided by its mission to increase the number of insured residents in Connecticut and reduce health disparities by improving access to high quality health care coverage. The Exchange intends that through the development of an innovative and competitive marketplace, consumers will be empowered to choose the health plan and providers that give them the best value.

As a further preface to the requirements for this Solicitation, the Exchange wants to remind interested Issuers of its five governing principles that it expects all of its partners to reflect in their own operations:

1. Create an easy and simple consumer experience for shopping and comparison of insurance options
2. Promote innovation and new options for benefit coverage in the State
3. Provide empathetic and responsive customer service
4. Work with our health plans, brokers, and navigators to provide more affordable products and broad distribution support
5. Launch a substantive and targeted communications and outreach campaign that promotes awareness of health reform and new options for consumers and small businesses in the State

In defining these principles, the Exchange realizes that broad success can only be achieved if its reform efforts are comprehensive and performed in partnership with Issuers, providers and consumers.

By creating the necessary infrastructure, the Exchange hopes to be, in part, a catalyst for broad and thoughtfully iterative health care reform. With the enactment of the ACA and the range of insurance market reforms that are currently in the process of being implemented, the Exchange understands Connecticut's health insurance marketplace will be transformed into a more consumer-oriented market that will reward better care management, prevention, and affordability.

Through this Solicitation the Exchange looks specifically to the Issuers to be a cooperative partner with the State in its reform agenda. The Exchange is confident that with this commitment from the Issuers, Connecticut can move closer toward the critical goal of achieving better health outcomes through better care.

### **C. Regulatory Filings**

The Connecticut Insurance Department ("CID"), responsible for licensing and monitoring insurance carriers in Connecticut, will continue to exercise its regulatory oversight of the health insurance market. In accordance with Connecticut state law, all fully insured products must have forms and rates approved by CID in advance of an Issuer presenting the product to the market for sale.

Any determinations by the Exchange to certify a health plan as "qualified" will be conditional upon CID approving the plan. Similarly, any stand-alone dental plan must be approved in advance by CID and certified by the Exchange.

As a result of the federal regulations effective January 1, 2014, including but not limited to QHP certification, CID anticipates there will be a large number of new health plans (form and rate filings) submitted by the Issuers to CID for review and approval for plan year 2014. To expedite CID approval and Exchange certification of the health plans, a coordinated multi-step submission process and aggressive timeline is proposed. The Exchange will partner with CID and the Issuers to establish the process and timing of all necessary regulatory filings (form and rates).

CID released a Bulletin outlining the State's filing requirements to the Issuers on November 1, 2012. Bulletin HC-90, "Filing Requirements for Individual and Small Employer Group Health Insurance Policies Subject to the Affordable Care Act", provides additional information on the process for rate and policy form filing submissions for issuers submitting health products for the 2014 plan year. The Bulletin is available on the CID website (at <http://www.ct.gov/cid/>) under the tab "BULLETINS." Issuers are encouraged to adhere to CID's timetable and two-stage process for form and rate approval.

Concurrent to CID's approval process, Issuers are encouraged to submit their QHP and stand-alone dental plan applications in accordance with this Solicitation to the Exchange.

### **D. Solicitation Process and Timetable**

The Solicitation process shall consist of the following steps:

- Release of the Final Solicitation
- Release of the Standard Plan Design

- Submission of Issuer's Notice of Intent to Respond to Solicitation
- Submission of Issuer forms and rates to CID for approval
- Submission of Issuer QHP application(s) to Exchange
- Evaluation and selection by Exchange of Issuer QHPs for certification
- Discussion and negotiation of final contract terms and conditions
- Certification of QHP and execution of contracts with the selected Issuers

In order for the plan design to be reviewed and certified by the Exchange in time for the initial open enrollment period, Issuers are advised of the following key dates and timeframes. Any changes to the dates will be communicated directly to the individual identified in the Issuer Notice of Intent and will be posted on the Exchange's website.

<b>Action</b>	<b>Due Date</b> <i>(all dates are subject to change)</i>
Final Release of Initial QHP and Stand-Alone Dental Solicitation	December 13, 2012
Release of Standard Plan Design	TBD
Issuer Contract of Coverage <b>Due to CID</b>	December 2012 (ongoing)
Issuer QHP Notice of Intent Due to Exchange	January 4, 2013
Plan Rates and Summary of Benefits <b>Due to CID</b>	March 2013 (ongoing)
QHP and Stand-Alone Dental Applications Due to Exchange	March 29, 2013*
CID Approval of Rates and Plans	July 2013 (ongoing)
Evaluation, Negotiation and Selection of Issuer QHPs for Certification by Exchange	March-July 2013
Anticipated Certification of QHP by Exchange <i>(Conditional QHP certification may be granted; however, QHP cannot be sold through Exchange without CID approving the plans' rates and forms)</i>	July 15, 2013
Carriers Attest Plan Data is Correctly Uploaded	September 1, 2013
Open Enrollment Period	October 1, 2013 – March 31, 2014
2014 Plan Year	January 1 – December 31, 2014

\*Dates are subject to change based on technical functionality of plan management system.

Following the release of this Solicitation, the Exchange intends to issue additional information as part of the Final Release of the Solicitation regarding:

- Benefit plan design for standard QHP
- Benefit plan design for pediatric dental benefit and stand-alone dental plans
- Qualified Health Plan model contract and required attestations
- Instructions to Issuers on how to submit application electronically
- Invitations to an Exchange-Issuer technical working group to define forms and formats of all required reporting documentation

## E. Notice of Intent (Pre-Requisite)

Following the Final Release of Initial QHP and Stand-Alone Dental Solicitation potential Issuers must submit a **Notice of Intent to Submit Qualified Health Plan** no later than 5:00 p.m. on January 4, 2013. The Notice of Intent is not binding; however, an Issuer cannot apply without first submitting a Notice of Intent. Only those Issuers acknowledging interest in this Solicitation by submitting a Notice of Intent will continue to receive Solicitation related correspondence from the Exchange.

### Submission Instructions and Deadlines for Notice of Intent

1. Please complete the form titled: **Notice of Intent to Submit Qualified Health Plan**.
2. Issuers should submit this form via email to the Exchange's contact person identified in Section 1.F no later than 5PM on January 4, 2013.
3. Please make sure the email subject line reads: "Notice of Intent to Submit Qualified Health Plan."
4. The Issuer will receive a response confirming the submission.

## F. Authorized Exchange Contact for Solicitation

The Exchange's authorized Contact Person for all matters concerning this Solicitation:

**Name:** Margo Lachowicz, Project Assistant

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**Mailing Address:**

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State of Connecticut  
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Hartford, CT 06106-1379

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All questions to, and requests for information from the State of Connecticut concerning this Solicitation by a Prospective Responder or a Responder, or a representative or agent of a Prospective Responder or Responder, should be directed only to the Authorized Contact Person. Include "Exchange QHP Solicitation" in all correspondence.

Questions should be in writing, and submitted by email or fax. All answers to questions, and any Addenda to this Solicitation, will be made available to all Prospective Responders.

## G. Certification, Recertification and Decertification

The subject matter contained in this document is strictly related to the initial application for Exchange certification of QHPs and stand-alone dental plans. Certification will be awarded by the Exchange. An award of certification does not necessarily mean the QHP or Issuer will be offered on the Exchange if there are an adequate number of Qualified Health Plans available to allow for sufficient consumer choice.

The Exchange will complete the recertification process for QHPs and Issuers participating in the Initial Solicitation on or before September 15, 2015. The Exchange has not yet defined the specific criteria for recertification.

The Exchange may decertify any QHP that fails to maintain the required certification standards, requirements for recertification or fails to comply with a corrective action plan. Issuers will have the right to appeal decertification decisions.

The Exchange's preliminary decisions about the process for periodic recertification requirements and defining criteria for the decertification of either an Issuer or specific QHP will be forthcoming and will be based on the QHP certification requirements included herein.

## **H. Amendments to Solicitation**

The Exchange reserves the right to amend this Solicitation. The Exchange will post any amendments on its website.

The Exchange anticipates it will release guidance on its enrollment policies and procedures, broker policy and compensation model, premium billing, pediatric and stand-alone dental, and establishing technical partnerships for distributing enrollment information and federal affordability subsidies to Issuers.

## **II. Application Components and Certification Requirements**

This section outlines the various components that the Exchange will require in the Issuer application for this Solicitation. The actual application and any associated guidance related to its submission, including the submission of any necessary (or optional) supporting documentation, will be provided to the primary point of contact identified by the Issuer for the Solicitation.

The Issuer's application(s) are intended to cover the Issuer's participation in both the Individual Exchange and SHOP Exchange. If the Issuer's responses to the application requirements differ based on the Issuer's individual or small group lines of business, the Issuer must indicate such and provide separate responses to the requirements.

Nothing in this Solicitation preempts a participating Issuer from adhering to all applicable federal regulations. Additionally, only plans approved by the CID and meeting any and all State regulatory requirements may be offered through the Exchange.

## A. Issuer General Information

*This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.*

### ACA Requirements

- This information is not specifically required by the ACA for QHP certification.

### Connecticut QHP Requirements

- *Issuer Information.* The QHP Issuer will need to be identified and included on the Letter of Intent and QHP Application. The information provided must match the information on file with CID and represent the legal entity that has the certificate of authority to offer health insurance policies in the State of Connecticut.
- *Issuer Management.* The Application will request contact information for the individuals responsible for the market for which a response is being submitted, including the following (or equivalent thereof):
  - President or CEO
  - Chief Medical Officer
  - Senior Vice President, Individual Products (if applicable)
  - Senior Vice President, Small Group Products (if applicable)
- *Primary Contact.* The Letter of Intent and Application will request contact information for the person with primary responsibility for and authority over the Issuer's QHP(s) in the Exchange and any related business operations related to this Solicitation.
- In its Application to the Exchange the Issuer will be required to attest to language similar to:

*We certify and attest that we currently have and will maintain appropriate staffing and qualified management to effectively manage all QHPs offered in the Exchange.*

### Stand-Alone Dental Requirements

- The same general Issuer information requirements will apply to dental plans.

## **B. Administrative Management**

*This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.*

### **ACA Requirements**

- This information is not required by the ACA for QHP certification.

### **Connecticut QHP Requirements**

- As it relates to an Issuer's fully-insured individual and small group products, the Issuer will be required to manage and resource their Exchange products and membership in the same manner as their non-Exchange products and membership.
- In its application to the Exchange the Issuer will be required to attest to language similar to:

*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 on the Connecticut Health Insurance Exchange.*

### **Stand-Alone Dental Requirements**

- The same Issuer attestation will apply to dental plans.

## **C. Licensure and Financial Condition**

*This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.*

### **ACA Requirement**

- A QHP issuer must be licensed and in good standing to offer health insurance coverage in each state in which the Issuer offers health insurance coverage.

### **Connecticut QHP Requirements**

- All Issuers must be licensed and in good standing with CID.
- In its application to the Exchange the Issuer will be required to attest to language similar to:

*We certify that we understand that only health benefits plans that have been approved and reviewed by the Connecticut Insurance Department and are in current good standing pursuant to 45 CFR §156.200(b)(4), may be offered through the Connecticut Health Insurance Exchange.*

### **Stand-Alone Dental Requirements**

- The same Issuer requirements and attestation will apply to dental plans.

## D. Market Participation

*This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.*

### ACA Requirements

- The Exchange must complete the certification process before the beginning of the open enrollment period.
- Regardless of the frequency of the certification process, the Exchange will monitor QHP issuers for ongoing compliance with all certification requirements.
- Issuers must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP.

### Connecticut QHP Requirements

- An Issuer may elect to participate in either the Individual Exchange or the Small Business Health Options Program (SHOP) Exchange or both.
- Any Issuer meeting the Exchange's 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 Exchange does not anticipate conducting a full solicitation process in 2014. However, the Exchange reserves the right to admit existing or newly licensed carriers for 2015 if the Exchange deems such an exemption would be in the best interest of the consumers. Any such certification would be strictly for one year.
- If a certified QHP Issuer ceases participation in the Exchange, the carrier will be denied re-entry for a minimum two (2) years until the next general solicitation. However, the Exchange will consider appeals to this general exclusion during the next general QHP solicitation.
- All forms and rates will need to be approved annually by the Connecticut Insurance Department, according to state regulation
- *SHOP Purchasing Model.* If participating in the SHOP, the Issuer must agree to not discriminate against any of the Exchange's potential purchasing options. Employers will have the option of choosing between three coverage models for their employees:
  - One Tier, Multiple Issuers (i.e. "Employee Choice"): 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.
  - One Issuer, Multiple Plans (i.e. "Employer Choice"): Employer selects a benchmark plan and then offer a choice of QHP options exclusive to the Issuer of the benchmark plan.
  - One Carrier, One Plan (i.e. "Sole Source"): An employer selects a benchmark plan and provide the option for employees to either select or reject enrollment in the benchmark plan.

### Stand-Alone Dental Requirements

- The same Issuer requirements and attestation will apply to dental plans.

## E. Marketing Initiatives

*This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.*

### ACA Requirement

- A QHP issuer must not employ marketing practices (or benefit designs) that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP.

### Connecticut QHP Requirements

- In its application to the Exchange the Issuer will be required to attest to language similar to:  
*We certify that we will cooperate in good faith with the Exchange's marketing and outreach efforts, including internal and external training, development of collateral materials and other efforts that are within reason and will not impose an undue administrative or financial burden on the Issuer.*
- Issuers will be required to provide one brochure, if applicable, and one "Summary of Benefits and Coverage" ("SBC"), including each of the coverage examples defined by HHS, for each QHP offered through the Exchange.
- Issuers will be required to include the Exchange's brand name, logo and tagline, and contact information on all billing statements and certain customer communications related to Exchange products. The location and size will be discussed with each Issuer.
- The Exchange will retain the right to communicate with an Issuer's Exchange enrollees regarding enrollment and renewal activities as well as satisfaction with coverage.

### Stand-Alone Dental Requirements

- The same Issuer requirements will apply to dental plans.

## F. Cost-Sharing, Plan Benefits and Rates

*This information will be QHP-specific and will need to be included for each submitted QHP in the Issuer's application.*

### ACA Requirements

- Each QHP must comply with the benefit standards required by the ACA, including:
  - Cost sharing limits
  - Actuarial value ("AV") requirements
  - Federally approved State-specific essential health benefits ("EHB")
- The Issuer must set premium rates for its QHP for the entire benefit year,
- An Issuer must submit a justification for a rate increase prior to the implementation of the increase. A QHP Issuer must prominently post the justification on its Web site.
- Except for impact of cost sharing reduction subsidies, each plan in a metal tier must meet the specified AV requirements based on the cost-sharing features of the plan:
  - Bronze plan – AV of 60 percent
  - Silver plan – AV of 70 percent
  - Gold plan – AV of 80 percent
  - Platinum plan – AV of 90 percent

*A de minimis variation of +/- 2 percentage points in AV is allowable.*

### Connecticut QHP Requirements

- If available, to avoid unnecessary duplication with CID, the Exchange will use the System for Electronic Rate and Form Filings (SERFF) to retrieve plan and benefit design information.
- The Exchange will work with the Issuers to develop standard templates for all necessary forms. If possible, the State will use federal templates to reduce administrative burden.
- *Rates.* Connecticut is a prior-approval state. CID is responsible for reviewing and approving any rate or rate increase. The Exchange will not duplicate the rate review process and will rely on any justification collected through CID's rate review process. The Exchange will post on its website the Issuer's published justification for its rate increases.
- *Essential Health Benefits.* With the potential exception of pediatric dental services, the QHP must include at a minimum the Connecticut-specific EHB. No substitution of actuarially equivalent benefits will be allowed. (See **Attachment 3** for Connecticut's Essential Health Benefits)
- *Pediatric Dental Services.* If a QHP includes pediatric dental services, the Issuer must separately price and rate the benefit. If a QHP includes pediatric dental services, enrollees under the age of 19 will be automatically assigned to the carrier's dental benefit, but the enrollee will retain the option of selecting another stand-alone dental plan if desired.

### Stand-Alone Dental Requirements

- Proposed federal regulations define the following as allowable AV standards for stand-alone dental:
  - Low Option – AV of 75 percent
  - High Option – AV of 85 percent

- The maximum out-of-pocket expenditure for any pediatric dental services provided through a stand-alone dental plan must be “reasonable” (to be determined by federal regulation)
- Stand-alone dental plans must provide coverage for all enrollees the pediatric dental benefits included as essential health benefits.
- The Exchange will work with the Issuers to develop standard templates for all necessary forms. Whenever possible the State will use federal templates to reduce administrative burden.

## G. Rating Factors

*This information will be QHP-specific and will need to be included for each QHP in the Issuer's submission.*

### ACA Requirements

- *Single Risk Pool.* An Issuer must consider all of its enrollees in all health plans offered by the Issuer (both inside and outside of the Exchange) to be members of a single risk pool encompassing either the individual market or small group market.
- The ACA allows health plans to be rated only on the basis of age, family composition, geography and tobacco-use. Federal regulations propose that the same rating factors be used in both the individual and small group markets, excepting rating factor tobacco use.
- *Tobacco Use.* Proposed federal regulations allow Issuers to vary rates based on tobacco use by up to 1.5:1.
- *Family Composition.* Proposed federal regulations require Issuers to add up the premium rate of each family member to arrive at a family rate. However, the rates of no more than the three oldest family members who are under age 21 would be used in computing the family premium.
- *Geography.* Proposed federal regulations allow a state to have a maximum of seven rating areas. The rating area factor is required to be actuarially justified for each area.
- *Age.* Proposed federal regulations require Issuers to use a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market. The federal government's proposed age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive, subject to the following:
  - Children: single age band covering children 0 to 20 years of age, where all premium rates are the same
  - Adults: one-year age bands starting at age 21 and ending at age 63
  - Older adults: a single age band covering individuals 64 years of age and older, where all premium rates are the same
  - Rates for adults age 21 and older may vary within a ratio of 3:1

### Connecticut QHP Requirements

- Rating factors and ratios will be the same for the individual and small group markets.
- *Tobacco Use.* Issuers are prohibited from using tobacco use as a rating factor in either their individual or small group products.
- *Geography.* Statewide coverage is not a prerequisite to certification, but a QHP will need to cover an entire rating area. Working in concert with the CID, the Exchange will standardize the geographic rating areas. The Exchange will allow Issuers to determine ratios between rating areas.

### Stand-Alone Dental Requirements

- At this time, HHS has not further defined specific information related to dental plan rating factors.

## H. Wellness Incentives

*This information will be QHP-specific and will need to be included for each QHP in the Issuer's submission.*

### ACA Requirements

- The ACA expands the Health Insurance Portability and Accountability Act of 1996 (HIPAA) wellness program exemption to allow employers to offer employees incentives of up to 30%, and could be expanded to 50% (with a federal waiver) of the cost of their coverage for meeting employer-defined health targets. "Participation only" programs do not have to meet additional requirements, but programs that are "standard-based" have to have certain requirements.

Examples of "participation-based" wellness programs:

- Incentives to participate in a health fair
- Waiver of co-payment/deductible for well-baby visits
- Reimbursement for gym membership
- Reimbursement for smoking cessation programs (regardless of outcome)

Examples of "standards-based" wellness programs:

- Providing a premium discount to employees who have an annual cholesterol test and achieve cholesterol levels below 200.
- Waiving the annual deductible for employees who have a body mass index (BMI) within a specified range.
- Imposing a surcharge on employees who don't provide an annual certification that they have not used tobacco products within the last 12 months.

### Connecticut QHP Requirements

- The Exchange encourages Issuers to offer both "participation-based" and "standard-based" wellness incentives to employers and their employees purchasing coverage in the SHOP Exchange.
- The Exchange will work with Issuers looking to offer both "participation-based" and "standard-based" wellness incentives for QHPs sold in the non-group market. (If there is Issuer interest, the Exchange will need to coordinate with Issuers to apply for a federal waiver)

### Stand-Alone Dental Requirements

- No wellness incentive information will be required for the dental application.
- An Issuer may offer enhanced dental benefits or a reduction in the costs thereof as part of their Wellness Incentive program.

## I. Number and Mix of QHPs

*This information will be Issuer and QHP-specific and refers to the entirety of the Issuer's submission.*

### ACA Requirements

- An Issuer must submit at least one (1) Silver plan and one (1) Gold plan to participate in an Exchange.
- For each metal tier for which an Issuer offers a QHP, the Issuer must provide a child-only option.
- Consistent with ACA, for each Silver plan, the Issuer must submit the three variations to the plan reflecting reduced cost sharing on the essential health benefits (see *45 CFR 156.420(a)*).
- Consistent with ACA, for each plan, the Issuer must submit a zero cost-sharing variation for Indians with incomes below 300% of FPL (see *45 CFR 156.420(b)*).

### Connecticut QHP Requirements

- To participate in either the Individual Exchange or SHOP Exchange, a QHP Issuer's application must include, at a minimum, the following mix of standard plans:
  - One (1) Standard Gold Plan
  - One (1) Standard Silver Plan
  - One (1) Standard Bronze Plan
  - \*The Exchange will define a cost sharing and benefit design for each standard plan.
  - *Individual Exchange Only.* A QHP Issuer's application must include:
    - Three (3) actuarial value alternatives for each Silver Plan to reflect federal cost sharing reduction subsidies for individuals under 250% of FPL.
    - One (1) zero cost-sharing alternative for each QHP, except Catastrophic Coverage, to reflect federal cost sharing reduction subsidies for American Indians under 300% of FPL. However, if the only difference between two or more QHPs is the plans' cost sharing parameters, then a zero cost-sharing alternative should only be included for the lowest cost option (i.e. Bronze) included in application.
    - One (1) child-only plan for each metal-tier for which a carrier submits a QHP
- In addition, a QHP Issuer is encouraged to submit the following mix of plans:
  - One (1) Standard Platinum Plan and/or one (1) Non-Standard Platinum Plan
  - One (1) Non-Standard Gold Plans
  - One (1) Non-Standard Silver Plan
  - One (1) Non-Standard Bronze Plan
  - \*Non-standard plans must exhibit a meaningful difference from the standard plans.
  - *Individual Exchange Only.* A QHP Issuer is encourage to submit:
    - One (1) Catastrophic Coverage Plan. These plans must have the same network as the standard plans. For any essential health benefit provided in-network, the enrollee's cost sharing must not exceed the Issuer's customary rate.
- Examples of meaningful plan design differences include:
  - Plan design has a different payment structure (co-payment versus co-insurance versus deductible versus high-deductible health plan (HDHP))

- Deductible and maximum out-of-pocket (OOP) differences:
  - Medical deductible difference of \$250 or more
  - Pharmacy deductible difference of \$100 or more
  - Maximum OOP difference greater than \$1000
- Changes in Cost Sharing for key service categories:
  - Inpatient/Outpatient Visit: at least 10% difference or if applicability of deductible is changed
  - PCP/Specialist Visit: at least \$10 or 10% difference or if applicability of deductible is changed
  - Generic Drugs: at least a \$5 average difference or if applicability of deductible is changed
  - Brand Drugs: at least a \$10 average difference or if applicability of deductible is changed
- Change from Coinsurance to Copay on Inpatient/Outpatient/PCP/Specialist Visits
- Plans have difference care management (e.g. gatekeeper model; patient centered medical home; community health teams; wellness programs)
- Plans reflect different product offering (e.g. HMO, POS, PPO, ACO)
- Plan design features payment reform (e.g. pay-for-performance, tiered networks, accountable care organization)

#### **Stand-Alone Dental Requirements**

- To participate in either the Individual Exchange or SHOP Exchange, an Issuer's application for stand-alone dental must include the following mix of standard plans:
  - One (1) Standard Low Plan
  - One (1) Standard High Plan
- An Issuer of a stand-alone dental plan must offer one (1) child-only dental plan for each tier

## J. Accreditation

*This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related Initial QHP application submissions.*

### ACA Requirements

- At a minimum, the Issuer must be accredited by an entity recognized by HHS, and provide the Exchange with a copy of its most recent accreditation survey. Accreditation must include:
  - local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS);
  - patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and;
  - consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.
- If not accredited, the Issuer must receive such accreditation within a period established by the Exchange for such accreditation that is applicable to all QHPs.

### Connecticut QHP Requirements

- The Exchange will accept all HHS accrediting entities, as long as they cover the basic ACA requirements. Accreditation must cover the Issuer's Connecticut operations.
- If the Issuer is NCQA accredited and basing the Exchange product off an already accredited plan, the Exchange will require the Issuer to complete the NCQA Exchange Add-On Survey
- Specific accreditation modules may be required by the Exchange (for later Solicitations); but the Issuer will be given sufficient time to meet new requirements.
- The Exchange will inform Issuers of additional accreditations modules recommended by the Exchange and believed to add valuable information to consumer's enrollment process.
- There will be a one-year grace period for compliance for plans that are not accredited at the time of application. For QHPs within the grace period, an attestation that the plan has applied for accreditation and an updated application status will be required. Because of the reliance CID will be placing on accreditation to assure adequacy of coverage offered by Issuer and QHPs, additional quality information may be required of Issuers in the grace period that have not yet obtained their accreditation.
- By January 1, 2016 a QHP Issuer's Exchange product must have full accreditation products and Issuer will need to submit performance data.

### Stand-Alone Dental Requirements

- This information will not be required for the stand-alone dental application.
- Additional quality information will be required of Issuers of stand-alone plans to assure adequacy of offered coverage.

## K. Reporting Requirements

*This information is either Issuer- or QHP-specific and need to be submitted as appropriate for the Initial QHP application submission.*

### ACA Requirements

- *Quality Improvement Strategies, Quality Reporting, and Enrollee Satisfaction.* Consistent with ACA the Issuer must disclose and report on the following information to the Exchange (see *45 CFR 156.200*):
  - Health care quality and outcomes measures
  - Implement and report on quality improvement strategy
  - Enrollee satisfaction surveys
- *Transparency and Performance Information.* Consistent with the ACA, the Issuer must provide the following information to the Exchange (see *45 CFR Part 156.220*):
  - Claims payment policies and practices;
  - Periodic financial disclosures;
  - Data on enrollment;
  - Data on disenrollment;
  - Data on the number of claims that are denied;
  - Data on rating practices;
  - Information on cost-sharing and payments with respect to any out-of-network coverage, and;
  - Information on enrollee rights under Title I of the Affordable Care Act.
- *Pharmacy Utilization.* Consistent with the ACA, the Issuer must provide to HHS information on its prescription drug distribution and costs (see *45 CFR 156.295*)

### Connecticut QHP Requirements

- Issuers will be required to report to the Exchange upon Connecticut-specific “quality information” to satisfy ACA quality reporting requirements.
- Issuers will be required to use the enrollee satisfaction survey system developed by the HHS and report results to the Exchange.
- For all data reporting requirements, the Issuers must use specific data formats, definitions, or frequency of reporting defined by HHS. If no federal standards are defined or if flexibility is left to the states to define the requirements, then the Exchange will work with the Issuers to define specific reporting requirements and standards.
- The performance information requirements of this section will be included in the attestation language of the application. The Exchange will monitor QHP reporting against this requirement.
- As part of their application for this Initial Solicitation, the Issuers will be require to provide the following to the Exchange:
  - CAPHS data for product most comparable to submitted QHP;
  - NCQA star rating in the five core areas (i.e. “Access and Service,” “Qualified Providers,” “Staying Healthy,” “Getting Better” and “Living with Illness”) for NCQA-accredited product most comparable to submitted QHP;
  - Medical Loss Ratio (“MLR”) for the most recent year and projected MLR for 2014, for non-group/small-group.

- *Quality Improvement Strategy.* 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.
- In its Application to the Exchange the Issuer will be required to attest to language similar to:
  - We certify and attest that we currently have in place, a quality improvement strategy consistent with the standards of section 1311(g) of the Affordable Care Act.*
  - We attest that we will disclose and report information on health care quality and outcomes as described in section 399JJ of the Public Health Service Act.*
  - We attest that we will report to HHS and the Exchange at least annually, the pediatric quality reporting measures described in section 1139A of the Social Security Act.*
  - We attest that confirm that we will conduct enrollee satisfaction surveys consistent with the requirements of section 1311(c) of the Affordable Care Act.*

**Stand-Alone Dental Requirements**

- Quality reporting will be required for the stand-alone dental application

## **L. Issuer and QHP Quality Rating**

*The rating will be QHP-specific. Some required information will be QHP-specific and will need to be provided in relationship to each QHP in the Issuer's submission. Other data will be Issuer-specific and only needed to be provided once.*

### **ACA Requirements**

- HHS will develop a rating system that would rate QHPs offered through an exchange in each benefits level on the basis of the relative quality and price (see *Section 1311(c)(3) of the ACA*).

### **Connecticut QHP Requirements**

- The Exchange will develop a quality rating and performance metric that will relate quality of health care to price per AV tier.
- The Exchange will use the quality and performance information requested in *Section J* and *Section K* of this Solicitation to implement and maintain a quality rating system developed by the Exchange.
- For the purpose of quality rating the Exchange may leverage additional Issuer and/or QHP-specific information already provided through this application.
- Reporting of quality data will be in a single form and format to be determined by HHS and/or the Exchange.

### **Stand-Alone Dental Requirements**

- Quality rating information will be required for the stand-alone dental application.

**M. Service Area**

*This information will be QHP-specific and will need to be included for each QHP in the Issuer's submission.*

**ACA Requirements**

- The Exchange must have a process to establish or evaluate the service areas of QHPs to determine whether the following minimum criteria are met:
  - The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.
  - The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

**Connecticut QHP Requirements**

- The Exchange may accept QHPs that provide less than statewide coverage.

**Stand-Alone Dental Requirements**

- Service area information will be included in the dental application.

## N. Network Adequacy and Provider Data

*This information may be Issuer or QHP-specific. If the provider network within the service area is consistent across all products and plans sold by the Issuer, the Issuer's provider data will need to be provided only once. If there is any variation in the provider networks across QHPs then the specific provider networks will need to be identified for each product and/or plan in the Issuer's response to this Solicitation.*

### ACA Requirements

- Consistent with section 2702(c) of the Public Health Service Act, Issuers must ensure a sufficient choice of providers
- Consistent with the ACA, Issuers must include a sufficient number and geographic distribution of Essential Community Providers ("ECP") that serve low-income and medically underserved individuals. This is not a requirement for any QHP to provide coverage for any specific medical procedure at an ECP, however.
- Issuers must provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.

### Connecticut QHP Requirements

- A QHP Issuer must ensure that the provider network of each of its QHPs meets these standards:
  - The network for each of its plans is URAC or NCQA accredited with respect to provider adequacy;
  - It includes essential community providers ("ECP") of a sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the service area;
  - The network is, and continues to be, 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;
  - The network is consistent with the network adequacy provisions of section 2702(c) of the PHSA; and,
  - 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 representing a similar product offered outside of the exchange.
- Reporting Requirements:
  - As required by HHS, provider network reporting requirements will be developed based on a standardized format to be developed in conjunction with the Issuers.
  - The Exchange will require each Issuer to provide the Exchange 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. All such standards shall be made readily available to the public and consumers on the Exchange
  - Issuers will be required to provide the Exchange with a list of all participating hospitals and non-hospital ECPs that is updated within 7 days of any change to the list. Issuers

with use a standard template developed by the Exchange in conjunction with the Issuers.

- Issuers will be required to provide the Exchange with a link to a publicly accessible website of the Issuer's current physician directory that is updated at least every 15 days.
- Issuers are encouraged to cooperate with the Exchange to develop a standardized template for an Issuer physician directory for the purpose of creating and maintaining a comprehensive physician directory for Connecticut. This directory will be to allow potential QHP enrollees to filter the QHP selection (directly in the Exchange portal) according to certain demographics of, and specialties practiced by, the providers and whether or not the providers are accepting new patients. If appropriate, the Exchange will coordinate its efforts with Connecticut's Health Information Exchange.
- *Essential Community Providers.* With respect to essential community providers, sufficiency shall be defined as carriers having contracts with:
  - At least 75% of the essential community providers located in any county in Connecticut; and,
  - At least 90% of the federally qualified health centers (FQHC) or "look-alike" health centers in Connecticut.Short of meeting such standards, Issuers will be allowed to evidence a good faith effort to contract with ECPs by, for example, providing contract terms accepted by comparable providers, and offered to, but rejected by, an ECP.
- The Exchange will define the essential community providers broadly to include:
  - Section 340B (of Public Health Services Act) and Section 1927 (of Social Security Act) hospital and non-hospital providers
  - Disproportionate Share Hospitals
  - Federally Designated Indian Health Services Facilities
  - Any provider that serves low income and underserved communities and meets the criteria set by the ACA
- *Monitoring of Network Adequacy.* The Exchange will actively monitor, through whatever means are most appropriate, an Issuer's provider networks to ensure it maintains a network adequacy standard equivalent to the standard agreed upon as a condition of certification.

### **Stand-Alone Dental Requirements**

- Provider network information will also be required for the stand-alone dental application.
- Stand-alone dental plans are not required to contract with any ECP but are encouraged to do so.

## **O. Attestations**

*This information may be Issuer or QHP-specific and will need to be included for in the carrier's application for this Solicitation.*

### **ACA Requirements**

- Consistent with ACA the Issuer must agree to comply with the minimum certification standards with respect to each QHP on an ongoing basis

### **Connecticut QHP Requirements**

- Attestations will be included in the application.
- The attestation language will cover the ACA requirements listed above, and will include specific attestations as outlined in the other sections of this Solicitation and required by the Exchange and/or CID.
- Attestations will cover Issuer's existing operations as well as any contractual commitments needed to meet Exchange requirements on an ongoing basis.

### **Stand-Alone Dental Requirements**

- Some of the same attestation language will apply to dental plans, but there may also be attestations that are unique to QHPs or stand-alone dental plans

**P. User Fees**

*This information will may be Issuer- or QHP-specific and will need to be included as appropriate for the Issuer's submission.*

**ACA Requirements**

- Issuer must pay any applicable user fees assessed by the Exchange.

**Connecticut QHP Requirements**

- Attestation language will be included in application that commits the Issuer to pay any applicable user fee in a form and manner to be determined.

**Stand-Alone Dental Requirements**

- Attestation language will be included in application that commits the Issuer of stand-alone dental plans to pay appropriate share of any applicable user fee in a form and manner to be determined.
- No fees associated with the risk adjustment and transitional reinsurance programs will apply to stand-alone dental plans

### **III. Appendices**

1. Notice of Intent to Submit Qualified Health Plans
2. Connecticut's Essential Health Benefits
3. Listing of Connecticut's Essential Community Providers
4. Standard Plan Designs
5. References: Federal statutory requirements, regulations, and guidance

### 1. Notice of Intent to Submit Qualified Health Plans

Please return this completed form by email followed by signed copy to the State of Connecticut Authorized Contact Person listed in Section 1.F: Authorized Exchange Contact Person, by no later than close of business on January 4, 2013.

I, \_\_\_\_\_, an authorized representative of \_\_\_\_\_, Issuer, have read the State of Connecticut Health Insurance Exchange solicitation for qualified health plans and stand-alone dental plans and have decided to submit an intention to apply for the initial certification.

The Issuer intends to submit applications for the following:

Product Type	Market Participation	
<input type="checkbox"/> Qualified Health Plan	<input type="checkbox"/> Individual Exchange	<input type="checkbox"/> SHOP Exchange
<b>Stand-Alone Dental</b>		
<input type="checkbox"/> Pediatric Only	<input type="checkbox"/> Individual Exchange	<input type="checkbox"/> SHOP Exchange
<input type="checkbox"/> Pediatric and Non-Pediatric		

The Issuer hereby agrees to be bound by and comply with all of the conditions, requirements and protocols set forth in the Solicitation instructions.

Agreed and Accepted by:

<b>Name</b>	
<b>Title</b>	
<b>Company</b>	
<b>Corporate Address</b>	
<b>Telephone</b>	
<b>E-Mail Address</b>	
<b>Date</b>	
<b>Signed</b>	

## 2. Connecticut's Essential Health Benefits

The State has selected a benchmark plan that is pending approval by HHS and will set the essential health benefits package for 2014 and 2015. All plans in the individual and small employer group markets both inside and outside of the exchange are required to provide at minimum coverage for the essential health benefits. A QHP's essential health benefits will form the basis for calculating the actuarial value of the QHP.

SERVICE	LIMIT
<b>Outpatient Services</b>	
PCP Office Visits (non-preventive)	
Specialist Office Visits	
Outpatient Surgery Physician/Surgical Services	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Home Health Care Services	100 visits/year
<b>Emergency Services</b>	
Emergency Room	
Emergency Transportation/Ambulance	per state mandate*
Walk-in/Urgent Care Centers	
<b>Hospitalization</b>	
Inpatient Hospital (Facility & Provider Services)	
Skilled Nursing/Rehabilitation Facility	90 days/year
Hospice	life expectancy of 6 months or less
Residential Treatment Facilities	
<b>Mental Health and Substance Use Disorder Services</b>	
Mental/Nervous and Substance Abuse Services	same as any other illness
<b>Rehabilitative and Habilitative Services and Devices</b>	
Outpatient Rehabilitation Services (PT/OT/ST)	40 visits (combined)/year
Cardiac Rehabilitation	
Chiropractic Visits	20 visits/year
Durable Medical Equipment	
Prosthetics	
Ostomy Appliances and Supplies	per state mandate*
Diabetic Equipment and Supplies	
Wound care supplies	per state mandate*
Disposable Medical Supplies	
Hearing Aids	for children under 12; 1/every 24 months
Surgically Implanted Hearing Devices	
Wigs	per state mandate*
Birth to Three	per state mandate*
<b>Prescription Drugs</b>	
<b>Laboratory and Imaging Services</b>	
Laboratory Services	
Non-advanced Radiology	
Advanced Imaging (includes MRI, PET, CAT, Nuclear Cardiology)	
<b>Preventive and Wellness Services and Chronic Disease</b>	
Adult Physical Exam	every 1-3 years for ages 22-49; 1/year for age 50+ as recommended by physician
Preventive Services	based on USPSTF A and B recommendation
Prenatal and Postnatal Care	
Infant/Pediatric Physical Exam	in accordance with national guidelines
Routine Immunizations	in accordance with national guidelines
Routine Gynecological Exam	1/year
Screening for Gestational Diabetes	for pregnant women between 24 and 28 weeks of gestation and at first prenatal visit for high risk of diabetes
Human Papillomavirus Testing	for women aged 30+; 1/every 3 years
Counseling for Sexually Transmitted Infections	for women 1/year
Counseling and Screening for HIV	for women 1/year

Note:

\*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

SERVICE	LIMIT
Contraceptive Methods and Counseling	for women
Breastfeeding Support, Supplies and Counseling	for women
Screening and Counseling for Interpersonal and Domestic Violence	for women 1/year
Preventive Lab Services	complete blood count & urinalysis, 1/year
Baseline Routine Mammography	1 between ages 35-39 ; 1/year for age 40+
Routine Cancer Screenings	in accordance with national guidelines
Blood Lead Screening and Risk Assessment	per state mandate*
Bone Sensity	1/every 23 months
Pediatric Hearing Screening	under age 19 as part of physical
<b>Other Services</b>	
Craniofacial Disorders	per state mandate*
Oral Surgery for Treatment of Tumors, Cysts, Injuries, Treatments of Fractures Including TMJ and TMD	TMJ for demonstrable joint disease only
Dental Anesthesia	per state mandate*
Reconstructive Surgery	to correct serious disfigurement or deformity resulting from illness or injury, surgical removal of tumor, or treatment of leukemia; for correction of congenital anomaly restoring physical or mechanical function
<b>Maternity Coverage</b>	
Mastectomy	per state mandate*
Breast Reconstructive Surgery after Mastectomy Including on Non-diseased Breast to Produce a Symmetrical Appearance	per state mandate*
Breast prosthetics	per state mandate*
Breast Implant Removal	per state mandate*
Autism Coverage	per state mandate*
Clinical Trials	per state mandate*
<b>Solid Organ and Bone Marrow Transplants</b>	
Medically Necessary Donor Expenses and Tests	
Transportation, Lodging and Meal Expense for Transplants	up to \$10,000 per episode (initial evaluation until sooner of discharge or cleared to return home)
Lyme Disease Treatment	per state mandate*
Allergy Testing	up to \$315 every 2 years
Diabetes Education	per state mandate*
<b>Sterilization</b>	
<b>Casts and Dressings</b>	
<b>Renal Dialysis</b>	
Sleep Studies	1 complete study/lifetime
Pain Management	per state mandate*
Neuropsychological Testing	per state mandate*
Accidental Ingestion of a Controlled Drug	per state mandate*
Diseases and Abnormalities of the Eye	annual retina exams for members with glaucoma or diabetic retinopathy
Corneal Pachymetry	1 complete test/lifetime
Infertility	per state mandate*
Genetic Testing	for members who have or are suspected of having a clinical genetic disorder
Specialized Formula	per state mandate*
Nutritional Counseling	2 visits/year
Enteral or Intravenous Nutritional Therapy	
Modified Food Products for Inherited Metabolic Disease	per state mandate*
<b>Pediatric Vision Care</b>	
Routine Eye Exam	1 exam/year
Lenses	1 pair/year
Frames	1 frame/year
Contact lenses	1 fitting and set of lenses/year
<b>Pediatric Oral Care</b>	
Exams	1 every 6 months
Bitewings	1 time/year
Other X-rays	

Note:

\*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

SERVICE	LIMIT
Sealants	on premolar and molar teeth
Fluoride treatments including topical therapeutic fluoride varnish application	for clients with moderate to high risk of dental decay
Access for Baby Care Early Dental Examination and Fluoride Varnish where an oral health screen, oral health education and fluoride varnish are applied to children's teeth during well child examinations	up to 4 years of age
Medically Necessary Orthodontia (under age of 19)	
Replacement Retainer	limited to 1 replacement/lifetime
Amalgam and Composite Restorations (Fillings)	
Fixed Prosthodontics: Crowns, Inlays and Onlays	
Re-cementing Bridges, Crowns Inlays & Space Maintainers	
Removable Prosthodontics: Full or Partial Dentures	
Repair, Relining and Rebasement Dentures	
Intermediate Endodontic Services	
Major Endodontic Services:	
Root Canal Treatment, Retreatment of root canal therapy; apicoectomy; apexification	
Oral Surgery: Surgical Extraction, including Impacted Teeth	
Non-surgical Extraction	
Periodontal Surgery and Services	
Space Maintainers	
General Anesthesia and Sedation	
Miscellaneous Adjunctive Procedures	

Note:

\*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

### 3. Listing of Connecticut Essential Community Providers

The Exchange will define a list of Essential Community Providers by county and publish it on Exchange website (<http://www.ct.gov/hix/>).

For purposes of this Solicitation, the **ECPs** in Connecticut include at a minimum the following:

1. **340B Essential Community Providers:**

Non-hospital and hospital entities located in Connecticut and included in HRSA's 340B non-hospital and hospital entities list are 340B Essential Community Providers for purposes of this solicitation.

To generate a statewide listing of 340B providers in the form of a worksheet go to: <http://opanet.hrsa.gov/OPA/CESearch.aspx>.

Under **Entity Type**: select "All"

Under **340B Number**: leave blank

Under **Entity Name**: leave blank

Under **Entity City**: leave blank

Under **State**: select "Connecticut"

Under **Zip and Grant/Provider Number**: leave blank

Under **Participating**: select "Yes"

For the purposes of this solicitation, 340B entities that do not appear in this list as of December 31, 2012, are not considered Essential Community Providers.

2. **Disproportionate Share Hospitals**

3. **Federally-designated Indian Health Service facilities**

#### **4. Standard Plan Designs**

The Exchange will define a standard Bronze, Silver, Gold and Platinum plan based on popular small group products and in consultation with the Issuers.

The Exchange will define cost sharing reductions for the standardized plan designs, defining the reduced out-of-pocket maximum and higher actuarial value for each of the federal subsidization levels.

These standard plan designs will be made available on the Exchange website (<http://www.ct.gov/hix/>).

## 5. References: Federal Statutory Requirements, Regulations, and Guidance

The ACA requires the Exchange to establish procedures for the certification of QHPs (ACA § 311(d)(4)(A)). In determining whether a health plan should be certified as a QHP, the Exchange is required and permitted to consider certain criteria regarding the Issuer and regarding the health plan. In general, the Issuer must provide evidence that it complies with the minimum certification requirements, and the Exchange must make a determination that the issuer is acting in accordance with the ACA and Exchange standards and that making the health plan available is in the interest of qualified individuals and qualified employers (45 CFR §155.1000(c)(2)).

The Exchange will maintain a reference for all statutory requirements and all current federal regulations—final and proposed—on the Exchange website (<http://www.ct.gov/hix/>).

Solicitation Section	Requirement Category	Federal Requirement	Reference
C	Licensing	<i>State Licensure</i>	45 CFR §156.200(b)(4)
D	QHP Certification Process	<i>Timing of QHP Certification</i>	45 CFR §155.1010(a)
		<i>Frequency of QHP Certification</i>	45 CFR §155.1075
	Continued Compliance with Criteria	<i>Exchange monitoring of QHP for compliance</i>	45 CFR §155.1010(d)
F	Actuarial Value	<i>Actuarial Value Standards</i>	Federal guidance not yet final
	Abortion Services	<i>Compliance with State Abortion Laws</i>	45 CFR §156.280(a)
		<i>Abortion Funds Segregation</i>	45 CFR §156.280
		<i>Rate Plan Year</i>	45 CFR §156.210(a)
	Premium Rate and Benefit Information	<i>Rate submission</i>	45 CFR §156.210 (b)
		<i>Rate Increase Justification</i>	45 CFR §156.210(c), 45 CFR §155.1020(a)
		<i>Rate Increase Consideration</i>	45 CFR §155.1020 (b)
		<i>Benefit and Rate Information</i>	45 CFR §155.1020(c)
	Plan Benefits	<i>Minimum Coverage</i>	45 CFR §156.200(b)(3)
		State-Specific Essential Health Benefits	Federal guidance proposed
Stand-Alone Dental		§9832(c)(2)(A) of the Internal Revenue Code, §2791(c)(2)(A) of the Public Health Service Act, 42 U.S.C. 18031(d).	
G	Rating variations	<i>Product Pricing</i>	45 CFR §156.255(b)
		<i>Allowable Variability</i>	45 CFR §156.255(a)
I	Plan Offering Requirements	<i>Actuarial Value Tiers</i>	45 CFR §156.200(c)(1)
		<i>Child-only plan.</i>	45 CFR §156.200(c)(2)
J	Accreditation	<i>General requirement</i>	45 CFR §156.275(a)
		<i>Timeframe for Accreditation:</i>	45 CFR §156.275(b)
K	Health care quality requirements	<i>Quality Improvement Initiative</i>	45 CFR §156.200(b)(5), Section 1311(g) of the ACA
		<i>Quality and Outcomes Reporting</i>	45 CFR §156.200(b)(5), Section 1311(c)(1)(l) of the ACA

Solicitation Section	Requirement Category	Federal Requirement	Reference
		<i>Enrollee Satisfaction Surveys</i>	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
	Transparency in Coverage	<i>Required Information Related to Coverage Transparency</i>	45 CFR §156.220(a)
		<i>Reporting Requirement</i>	45 CFR §156.220(b), 45 CFR §156.220(c)
		<i>Enrollee Cost Sharing</i>	45 CFR §156.220(d)
M	Service Area	<i>Minimum Service Area</i>	45 CFR §155.1050(a)
		<i>Non-Discriminatory Service Area</i>	45 CFR §155.1050(b)
N	Network Adequacy	<i>Network Adequacy Standards</i>	45 CFR §156.230
		<i>Provider Directory</i>	45 CFR §156.230(b)
		<i>Essential Community Providers</i>	45 CFR §156.235
P	User Fees	<i>Issuer Payment of Fees</i>	45 CFR §156.200(b)(6)
Other	Marketing	<i>Marketing Rule Compliance</i>	45 CFR §156.225(a)
		<i>Non-discrimination</i>	45 CFR §156.225(b)
	Enrollment Processes and Periods	<i>Enrollment Periods and Processes</i>	45 CFR §156.260, §156.265 (small employer: 45 CFR §155.725)
		<i>Termination</i>	45 CFR §156.270
	Risk Adjustment	<i>Participation in Risk Adjustment Programs</i>	45 CFR §156.200(b)(7)
	Non-discrimination	<i>Non-Discrimination</i>	45 CFR §156.200(e)
	Cost Sharing Reduction	<i>Cost Sharing Reductions</i>	§1402(a)-(d) of the ACA