access health CT

Connecticut's Health Insurance Marketplace

Connecticut Health Insurance Exchange
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Access Health CT:

Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace

Release Date: March 17, 2014

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I. General Information and Background

The Connecticut Health Insurance Exchange (Exchange) d.b.a Access Health CT (AHCT) is soliciting applications from health insurance issuers ("Issuers") to market and sell Qualified Health Plans ("QHPs") through the AHCT Marketplaces (Small Business and individual) beginning on November 15, 2014 with active coverage beginning on January 1, 2015 for all plans entered into by December 15, 2014. The Solicitation defines the requirements an Issuer must comply with to participate in the Individual Marketplace and/or the Small Business Health Options Program (SHOP) Marketplace.

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 authority to the Exchange with respect to administering and managing exchange activity of the plans, certification of QHPs, compliance with federal and state laws and regulations that relate to exchange activities and well as this Solicitation and any related documents.

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

Issuers participating in the Individual Marketplace must agree to offer QHPs to any eligible consumer seeking to purchase such coverage for a term of up to twelve (12) months during the open enrollment period. The open enrollment period for the2015 plan year is proposed to begin on November 15, 2014 and end on February 15, 2015. The Issuer will also agree to offer its QHPs during special enrollment periods to eligible enrollees, and their currently enrolled eligible co-beneficiaries where applicable, who may experience a valid change in circumstances as defined in 45 C.F.R. §155.420.

Issuers participating in the SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage (45 C.F.R. §155.725(b).) Issuers offering QHPs through SHOP must also charge the same contract rate for each month of the applicable small businesses' s policy year in accordance with 45 C.F.R. § 156.285(3).

Only health plans certified as a QHP by AHCT for the plan year in question can be sold through the AHCT Marketplace. AHCT offers Issuers a state-wide Marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance.

AHCT is the only distributional channel in Connecticut through which individuals and small employers will be able to purchase coverage that may be eligible for certain affordability subsidies, including:

- Premium tax credits and/or reduced cost-sharing for Individuals and families purchasing health insurance through the individual Marketplace whose household income is between 133 percent and 400 percent of the Federal poverty level;

- An Alaska Native/American Indian (as defined in 45 CFR § 155.300) plan and a limited cost sharing plan variant for each plan offered by a QHP in accordance with 45 CFR § 155.350; and
- Affordability tax credits available to eligible employers offering coverage in the small group market.

To be certified as a QHP, an Issuer and its health plans must meet all federal and state statutory requirements, as well as the standards set by AHCT. AHCT is responsible for certifying health plans and ensuring that plans remain compliant with AHCT's QHP certification requirements.

The QHP certification process and requirements for the 2015 benefit year maintain many aspects of the process and requirements carried out for 2014, including close coordination and collaboration with the Connecticut Insurance Department ("CID"). This Solicitation reflects the criteria approved by the Board for the previous benefit year and subject to the reasonable considerations of AHCT with regard to what it deems are in the best interest of individuals and employers with a principal place of business or principal residence in the State of Connecticut.

In setting the criteria outlined in this Solicitation that AHCT will use to certify health plans as "qualified," AHCT 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.

Through this Solicitation AHCT looks specifically to the Issuers to be a cooperative partner with AHCT in reaching our common goal of providing quality health care coverage to Connecticut residents.

A. Regulatory Filings

In accordance with Connecticut state law, all fully insured products, except for small group indemnity, must have forms and rates approved by the CID in advance of an Issuer presenting the product to the market for sale.

Any determinations by AHCT to certify a health plan as "qualified" will be conditional upon the CID approving rate and form filings with respect to those plans to be offered on the exchange. A carrier will not be prevented from obtaining a QHP status due to filing issues alone as long as all of their AHCT standard plan offerings are approved by CID and are not otherwise in issue by AHCT or any other regulatory body.

AHCT will require carriers offering QHPs through the AHCT Marketplace to use AHCT's template for the Schedule of Benefits form filings (Appendix 1 and 1(a).)

Concurrent to the CID's approval process, Issuers will be required to submit their QHP applications in accordance with this Solicitation to AHCT.

B. Segregation of Funds for Abortion Services

In accordance with 45 C.F.R. §156.280, an Issuer offering coverage for the non-excepted abortion services should, as a condition of participating in the AHCT Marketplace, submit a plan to the State Insurance Commissioner that details its process and methodology for complying with the segregation of funds requirements. For additional information, please refer to the CID Bulletin No. FS-27.

C. Solicitation Process and Timetable

The following schedule represents pertinent dates necessary for Issuer and QHP certification. Please note that the due dates are subject to change. Any subsequent updates will be communicated, within a reasonable time, directly to the individual identified in the Issuer Notice of Intent and posted on the AHCT website at www.ct.gov/hix .

Key Deliverables/Milestones	**Target Dates** *(dates are subject to change)*
Proposed HHS Notice of Benefit and Payment Parameters and AV Calculator Released by CMS	November 25, 2013
Assess Proposed Regulations/Run Draft Model AV Calculator	February 1 – February 28, 2014
Develop Proposed Standard Plan Designs/Review with Health Plan Benefits and Qualifications and Consumer Experience and Outreach Advisory Committees	February 1 – March 24, 2014
Template to be used by Issuers for Schedule of Benefits (SOB) (standard and non-standard plans) Released	February 24, 2014
Final AV Calculator Released	March 5, 2014
CID Bulletin Release	March 10, 2014
HHS Notice of Benefit and Payment Parameters for 2015 – Posted to the Federal Register	March 11, 2014
Release Issuer Solicitation and Notice of Intent (for New Entrants & Existing Issuers Expanding into a New Market)	March 17, 2014
Present Draft Standard Plan Designs and Actuarial Value (AV) of EHB Components at the Board of Directors (BOD) Meeting for Approval	March 27, 2014
Refine Draft 2015 Standard Plan Designs	March 28 – April, 6, 2014
Issuer Non-Binding Notice of Intent is due to AHCT	March 31, 2014
Publish 2015 Standard Plan Designs	April 7, 2014
Publish 2015 QHP Issuer Application (for New and Existing Issuers)	April 23, 2014
QHP Issuers Prepare Federal QHP Data Templates	May 1 – May 30, 2014
In person meetings w/ AHCT& each Issuer's SME to Address/Resolve Federal QHP Data Template Questions & Concerns	May 1 – May 30, 2014
Inquiries from Issuers on QHP Application Due to AHCT	May 7, 2014
Responses to Issuer Questions Due from AHCT	May 21, 2014
QHP Applications due to AHCT	May 30, 2014
Form Filings Due to Connecticut Insurance Department (CID): Evidence of Coverage (EOC), Schedule of Benefits (SB), Rates	May 31, 2014
AHCT Review of Federal QHP Issuer Data Template Submissions	June 3 – August 15, 2014
In person meetings w/ AHCT, CID & each Issuer's SME to resolve Federal Data Template Entries and Ensure All Source Materials Align.	June 3 – August 15, 2014

Key Deliverables/Milestones	Target Dates *(dates are subject to change)*
CID Approvals Due for Issuer Submitted Rate & Form filings	August 30, 2014
Certification of QHP Issuer Plan Submissions	July 30 – September 12, 2014
Upload QHP Plan Data into AHCT Plan Management System	September 15, 2014
AHCT/Issuer Preview	September 16 – October 9, 2014
Refine/Approve Pre-Published QHP Plan Data	October 15 - November 1, 2014
Certified Plan Data Made Available to CMS	October 15, 2014
AHCT QHP Plan Data (uploaded) Published in Consumer Worker Portal	November 14, 2014
Plan Year 2015 Open Enrollment Period	November – February 15, 2015

D. Non-Binding Notice of Intent (Pre-Requisite)

Following the release of Solicitation to Health Plan Issuers for Participation in the Individual Marketplace and/or Small Business Health Options Program (SHOP), potential Issuers must submit the **Non-Binding Notice of Intent (NOI) to Submit Qualified Health Plans** no later than 5:00 p.m. on March 31, 2014. An Issuer cannot apply without first submitting the NOI, unless exceedingly important, good faith circumstances exist and only as pre-approved by Access Health CT. Only those Issuers acknowledging interest in this Solicitation by submitting the NOI will continue to receive Solicitation related correspondence from AHCT.

Submission Instructions and Deadlines for Notice of Intent:

1. Please complete the form titled "**Non-Binding Notice of Intent to Submit Qualified Health Plan (NOI)"** included in the Exhibit 1 of the Solicitation.
2. Issuers should submit this form via email to the AHCT's contact person identified in Section E no later than 5PM on March 31, 2014.
3. Please make sure the email subject line reads: "Non-Binding Notice of Intent to Submit Qualified Health Plans (NOI)."
4. The Issuer will receive a response confirming the submission.

E. Authorized AHCT Contact for Solicitation

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

Name: Michele Barnett

E-Mail: CTHIX-Issuers@ct.gov

Mailing Address:

Connecticut Health
Insurance Exchange dba
Access Health CT

280 Trumbull Street
Hartford, CT 06103

Phone: 860-757-6802

All questions to, and requests for information from AHCT concerning this Solicitation by a Prospective Responder or a Responder, or a representative or agent of a Prospective Responder or Responder, should be directed to the Authorized Contact Person. Please include "Access Health CT QHP Solicitation" in all correspondence.

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

F. Eligibility and Enrollment

a. Individual Marketplace

AHCT is responsible for the enrollment of individuals and families as well as eligibility determinations. In addition, all eligibility changes need to be made through AHCT. Any change in an individual or family eligibility will result in re-determination of the eligibility which needs to be conducted through AHCT.

Primary verifications through the Federal Data Services Hub (FDSH) will capture changes not reported by the individual.

Please refer to the US Code of Federal Regulations for eligibility requirements. All eligibility determinations, re-determinations and changes will be made in accord with federal and state law and in accord with the terms of the Issuer Agreement and any related transactions between the Issuer and AHCT. AHCT will distribute an 834 Companion Guide to all participating Issuers, which will include the specifics with regard to transactions and the coding of transactions.

b. SHOP Marketplace

Currently, AHCT's SHOP vendor assists small employer groups, and the employees of those groups, with QHP selection and enrollment assistance. In addition, the SHOP vendor interacts with the licensed brokers and navigators to provide assistance to small employer groups in evaluating and obtaining coverage options.

AHCT's SHOP vendor transfers data electronically between the SHOP vendor and third parties (i.e., AHCT, Issuers). The SHOP vendor issues a single premium invoice to the small employer group for the total premium dollars due. The small employer group sends the premiums due (both employee and employer contributions) to the SHOP vendor. The SHOP vendor processes the small employer group payments by disbursing the applicable amount to the appropriate Issuers. The SHOP vendor is also is responsible for sending aggregated broker commission payments to the individual brokers for enrolled members.

G. Qualifying Events and Special Enrollment

AHCT allows special enrollment periods for triggering events identified in 45 C.F.R. §155.420(d) for the Individual Market and 45 C.F.R. §155.725(j) for the SHOP.

Additionally, pursuant to Conn. Gen. Stat. Ann. § 38a-564, special enrollment in the SHOP is available when a court has ordered coverage be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within thirty days after issuance of such court order.
All special enrollment periods begin as of the date of the event triggering the new eligibility period, not as of the date reported to AHCT. It is from this triggering event date that the 30 day (SHOP) or 60 day (Individual and SHOP) special enrollment period will run.

H. Grace Periods

a. Individual Marketplace

i. Enrollees Receiving Advance Premium Tax Credit

Issuers offering QHPs in Individual Marketplace must adhere to the requirements contained in 45 C.F.R. §156.270 in determining grace period and termination procedures due to non-payment of the premium for enrollees receiving Advanced Premium Tax Credit (APTC). The current such grace period is as follows: 1) during the first month where premium is in arrears, coverage shall remain as if the account was not in arrears, 2) during the second and third months, the carrier may pend payments on claims they receive but may not limit the access to coverage. Issuers may notify a requesting provider of the status of the account, 3) the total grace period is 90 days. The account may be cancelled at the culmination of this grace period.

ii. Enrollees Not Receiving Advance Premium Tax Credit

Issuers offering QHPs in the Individual Marketplace must adhere to C.G.S.A. § 38a-483 and provide grace period for premium payment of no less than ten days to enrollees not receiving APTC. Carriers may mutually elect to extend such period; however, the grace period must be consistent among all participating carriers for policies written for exchange enrollees. Currently, the three carriers participating in the 2014 plan year have agreed to and are offering a grace period for 2014 whereby the carrier may not pend or suspend coverage during any point of the month that the beneficiary is in arrears. The account may be cancelled at the culmination of that one month grace period.

b. SHOP Marketplace

AHCT has established a 30 day grace for employer groups that do not pay on time. To account for months without 30 days, the grace period extends to the end of the month.

I. OPM Certification of Multi-State Plans

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan Program (MSPP) as required under section 1334 of the Affordable Care Act. In accordance with section 1334(d) of the Affordable Care Act, Multi-State Plans (MSPs) offered by MSPP issuers under contract with OPM are deemed to be certified by AHCT.

AHCT requires MSPP Issuers to comply with all of the standards and requirements set forth in AHCT's QHP Issuer Application for Participation and all applicable Federal and Connecticut State laws that may apply to either health insurance, in total, or exchanges. Additionally, Issuers offering MSPs on the AHCT's Marketplace must be distinguished from any other Issuer participating on the AHCT Marketplace by both, Issuer HIOS ID number and plan marketing names. A MSPP must adhere to the requirements of this solicitation and any other exchange policy or procedure where such is not in direct conflict with section 1334 of the ACA. In addition, an MSPP may not utilize any unused plan options that another participating carrier has elected not to use.

J. Amendments to Solicitation

AHCT reserves the right to amend this Solicitation. AHCT will post any amendments on its website (www.ct.gov/hix).

II. Application Components and Certification Requirements

This section outlines the various components that AHCT will require in the Issuer application for this Solicitation. The QHP 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 in the Non-Binding Notice of Intent.

The QHP application is intended to cover the Issuer's participation in the Individual Marketplace and/or SHOP.

The QHP Application will collect both Issuer-level information and plan-level benefit and rate data, largely through standardized Federal data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 C.F.R. parts 155 and 156, and AHCT requirements and provide requested supporting documentation. Based on the requirement set forth in 45 C.F.R. 156.340 that QHP Issuers maintain responsibility for the compliance of their delegated and downstream entities, these attestations will also reflect that vendors and contractors of the Issuer will adhere to applicable requirements.

Issuers must also submit the Unified Rate Review Template (URRT) to the CID and AHCT.

A. Issuer General Information

The QHP Application will request the name and address of the legal entity that has obtained the Certificate of Authority to offer health insurance policies in the State of Connecticut. This information must match the information on file with the CID. Issuers will be required to provide AHCT with the following information:

- Company information;
- Primary contact for each Marketplace the Issuer applies to participate in;
- Market coverage (Individual, SHOP, or both);
- List of vendors directly involved in service delivery.

Additionally, as part of QHP Application, issuers will be required to complete the Administrative Data template which contains further detail related to company information.

B. QHP Issuer Compliance and Performance Oversight

AHCT will request Issuers to submit a compliance plan as part of the QHP Application. The compliance plan is intended to document the Issuer's efforts to ensure that appropriate policies and processes are in place to maintain adherence with Federal and State law as well as to prevent fraud, waste and abuse. AHCT expects an Issuer's compliance program to include the following elements:

- Designation of a compliance officer and compliance committee

- Written policies and procedures and documentation of proven adherence
- Effective communication among all levels of the company ensuring a shared responsibility to compliance
- A record retention policy, not less than 10 years for any information related to CSR or APTC
- Compliance education and an effective training program
- Compliance metrics as part of an employee performance appraisal process and compliance standards enforced through well-publicized disciplinary guidelines
- An internal audit process and the monitoring of such
- Corrective action plan initiatives to monitor and respond to detected offenses
- A statement of corporate philosophy and codes of conduct

Further, the Issuer will provide attestation language as follows or similar to:

- Applicant attests that its compliance plan adheres to all applicable laws, regulations, and guidance and that the compliance plan is implemented or ready to be implemented.

AHCT also intends to monitor and evaluate Issuers' performance using information received directly by AHCT as well as from other sources, including the CID, Office of Healthcare Advocate, consumers and providers. AHCT will utilize complaint data, Issuer self-reported problems, information related to consumer service and satisfaction, health care quality and outcomes, QHP Issuer operations, and network adequacy in its assessment of Issuers' performance in the Marketplace.

AHCT expects Issuers to thoroughly investigate and resolve consumer complaints received directly from members or forwarded to the Issuer by AHCT or any other individual or organization through the Issuer's internal customer service process and as required by state law. As part of compliance and performance monitoring, AHCT intends to require the Issuers to provide complaints reports at a frequency established by AHCT.

C. Licensure and Financial Condition

Consistent with 45 C.F.R. §156.200(b)(4), AHCT requires participating Issuers to be licensed by the CID as well as have a designation of good standing. The licensing and monitoring functions are the responsibility of the CID. The following are some examples of a designation of good standing:

- the CID has not restricted an Applicant's ability to underwrite new health plans
- the issuer is not in hazardous financial condition
- the issuer is not under administrative supervision
- the issuer is not in receivership

AHCT will require Issuers to submit a State Certification Form. The Form will be provided to Issuers at a later date. The form must further include a certification from the CID that the Issuer is licensed and is in good standing in Connecticut, including meeting State solvency requirements. Issuers applying for QHP certification must be able to demonstrate State licensure by the date determined by AHCT.

D. Market Participation

- An Issuer may elect to participate in either the Individual Marketplace or the Small Business Health Options Program (SHOP), or both.
- Any Issuer meeting AHCT's certification standards will be granted a one-year certification for its QHPs.
- If a certified QHP Issuer ceases participation in AHCT's Marketplace, the Issuer may be denied re-entry until the next general solicitation which will take place in 2015 for the 2016 plan year.
- If participating in the SHOP, the Issuer must agree to fully participate in each of the AHCT's purchasing options. The four options are vertical choice, horizontal choice, a single plan option, or an employee choice model. Each choice model has been defined below:
    - **Vertical Choice**: Allows an eligible employer to offer their eligible employees plan options from all available "metal tiers" from any one selected Issuer (i.e. any Issuer A plan in any tier)
    - **Horizontal Choice**: Allows an eligible employer to offer their eligible employees plan options from all of participating Issuers, across any one selected "metal tier" (i.e. any silver plan from any of the Issuers)
    - **Single Choice**: Allows an eligible employer to offer their eligible employees one plan design in any one metal tier from any one issuer for group offering. Employees must choose this exact plan design and will not have access to any other plan offerings.
    - **Employee choice**: Allows an eligible employer to offer their eligible employees plan options from all of participating Issuers, across all "metal tier" (i.e. any plan offered on the SHOP marketplace regardless of carrier or metal level)

E. Marketing Guidelines

AHCT does not currently allow co-branding. Specifically, participating Issuers are not allowed to use AHCT's name or logo in any of their marketing materials.

AHCT requires participating Issuers to provide AHCT with an opportunity to review and provide feedback on any marketing materials specific to QHPs offered on the AHCT's Marketplace. Issuers must allow up to five business days for AHCT's review and approval.

AHCT requires the Issuers' Plan Marketing Names to be consumer friendly; specifically, AHCT prohibits inclusion of an Issuer's internal coding in the Plan Marketing Names. Issuers will be allowed to include commonly used abbreviations such as "PPO", "HMO", "POS" or "HSA" in the Plan Marketing Names. AHCT's current limit on the Plan Marketing Names is set at 75 characters.

F. Consumer Information

a. Enrollee Materials

Issuers will be required to submit to AHCT in English and Spanish:
• Evidence of Coverage (EOC): the document(s) for each QHP product the Issuer intends to offer on the Exchange for sale (PPO, HMO, POS); and,
• Schedule of Benefits (SOB): the documents for each unique offering that depicts the cost-sharing for each metal tier.

The EOC and SOB should be combined in a portable document format (PDF) and submitted through the System for Electronic Rate and Form Filing ("SERFF") Plan Management System. The SOB should appear first in the combined PDF. The reason for this requested formatted approach is to enhance the consumer shopping experience permitting the consumer to more easily review the cost sharing and contract by company and plan design.
SOB and EOC must be approved by the CID prior to Issuers' submission to AHCT.

• Summary of Benefits and Coverage (SBC): provide the SBC for each plan design and plan variation including each of the coverage examples defined by HHS for each QHP offered through the AHCT Marketplace. AHCT expects to access this information via a link or URL from the Issuer through the Plan and Benefits Template.

b. Company Logo

Issuers will be required to provide an electronic image of the Issuer's logo in order to differentiate the Issuer's products for display on the AHCT Marketplace shopping screens.

c. Provider Directory

Pursuant to 45 C.F.R. 156.230(b), AHCT will require Issuers to make their provider directories available to AHCT for publication online by providing the URL link to their network directory in the Network Template.

AHCT expects the URL link to direct consumers to an up-to-date provider directory where the consumer can view the provider network that is specific to a given QHP. If a provider incorrectly refuses to see a patient under the misunderstanding that they are not honoring or in-network for such coverage and where such provider is listed on the carriers participating provider list, the Issuer shall ensure that the patient will receive specific performance (at in-network costs) on that visit with that provider.

The URL provided to AHCT as part of the QHP Application should link directly to the directory, such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer's website before locating the directory. If an issuer has multiple provider directories, it should be clear to consumers which directory applies to which QHP(s). AHCT will not certify any QHPs unless the URL is direct to the provider directory search engine for the specific QHP.

Further, AHCT expects the directory to include location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. AHCT will require Issuers to include an option for consumers to search the directories by filtering those providers that are accepting new patients versus those that are not. Additionally, the provider directory should include an indicator for each provider that clearly states whether the provider is accepting new patients or not. Such information must be kept up-to-date.

AHCT encourages Issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider. Directory information for Indian health providers should describe the service population served by each provider, as some Indian health providers may limit services to Indian beneficiaries, while others may choose to serve the general public.

AHCT requires Issuers to submit in-network provider directories for each QHP in a searchable PDF or excel format. Additionally, Issuers will be required to provide updates to AHCT electronically no less often than quarterly.

d. Prescription Drug Formulary

As part of the QHP Application, issuers must provide a URL to their formularies and must also provide information regarding formularies to consumers, pursuant to 45 C.F.R. 147.200(a)(2)(i)(K). AHCT expects the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering and cost sharing, that are specific to a given QHP. The URL provided AHCT as part of the QHP Application should link directly to the formulary, such that consumers do not have to log on, enter a policy number or otherwise navigate the issuer's website before locating it. If an issuer has multiple formularies, it should be clear to consumers which directory applies to which QHP(s).

AHCT requires Issuers to submit drug formularies for each QHP electronically. Additionally, Issuers are required to provide updates to AHCT no less often than quarterly.

G. QHP 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. AHCT will request a URL to the Issuer's web site where the rate increase justification has been posted. To ensure consumer transparency, AHCT will provide access to such justification on the Marketplace website.
- 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.

All QHPs offered through AHCT's Marketplace must include, at a minimum, the Connecticut specific EHBs. No substitution of actuarially equivalent benefits will be allowed. Please refer to Appendix 2.

Issuers must not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs (see 45 C.F.R. 156.225). To ensure non-discrimination in QHP benefit design, AHCT will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) for Issuer's plans as part of the QHP certification application process. QHPs identified as outliers may be given the opportunity to modify cost sharing for certain benefits if AHCT determines that the cost sharing structure of the plan that was submitted for certification could have the effect of discouraging the enrollment of individuals with significant health needs.

Regulations at 45 C.F.R. 156.420 generally require QHP Issuers to submit three plan variations for each silver level QHP an issuer offers through the Marketplace, as well as zero and limited cost-sharing plan variations for all QHPs, except catastrophic plans, an Issuer offers through the Marketplace.

AHCT's Standard Plans are not "gatekeeper" plans as they were designed to provide enrollees with direct access to specialists. Accordingly, AHCT will not allow Issuers to require a Primary Care Provider (PCP) referral in order for a member to be able to access specialists when the member is enrolled in the Issuer's Standard Plan. Should an Issuer impose the "gatekeeper" requirement in its non-Standard Plans, such requirement must be described explicitly in the Issuer's Evidence of Coverage. AHCT reserves the right to require an Issuer to identify "gatekeeper" requirement in the Schedule of Benefits and/or the Issuer's Plan Marketing Name(s).

An Issuer will be required to provide a prescription drug formulary in accord with the greater of either 45 C.F.R. 156.122 or equal in number and type to the formulary in the plan with the highest enrollment (representing a similar product) offered outside of the Marketplace.

H. Plan Options

Standardized plan designs promote transparency, ease, and simplicity for comparison shopping by enrollees. AHCT has developed standard plan design for each metal tier for the 2014 benefit year which defined the QHP's deductible, co-payment and/or co-insurance mix for the essential health benefits offered in-network and out-of-network. AHCT is currently working on making revisions to its Standard Plan Designs for the 2015 benefit year. The 2014 Standard Plan Designs can be found on AHCT's website (http://www.ct.gov/hix/cwp/view.asp?a=4295&q=532148).

a. Individual Marketplace

To participate in the Individual AHCT Marketplace the following criteria must be met:

- An Issuer **must** submit at least one Standard Gold Plan, one Standard Silver Plan, and one Standard Bronze Plan.
- The Standard Silver Plan offered **must** be the lowest or equal in cost to the lowest cost Silver Plan offered by the carrier in the AHCT individual Marketplace.
- An Issuer **must** submit three cost-sharing alternatives for each Silver Plan to reflect Federal cost-sharing reduction subsidies for households under 250% of Federal Poverty Level (FPL).
- An Issuer **must** submit two cost-sharing alternatives for each QHP to reflect the Federal cost-sharing reduction subsidies for American Indians. There must be:
    1. one alternative that offers zero cost-sharing for American Indians under 300% of the FPL; and
    2. one alternative that offers limited cost-sharing for American Indians, regardless of income, for any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.
- An Issuer **must** offer a child-only QHP option at the same level of coverage(s) as any QHP offered through the AHCT Marketplace in accordance with 45 C.F.R. §156.200(c). An enrollee seeking child-only coverage may obtain that coverage through the purchase of a single QHP with applicable rating for child-only coverage. In other words, any QHP can be sold as a child-only plan.

Issuers are also encouraged to submit any combination of QHP plan designs:

- The Issuer may opt to offer a catastrophic coverage plan. Any Issuer offering the catastrophic coverage plan option must comply with Federal law including Section 1302 (e) of the ACA and 45 C.F.R. § 156.155; and any applicable State law.
- One Standard Platinum Plan and up to two Non-Standard Platinum Plans
- Up to two Non-Standard Gold Plans
- Up to two Non-Standard Silver Plans with the corresponding cost-sharing reduction plans
- Up to two Non-Standard Bronze Plans

b. SHOP Marketplace

Please note that the Standard Plan Designs for the SHOP Marketplace may differ from the Standard Plan Designs in the Individual Marketplace. To participate in the SHOP, an Issuer must offer the following combination of Standard plans:

- One Standard Gold Plan
- One Standard Silver Plan
- One Standard Bronze Plan

In addition, Issuers are encouraged to submit any combination of the following plans:

- One Standard Platinum Plan and up to two Non-Standard Platinum Plans
- Up to two Non-Standard Gold Plans
- Up to two Non-Standard Silver Plans
- Up to two Non-Standard Bronze Plans

I. Federal QHP Data Templates

The Federal QHP data templates must be completed and submitted via the System for Electronic Rate and Form Filing (SERFF). The templates listed below illustrate the data requirements for an Issuer to obtain QHP Certification for each plan design intended for sale on the AHCT Marketplace. The templates are located on the SERFF website and contain Issuer and Plan information required to effectively evaluate the Issuers QHP submissions.

The data templates can be found on the SERFF website http://www.serff.com/plan_management_data_templates.htm. AHCT intends to extract information from these Templates to optimize the consumer shopping experience screens.

AHCT anticipates requiring Issuers to provide the following templates, as part of QHP Application:

- Administrative Data - General Company Contact Information.
- Plans and Benefits Template & Add-In – Plan and Benefit Data.
- Prescription Drug Formulary Template - Prescription drug benefit information and formulary information, including formulary URL.
- Network Template - Provider network information; URL to company directory.
- Service Area Template - Geographic service area information.
- Rates Table Template – Premium information by Plan for each age band.
- Business Rules Template - Supporting business rules.
- Provider Directory Template – Network Adequacy information.
- NCQA / URAC / AAAHC Template - Accreditation Information.
- Uniform Rate Review- Data for market-wide rate review – the template includes some Issuer information to support rating development; and may be used by the CID and AHCT.

AHCT does not intend to require Issuers to submit the Federal ECP Template, unless there are system limitations that require this Template to be submitted.

J. Rating Factors

Issuers should refer to the CID Bulletin HC-91 for information regarding rating factors in Individual and SHOP markets.

- *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 AHCT Marketplace) to be members of a single risk pool encompassing either the individual market or small group market.
- *Tobacco Use*. AHCT currently prohibits Issuers from using tobacco use as a rating factor in the AHCT Individual Marketplace. However, AHCT reserves the right to require Issuers to use tobacco use as a rating factor in AHCT Individual Marketplace for 2015 benefit year.
- *Family Composition*. 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.
- *Age.* 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

- AHCT has adopted the CMS recommendation referenced in "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Federal Register page 13411, (February 27, 2013)" regarding alignment of Connecticut's rating and service areas. . The rating area factor is required to be actuarially justified for each area. AHCT currently requires the Issuers to offer QHPs in all counties identified below.

RATING AREA	SERVICE AREA	COUNTY
Rating Area 1	Service Area 1	Fairfield
Rating Area 2	Service Area 2	Hartford
Rating Area 3	Service Area 3	Litchfield
Rating Area 4	Service Area 4	Middlesex
Rating Area 5	Service Area 5	New Haven
Rating Area 6	Service Area 6	New London
Rating Area 7	Service Area 7	Tolland
Rating Area 8	Service Area 8	Windham

K. Wellness Incentives

AHCT encourages Issuers to offer wellness programs-as described in 45 C.F.R. §146 and 147. Issuers planning to offer a wellness program(s) in the SHOP will be required to describe wellness programs they currently offer outside of the AHCT Marketplace and provide information on how success of such programs is monitored as well as the program(s) outcomes. AHCT will also require Issuers intending to offer a wellness program(s) to provide a detailed proposal of such programs. AHCT reserves the right to decide whether a wellness program(s) as described by an Issuer should be offered in the SHOP.

L. Accreditation

Issuers entering their initial year of QHP certification for the 2015 benefit year that do not have an existing commercial health plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is applying to offer coverage must schedule or plan to schedule with a recognized accrediting entity a review of its QHP policies and procedures. New QHP issuers may submit accreditation information for display if they have existing accreditation.

In addition to the attestation noted above, Issuers will be asked to provide some information about their accreditation status to determine if the standard in §155.1045(b) is met. This information will be verified with the indicated accrediting entity. For certification in 2014 for the 2015 benefit year, the National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC) have been recognized by CMS as accrediting entities for the purpose of QHP certification.

The accreditation must cover the Issuer's Connecticut operations. If an Issuer is already NCQA accredited, the Issuer must have its AHCT product accredited by October 15, 2016 (beginning of enrollment for the 2017 plan year). This can include the NCQA Exchange Add-On Survey.

Issuers will be considered accredited if the QHP issuer is accredited with the following status: by AAAHC with "Accredited," status; by NCQA with "Excellent," "Commendable," "Accredited," and /or "Interim" status; or by URAC with "Full," "Provisional," and/ or "Conditional," status. An Issuer will not be considered accredited if the accreditation review is scheduled or in process.

Issuers will be required to authorize the accrediting entity to release to AHCT and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

M. Reporting Requirements

As part of QHP Application, Issuers will be required to provide the following to AHCT:

- CAHPS 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 2015, 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 and metrics Issuers intend to use to demonstrate program success.
    - Issuers may be required to submit reports demonstrating success of their Quality Improvement Strategy to AHCT on ongoing basis throughout the benefit year.

N. Patient Safety Standards

Beginning on January 1, 2015 QHP Issuers are required to comply with patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria. Proposed regulatory requirements at §156.1110 in the CMS 2015 Payment Notice outline how QHP issuers can demonstrate compliance with these standards, on a transitional basis, for 2 years beginning January 1, 2015 or until further regulations are issued, whichever is later.

Specifically, the proposal requires QHP issuers that contract with a hospital with greater than 50 beds to verify that the hospital, as defined in section 1861(e) of the SSA, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:

(1) A quality assessment and performance improvement program as specified in 42 C.F.R. § 482.21; and
(2) Discharge planning as specified in 42 C.F.R. § 482.43.
In addition, QHP issuers would be required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the certification for the 2015 benefit year, AHCT anticipates requiring QHP issuers to demonstrate compliance with these patient safety standards as part of the QHP Application with an attestation that they have collected and are maintaining the required documentation from their network hospitals. AHCT intends to develop a standard form for Issuers to demonstrate compliance with Patient Safety Standards.

Please note that CMS has yet to finalize this proposed rule, and subsequently, the underlying regulation and this accompanying requirement for the QHP application may change.

O. Network Adequacy

Pursuant to 45 C.F.R. § 156.230(a)(2), an Issuer of a QHP that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay. Issuers will need to attest that they meet this standard as part of the certification/recertification process.

In addition to the attestation, AHCT requires Issuer's provider network for each QHP based on AHCT standard plan design to be substantially the same as the provider network available to the Issuer's largest plan (representing a similar product) offered outside of the Marketplace with the addition of the inclusion of Essential Community Providers ("ECPs"). AHCT determines whether an Issuer meets the "substantially the same" requirement. AHCT will consider the networks to be "substantially the same" when an Issuer's networks for QHPs based on the standard plan designs offered through AHCT Marketplace includes at least 85% of those unique providers and facilities that are in the Issuer's provider network outside of the Marketplace for the same product type. Issuers' networks for all QHPs will need to adhere to AHCT's reasonable access standards.

In order to determine whether the Issuer's provider network(s) meet the "substantially the same" requirement, AHCT will periodically request provider network information for both, QHP networks and Issuer's network available to the largest plan (representing a similar product) outside of the Marketplace.

AHCT is currently evaluating the requirements for the 2015 benefit year. AHCT's intention is to develop reasonable access standards based on membership distribution by Issuer throughout the State and implement specific geographical access standards by provider type. Issuers will be required to submit provider network information in a format specified by AHCT.

Issuers are also required to meet specific standards approved by the AHCT Board of Directors for the inclusion of ECPs within their QHP provider networks. To qualify as an ECP, a health care provider must be a 501(c)(3) entity, or a state or city owned or operated entity. The ECP must provide services that are considered covered health services under the currently adopted definition of Essential Health Benefits to individuals at disparate risk for inadequate access to healthcare.

ECP Network Adequacy standards:

- By January 1, 2015 carriers must contract with 90% of the Federally Qualified Health Centers (FQHCs) in Connecticut.
- By January 1, 2015, carriers must contract with 75% of the non-FQHC providers on the ECP list that was published in May 2013.

To determine whether an Issuer is meeting the ECP standards, AHCT will require the Issuer to complete "ECP List" on a quarterly basis. AHCT will provide Issuers that submit the Non-Binding Notice of Intent with the ECP list/template for ECP data submission. AHCT intends to implement ECP contracting standards and monitor progress from the time of the QHP Application submission through January 1, 2015 when the standards should be met. If an Issuer does not meet the standard(s) at the time of quarterly submission of ECP data to AHCT, the Issuer will be required to provide AHCT with a demonstration of a good faith effort as described in Appendix 3.

P. Attestations

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

- Attestations will be required in the QHP application.
- The attestation language will cover the minimum certification standards and will include specific attestations as outlined in the other sections of this Solicitation and required by CMS, AHCT and/or the CID.
- Attestations will cover Issuer's existing operations as well as any contractual commitments needed to meet AHCT requirements on an ongoing basis.
- Issuer will attest that it has in place an effective internal claims and appeals process and agrees to comply with all requirements for an external review process with respect to QHP enrollees, consistent with state and federal law. (45 C.F.R. § 147)

Q. User Fees/Market Assessment

Attestation language will be included in the QHP application that commits the Issuer to pay user fee and /or carrier assessments, as applicable.

Appendix 1 – Schedule of Benefits Template

[COMPANY NAME]
[PLAN NAME]
SCHEDULE OF BENEFITS

Benefits	**In-Network Member Pays**	**[Out-of-Network Member Pays][1]**
[Medical][2] Deductible *Individual* *Family* (copays and coinsurance are not applied to deductible) [Deductible is combined for Medical services and Prescription drugs][3] **[**(In-Network Deductible is waived when services are rendered by an Indian Health Service provider)**]**[9]		
[Prescription Drug Deductible *Individual* *Family* (copays and coinsurance are not applied to deductible)**]**[4] **[**(In-Network Deductible is waived when services are rendered by an Indian Health Service provider)**]**[9]		
Out-of-Pocket Maximum [for Medical Services][5] *Individual* *Family* (Includes a combination of deductible, copayments and coinsurance for health **[**and pharmacy**]**[6] services)		
[Out-of-Pocket Maximum for Prescription Drugs Services *Individual* *Family* (Includes a combination of deductible, copayments and coinsurance for prescription drugs)**]**[7]		
Provider Office Visits		
Adult Preventive Physical Exam (one exam per calendar year when provided by a PCP)		

Appendix 1 – Schedule of Benefits Template

[COMPANY NAME]
[PLAN NAME]
SCHEDULE OF BENEFITS

Benefits	In-Network Member Pays	[Out-of-Network Member Pays][1]
[Note: preventive services are not subject to cost-sharing][8]		
Infant / Pediatric Preventive Physical Exam [Note: preventive services are not subject to cost-sharing][8]		
Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Specialist Office Services	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Mental Health and Substance Abuse [Note: cost-sharing has to be the same as PCP cost-sharing unless the carrier provider actuarial justification pursuant to the CID Bulletin HC-87][8]	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI) (Copays for MRIs and CAT scans are limited to $375 for all such services from in-network providers annually. Copays for PET scans are limited to $400 for all such scans from in-network providers annually) [Note: cost-sharing is limited per services pursuant to CT Gen Stat § 38a-511 (Ind) and CT Gen Stat § 38a-550 (Group)][8]	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Laboratory Services	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Non-Advanced Radiology (X-ray, Diagnostic)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Prescription Drugs - Retail Pharmacy ***(30 day supply per prescription)***		
Tier 1 Prescription Drugs	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Tier 2 Prescription Drugs	[No Member cost when services are rendered by an Indian Health Service provider][10]	

Appendix 1 – Schedule of Benefits Template

[COMPANY NAME]
[PLAN NAME]
SCHEDULE OF BENEFITS

Benefits	In-Network Member Pays	[Out-of-Network Member Pays][1]
Tier 3 Prescription Drugs	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Tier 4 Prescription Drugs	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Prescription Drugs - Mail Order Pharmacy ***(90 day supply per prescription)***		
Tier 1 Prescription Drugs		
Tier 2 Prescription Drugs		
Tier 3 Prescription Drugs		
Tier 4 Prescription Drugs		
Outpatient Rehabilitative and Habilitative Services		
Occupational Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Physical Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Speech Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Diabetic Equipment and Supplies	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Durable Medical Equipment	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Home Health Services (up to 100 visits per calendar year) [Note: deductible for HHC cannot exceed $50 per year (except HSA) and the carrier must reimburse	[No Member cost when services are rendered by an Indian Health Service provider][10]	

Appendix 1 – Schedule of Benefits Template

[COMPANY NAME]
[PLAN NAME]
SCHEDULE OF BENEFITS

Benefits	In-Network Member Pays	[Out-of-Network Member Pays][1]
a minimum of 75% coinsurance][8]		
Outpatient Services (in a hospital or ambulatory facility)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse and maternity)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Skilled Nursing Facility (up to 90 days per calendar year)	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Hospice		
Hospice Services	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Emergency and Urgent Care		
Ambulance Services	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Emergency Room	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Urgent Care Centers	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	[Note: preventive services are not subject to cost-sharing][8]	
Basic Restorative	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Major Restorative	[No Member cost when services are rendered by an Indian Health Service provider][10]	
Orthodontia Services (medically necessary only)	[No Member cost when services are rendered by an Indian Health Service provider][10]	

Appendix 1 – Schedule of Benefits Template

[COMPANY NAME]
[PLAN NAME]
SCHEDULE OF BENEFITS

Benefits	In-Network Member Pays	[Out-of-Network Member Pays][1]
Pediatric Vision Care (for children under age 19)		
Prescription Eye Glasses (one pair of frames and lenses per calendar year)	Lenses: $0; Collection frame: $0; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer. **[**No Member cost when services are rendered by an Indian Health Service provider**]**[10]	Not Covered
Routine Eye Exam (one exam per calendar year)	**[**No Member cost when services are rendered by an Indian Health Service provider**]**[10]	

Appendix 1(a) – Memorandum of Variable Material

1. Include out-of-network category only in PPO & POS products
2. Include only when the plan includes separate deductibles for medical services and prescription drugs
3. Include only if there is an integrated deductible for medical services and prescription drugs
4. Include only if there is a separate prescription drug deductible
5. Include only if there is an integrated out-of-pocket for medical services and prescription drugs
6. Include only if there is an integrated medical services and prescription drug out-of-pocket maximum
7. Include only if there are separate out-of-pocket maxima for medical services and prescription drugs
8. Note is included for issuer's informational purposes; please remove it once the form filing is finalized
9. Include the language in American Indian Limited Cost-sharing plan variations
10. Include the language in American Indian Limited Cost-sharing plan variations

Appendix 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
Outpatient Services	
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
Emergency Services	
Emergency Room	
Emergency Transportation/Ambulance	per state mandate*
Walk-in/Urgent Care Centers	
Hospitalization	
Inpatient Hospital (Facility & Provider Services)	
Skilled Nursing/Rehabilitation Facility	90 days/year
Hospice	life expectancy of 6 months or less
Residential Treatment Facilities	
Mental Health and Substance Use Disorder Services	
Mental/Nervous and Substance Abuse Services	same as any other illness
Rehabilitative and Habilitatlve Services and Devices	
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*
Prescription Drugs	
Laboratory and Imaging Services	
Laboratory Services	
Non-advanced Radiology	
Advanced Imaging (includes MRI, PET, CAT, Nuclear Cardiology)	
Preventive and Wellness Services and Chronic Disease	
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
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+

Appendix 2 - Connecticut's Essential Health Benefits

SERVICE	LIMIT
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
Other Services	
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
Maternity Coverage	
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*
Solid Organ and Bone Marrow Transplants	
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*
Sterilization	
Casts and Dressings	
Renal Dialysis	
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*
Pediatric Vision Care	
Routine Eye Exam	1 exam/year
Lenses	1 pair/year
Frames	1 frame/year
Contact lenses	1 fitting and set of lenses/year
Pediatric Oral Care	
Exams	1 every 6 months
Bitewings	1 time/year
Other X-rays	
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)	

Appendix 2 - Connecticut's Essential Health Benefits

SERVICE	LIMIT
Fixed Prosthodontics: Crowns, In lays and Onlays	
Re-cementing Bridges, Crowns Inlays & Space Maintainers	
Removable Prosthodontics: Full or Partial Dentures	
Repair, Relining and Rebasing 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.

Appendix 3 – Supplementary Response: Inclusion of ECPs

Demonstration of Good Faith Effort Instructions

If the carrier cannot meet the contracting standard, carrier will provide a narrative describing the reason why the Connecticut ECP contracting standards cannot be achieved by January 1, 2015. The response should address the carrier's current and planned efforts to contract with additional ECPs and shall reference the provider information and contract offer dates, as well as why those efforts have been unsuccessful.

Be as specific as possible in your responses. For example, the carrier shall indicate whether contract negotiations are still in progress or the extent to which the carrier was not able to agree on contract terms with the ECP (and if so, specify which terms).

The carrier shall provide a narrative describing its strategy as to how the carrier will increase ECP participation in its provider networks in the future to comply with the contracting requirements. For example, the carrier shall describe plans to offer contracts to additional ECPs or to modify current contract terms.

Carriers shall specifically address the following questions in their responses:

- How does the carrier's current network provide an adequate access to care for individuals with HIV/AIDS (including those with co-morbid behavioral health conditions)?
- How does the carrier's current network provide an adequate access to care for American Indians and Alaska Natives?
- How does the carrier's current network provide an adequate access to care for low-income and underserved individuals seeking women's health and reproductive health services?
- How does the carrier's current mental health network meet the State and federal requirement for mental health parity, specifically addressing the full continuum of care? If the current network does not meet the parity requirements, what is the carrier's corrective action plan?
- What steps has the carrier taken to contract with the School-Based Health Centers (SBHCs)?
- The carrier may provide additional information that demonstrates good faith effort to meet the Connecticut standards for ECP contracting.
- The carrier shall provide additional documentation as requested by Access Health CT to demonstrate its contracting efforts to meet Connecticut's ECP standards, within 5 business days upon written request.