

Proposed Certification Requirements for Carriers and Qualified Health Plans

Recommendations of the Plan Certification Subgroup

September 4, 2012

(As amended by the Advisory Task Force
at its September 27, 2012 meeting)

Note: This document is intentionally presented with modifications made by on September 19, 2012 by the Adverse Selection Work Group members and technical corrections in a format which makes these modifications and technical corrections readily apparent and represented in red. The amendments made by the Advisory Task Force on September 27, 2012 are represented in blue.

Background

The Patient Protection and Affordable Care Act (ACA) directs the U.S. Department of Health and Human Services (HHS) to issue certification criteria for Qualified Health Plans (QHPs) sold in American Health Benefit Exchanges. In March 2012, HHS issued final rules governing the Exchanges, including requirements for issuers and QHPs¹ offered through the Exchange. State-based Exchanges must ensure their standards for QHPs and issuers meet federal requirements and may also choose to create additional certification standards.

The Plan Certification Subgroup held ~~sevensix~~ meetings between May 30 and August ~~2215~~, 2012 to discuss proposed standards for carriers and QHPs. The Plan Certification Subgroup began its work by gaining familiarity with federal standards and existing state laws and regulations in similar areas to the extent they exist. A crosswalk of federal standards and existing related state laws and regulations was presented to the group in June and was posted for public comment in July.

The Plan Certification Subgroup had two charges:

- 1) to understand how existing state laws and regulations will likely serve as the basis for QHP criteria for the first year of Exchange certification and operation; and
- 2) to identify potential other options or areas of interest for additional certification standards for 2015 and beyond.

As we look ahead to numerous activities required of carriers to develop proposed qualified health plans, of regulators to evaluate various components of QHP certification, and of the Exchange to ensure its on-line web portal is available for open enrollment as required by federal rules on October 1, 2013, it will likely be necessary to apply current state laws and rules as the initial basis for issuer and QHP certification standards. Adoption of other standards would require modifications to existing state laws and rules. Carriers will need to begin to submit proposed QHPs through the certification process during the first quarter of 2013 and it will likely not be possible for carriers to incorporate other standards that may emerge during the 2013 legislative session into QHPs that need to be certified and available on the

¹ The term “issuer” and “carrier” are used in this document to describe the company issuing a health benefit plan, while the term “qualified health plan” (QHP) refers to a specific policy to be sold to a consumer.

Exchange by October 1, 2013. Insurers would subsequently need adequate lead time to develop and seek certification for new QHPs meeting different standards.

Two key observations were noted as context for the Plan Certification Subgroup's discussions:

- 1) The Exchange Advisory Task Force adopted a recommendation in January 2012 that market rules and certification requirements be the same inside and outside the Exchange in order to prevent adverse selection². This means that recommended QHP certification requirements proposed here, if adopted by the Exchange Advisory Task Force, would apply both inside and outside the Exchange beginning in 2014. Some Subgroup members voiced concern about market-wide application of the recommended standards.
- 2) Each State-based Exchange is required to offer two multi-state plans (MSPs). These MSPs will be chosen by the federal Office of Personnel Management (OPM) and subject to certification standards established by OPM. Minnesota cannot require MSPs to meet the same standards required of Minnesota QHPs. Some Subgroup members raised concerns about Minnesota carriers being held to potentially higher standards than national plans chosen by OPM.

Issues of Specific Concern to Stakeholders

Work group members identified the following topics as priority areas for discussion related to proposed certification standards:

- Network adequacy requirements, provider directories, and enrollee notification when provider networks change
- Essential community providers
- Service areas
- Enrollment issues
- Accreditation timelines
- Recertification, decertification and non-renewal processes and their relationship with the state's requirements around guaranteed renewability
- Streamlining QHPs offered to consumers
- Use of the Tribal Addendum

Federal certification requirements exist in other areas as well, such as marketing standards and licensing. Similar to other areas of certification, the Exchange will likely initially rely on related state laws and rules where they exist in the first year of Exchange certification and operation. This document notes those other requirements as well and the State's existing laws and rules related to them.

Recommendations on Network Adequacy Certification Standards

Federal Requirements

Federal rules governing Exchanges include network adequacy standards requiring Exchanges to ensure that QHP provider networks are sufficient in number and types of providers, including mental health and substance abuse providers, to assure that all services are accessible without unreasonable delay.ⁱ

² See <http://mn.gov/commerce/insurance/images/ExchTaskForceHealthRec.pdf> (page 6)

Existing State Requirements

While Minnesota does not currently have market wide requirements for network adequacy, the state does have network adequacy standards for Health Maintenance Organizations (HMOs). Minnesota Statutes 62.D 124 prescribes geographic access standards for HMOs, guaranteeing enrollee access to primary and specialty care within in the service area. Enrollees must have access to primary care within 30 miles or 30 minutes of travel time while specialty care must be available within 60 miles or 60 minutes. HMOs must also contract with or provide enrollees with sufficient and appropriate resources to meet anticipated need for health services and implement guidelines to assess the capacity of each provider network to provide timely access to care. Exceptions to HMO network adequacy requirements are generally granted in more sparsely populated regions of the state in which providers are in shorter supply. Minnesota Rules Chapter 4685 further define more detailed network adequacy requirements. Relevant provisions of state law and rule are excerpted below:

Summary of Minnesota's Network Adequacy Standards for Health Maintenance Organizations

[MN Statutes § 62.D 124] Within the health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following: primary care services, mental health services, and general hospital services. The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty services. HMOs unable to meet these requirements must provide data demonstrating that the requirement is unfeasible in some part of the service area.

[MN Statutes § 62.D 121, Subd. 7] If the Minnesota Department of Health (MDH) determines that there are not sufficient providers within the approved service area, they may institute a corrective action plan with the health maintenance organization. This corrective action plan may include but not be limited to requiring HMO to pay nonparticipating providers, reducing the HMO service area, or limiting new enrollment to those areas with sufficient provider availability.

Minnesota Rules 4685.1010:

1. The HMO shall have appropriate and sufficient personnel, physical resources, and equipment to meet the projected need for covered services. The HMO shall develop written standards or guidelines to assess the capacity of each network to provide timely access to care.
2. Primary and specialty physician services and emergency and urgent care shall be available 24 hours a day within the HMO service area;
 - a. HMO must have standards for regularly scheduled appointments; after hour clinics; 24 hour answering service; back up coverage; referrals to ER and urgent care; and
 - b. HMO must contract with or provide a sufficient number of providers to meet projected need and ensure a number of primary care physicians have admitting privileges.
3. Services of facilities licensed as general hospitals must be available on a timely basis 24 hours a day in accordance with generally accepted practice patterns.
4. HMOs must contract with or provide sufficient numbers of mental health and substance abuse providers to meet the projected need of enrollees either inside or outside the service area; and

- a. HMOs must make available a full range of licensed mental health and chemical dependency providers.
5. The HMO shall provide for the coordination of care for enrollees given a referral. Wherever possible, this care should be coordinated through an enrollee's primary care physician.
6. HMOs must arrange for covered services including referrals to nonparticipating and specialty providers to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines. The organization must also, in conjunction with providers, develop and implement written appointment scheduling guidelines based on the type of health care services.
7. HMOs must implement a system for routine referrals and include a description of referral procedures in an enrollee's evidence of coverage.
8. An HMO must notify enrollees how to obtain emergency care. Where circumstances warrant emergency care, such care must be covered whether provided in or out of network.

Recommendations for 2014

- Generally use the State's existing standards for HMOs related to network adequacy, including those related to notification periods for enrollees about changes in networks, on a market-wide basis. Subgroup members noted that some of the existing network adequacy requirements are not relevant to other product types, such as the requirement to refer to non-participating providers (which are relevant only if the product restricts enrollees to a closed network) or coordinate care for enrollees given a referral or implement a system for routine referrals (which is relevant only if the product requires referrals for certain types of care). In response to these concerns, requirements that are not relevant to particular product types are not recommended to be extended to qualified health plans within those product types.
- Require carriers to file a provider network at the time of QHP certification, update it shortly before the open enrollment period begins, and update it on a regular interval (monthly or quarterly) throughout a benefit year.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Future Considerations

Subgroup members raised a number of issues they would like to explore for future QHP certification criteria, including the following:

- QHP certification standards should take into account and encourage development of innovative access models (such as telemedicine and retail clinics) to meet patient needs, especially in areas where resources or provider availability are constrained.
- Network adequacy requirements for subspecialists (e.g. pediatric and adult)
- The availability of culturally competent providers
- More specific requirements for timely access to care (such as establishing standards for appointment wait times). A suggestion was to survey enrollees about their experience with appointment wait times as one component of assessing the need for and informing the

development of more specific requirements related to timely access to care. [Current HMO network adequacy standards require HMOs to set their own standards for appointment wait times and that covered services “be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines”.]

- Requirements related to network adequacy should be viewed in the context of significant changes to insurance markets and the likelihood that more consumers are likely to seek medical care in 2014 and future years because they have obtained insurance coverage. There potentially may be some system-wide strains on provider availability to serve the newly insured as well as currently insured consumers.

Recommendations on Essential Community Providers Certification Standards

Federal Requirements

Federal Exchange rules require a QHP to include within its network a sufficient number and geographic distribution of essential community providers, where available, that serve predominantly low income, medically underserved individuals. Providers meeting this definition deliver significant care to the uninsured and enrollees in public programs.ⁱⁱ A staff model health plan or integrated delivery system plan that contracts with a single medical group must have a sufficient distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals in its service area.

Existing State Requirements

Minnesota Statutes 62Q.19 requires all health plans to offer contracts to state designated essential community providers within their service areas.ⁱⁱⁱ The Minnesota Department of Health designates essential community providers pursuant to statutory requirements. Once providers receive this designation, the designation remains in effect for five years. In practice, the vast majority of essential community providers designated by the Minnesota Department of Health also meet the similar federal definition of essential community provider.^{iv} The state requirement to offer contracts to essential community providers is more expansive than the federal certifications standards for qualified health plans.

Recommendations for 2014

Use the existing state standard already established in Minnesota Statutes 62Q.19.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Recommendations on Service Area (Minimum Geographical Area) Certification Standards

Federal Requirements

A QHP service area must cover a minimum geographical area that is at least an entire county or group of counties unless the Exchange determines that serving a smaller area is necessary, nondiscriminatory, and in the best interest of enrollees. The QHP service area must be established without regard to racial, ethnic, language, health status related factors, or other factors that exclude specific high utilizing, high

cost, or medically underserved populations.^v As noted in the preamble to the final rules, this service area standard mirrors the “county integrity rule” for Medicare Advantage plans.

Existing State Requirements

Health Maintenance Organizations seeking a certificate of authority from the Minnesota Department of Health provide regulators a statement describing the geographic service area where they plan to market and sell health plans. This service area relates to Minnesota’s network adequacy requirements. HMOs may enroll people residing outside the service area, but they must notify those individuals of the potential consequences of enrollment.^{vi} HMOs wishing to expand their service area must file a request with the Minnesota Department of Health including a detailed map of the proposed area containing network provider locations, evidence of provider contracts, and other supporting documentation.^{vii}

Recommendations for 2014:

With some exceptions, members recommended that service areas for QHPs should be no smaller than a county. Members supported the guidance from the Medicare Advantage “county integrity rule” that establishes criteria for regulators evaluating proposed service areas smaller than a single county. To obtain an exception from the county minimum, a Medicare Advantage organization must demonstrate that the sub-county area is necessary, non-discriminatory, and in the best interest of beneficiaries.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Future Considerations

- Workgroup members may want to revisit their recommendations related to service areas after the Department of Commerce establishes rating areas (see note on page eight). Depending on the timing of when Commerce sets rating areas and how those rating areas are set, members may wish to reconsider whether they prefer to recommend linking service areas to rating areas as part of 2014 or 2015/future year QHP certification criteria. This would be a significant change.
 - Members further discussed the current statutory requirement that rating areas include a minimum seven contiguous county geographic area and how the context for this requirement is changing now that states are required to create standardized rating areas to be used by all carriers. If service areas were linked with rating areas, the implication of this current statutory requirement would be to have significantly larger service areas than what federal Exchange rules require. Linking service areas to rating areas is considered by some members as a way of addressing the potential for carriers to carve out healthier segments of risk in a geographic area. Members also noted that a significant disadvantage of linking service areas to rating areas that are this large is that it would likely pose barriers to new carrier entrants in the market and therefore reduce competition.

Recommendations on Accreditation Certification Standards

Federal Standards

State-based Exchanges must establish a timeframe in which QHP issuers must be accredited. A QHP issuer must maintain accreditation on the basis of the local performance of its QHPs within its accredited product type in the following categories by an accrediting agency recognized by HHS: (1) Clinical quality measures; (2) CAHPS patient experience ratings; (3) Consumer access; (4) Utilization management; (5) Quality assurance; (6) Provider credentialing; (7) Complaints and appeals; (8) Network Adequacy and Access; and (9) Patient information programs. [§ 156.275]. Carriers will be required to obtain accreditation at the product type level, which will include QHPs offered by the issuer through the Exchange. HHS initially recognized the National Committee for Quality Assurance (NCQA) and URAC as accrediting entities in a final rule published on July 20, 2012.

Existing State Requirements

There are no existing state laws or regulations requiring carriers to be accredited in either the private insurance market or for purposes of serving as a Managed Care Organization for Minnesota Health Care Program enrollees.

Recommendations for 2014

The Plan Certification Subgroup recommended that each carrier obtain the appropriate level of accreditation in the third year after the issuer offers a QHP on the Exchange. Thus, a carrier that first offers a QHP during 2014 must obtain accreditation by the end of 2016. In addition, a carrier must take the first step of the accreditation process in the first year in which it offers a QHP. [Note: This recommendation would only apply to QHPs rather than managed care organizations serving public program enrollees.]

It was noted the accreditation process includes measurements that are dependent on designated volumes of enrollees. It is possible that a new market entrant may not be able to obtain accreditation within the recommended three-year window because they lack a sufficient number of enrollees. It is recommended that carriers in this situation should not be viewed as non-compliant with this requirement.

As part of a broader conversation about extending QHP certification rules to plans sold outside the Exchange, it was noted that requiring issuers operating solely outside the Exchange to become accredited would be a significant shift in requirements for insurers and that it may not be appropriate to require carriers operating solely outside the Exchange to become accredited in the interests of mitigating against adverse selection.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Recommendations on Enrollment and Termination Certification Standards

Federal Requirements

Federal regulations require issuers to enroll qualified individuals during designated periods, observe all standards for the collection and transmission of enrollment and premium payment information, and conduct monthly reconciliation of enrollment files with the Exchange. All issuers and brokers providing

assistance during enrollment must first verify that the enrollee received an eligibility determination from the Exchange. The federal rules also include QHP termination requirements including enrollee notification and grace periods. QHPs participating in the Exchange may only terminate enrollees for non-payment of premium, enrollee fraud or misrepresentation, enrollee relocation outside of the QHP service area, or transition to another qualified health plan during designated enrollment periods.^{viii} Issuers terminating coverage in a QHP for any reason must provide enrollees with a notice of termination of coverage at least 30 days prior to the last day of coverage during which the policy remains in effect. Issuers must provide a grace period of three consecutive months for enrollees receiving advance payment of the premium tax credit.

Existing State Requirements

Various provisions of Minnesota state laws provide a grace period after the premium due date during which policies must remain in force. For individual HMO contracts, the grace period is 31 days.^{ix} For all other commercial health plans in the individual and small group markets, the grace period is 7 days for premiums paid weekly, 10 days for those paid monthly, and 31 days for all other payment installment periods.^x Plan issuers in the individual market must provide enrollees with 30 days written notice prior to cancellation due to non-payment of premium.^{xi}

Recommendations for 2014

Members did not identify any additional recommendations beyond what is already required under federal rules and state law.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Recommendations on Benefit Design Certification Standards

Federal Requirements

Coverage requirements within the Affordable Care Act include the essential health benefits described in 1302(b) of the ACA, cost sharing limits as described in 1302 [c], and the metal levels in 1302 (d). Broadly speaking, the essential health benefit package includes ambulatory and emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative services and devices, laboratory services, preventive services, and pediatrics. The essential health benefits package and cost sharing limits are market wide reforms applying to all non-grandfathered health plans.

Existing State Requirements

Minnesota's coverage requirements are located throughout state statutes.

Recommendations for 2014

Members did not identify any additional recommendations beyond what is already required under federal and state law. Issues related to the essential health benefits package are being evaluated in the Access Workgroup of the Governor's Health Care Reform Task Force.

Recommendations for 2015 and Beyond

The Plan Certification Subgroup adopted a recommendation to study potential options for standardizing benefits and cost-sharing structures beyond standardization already required under the ACA. See “Streamlining QHP Offerings” on pages 13-17 below.

Recommendations on Rating Variation Certification Standards

Federal Requirements

Issuers may vary premiums for a QHP in accordance with permitted geographic rating areas, age (3-1 ratio), tobacco use (1.5-1 ratio), and whether the coverage is for individuals or families. Issuers may not vary premiums for the same plans offered both inside and outside of the Exchange.^{xii}

NOTE: The Affordable Care Act requires states to establish standardized geographic rating areas to be used by all carriers effective beginning in 2014. The Department of Commerce is currently considering how rating areas should be established and solicited input from stakeholders in July 2012 about issues the Department should consider as these rating areas are established. The Department intends to issue a proposed set of geographic areas by this fall.

Existing State Requirements

Minnesota Statutes 62A.021 permits rating variation in the individual and small group markets by limited rating bands between two policies with the same or similar coverage. Issuers may vary premiums by a health status including tobacco use (1.67 to 1 ratio), and age (3 to 1 ratio). Issuers may also vary premium between approved geographic rating areas. Annual premium changes based on health status in the small group market may not exceed 15 percent.

Recommendations for 2014

Members did not identify any additional recommendations.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Recommendations on Licensure Certification Standards

Federal Requirements

Federal rules require that all QHP issuers be licensed and in good standing to offer health insurance in each state in which it provides coverage.

Existing State Requirements

Minnesota Statutes 62D.03 requires [health maintenance organizations insurers](#) to receive a certificate of authority from the Minnesota Department of [HealthCommerce](#) to conduct business in the state, [while similar provisions in Minnesota Statutes 60A.06 and 62C.08 respectively require insurers and service plan corporations to obtain a certificate of authority from the Minnesota Department of Commerce.](#)

Recommendations for 2014

Members did not identify any additional recommendations beyond what is already required under federal and state law.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Future Considerations

A suggestion was made to explore the issue of for-profit/non-profit status as a potential requirement for QHP issuers. It was noted this is a significant issue, particularly in the context of applying certification standards inside and outside the Exchange.

Recommendations on Rating Information Certification Standards

Federal Requirements

Rates must be set for the entire benefit year (or plan year for the SHOP). QHP issuers must submit required justification for rate increases in advance and post justifications on their website. The Exchange must consider rate increases in its QHP determination. In doing so, the Exchange may consider the recommendations of state insurance regulators and the rate of premium growth both inside and outside of the Exchange. The Exchange must receive annual updates from issuers regarding rates, covered benefits, and cost sharing requirements of each QHP.

Existing State Requirements

Minnesota Statutes requires prior approval for rate filings in the small group and individual markets. Rate filings may be disapproved for the following reasons: (1) the benefits provided are not reasonable in relation to the premium charged; (2) (filings) contain a rate or provision which is unjust, unfair, inequitable, misleading, deceptive, or encourages misrepresentation of the form; (3) if the proposed rate is excessive or not adequate; (4) the actuarial reasons and data submitted do not justify the rate.

Recommendations for 2014

Members did not identify any additional recommendations beyond what is already required under federal and state law.

Recommendations For 2015 and Beyond

No specific recommendations were made.

Recommendations on Quality Improvement Certification Standards

Federal Requirements

Federal rules require Exchanges to develop and implement quality rating and enrollee satisfaction survey systems by 2016. Issuers are also required to implement and report on a quality improvement strategy or strategies consistent with the standards of the ACA, disclose and report information on health care quality and outcomes, and implement appropriate enrollee satisfaction surveys.^{xiii}

Existing State Requirements

Minnesota Rules Chapter 4685 require the development of a quality assurance plan to evaluate clinical and organizational components of health maintenance organizations. This includes evaluating the consumer perception of health care quality as measured through consumer satisfaction surveys.

Recommendations for 2014

None (see below).

Recommendations for 2015 and Beyond

No specific recommendations were made.

Future Considerations

Pending direction from the Exchange Advisory Task Force, the Subgroup will have an opportunity to revisit the concept of potential quality requirements as they relate to QHP certification standards for 2015 and beyond. The Measurement and Reporting Workgroup will work with a vendor beginning this fall on devising the methodologies for an evolving quality rating system and enrollee satisfaction survey system. It will be important for any quality standards related to QHP certification to align with the Exchange quality rating system. The Subgroup, therefore, may return to this topic after the Measurement and Reporting Workgroup issues recommendations on a quality rating system at the direction of the Exchange Advisory Task Force.

Recommendations on Risk Adjustment Certification Standards

Federal Requirements

QHP issuers must comply with the standards related to the risk adjustment program developed or certified by the United States Department of Health and Human Services.^{xiv}

Existing State Requirements

None.

Recommendations for 2014

Members did not identify any additional recommendations beyond what is already required under federal law and regulations.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Future Considerations

The federal risk adjustment program under development is likely to include a data validation process that will involve verification of health status by confirming diagnoses on a sample of medical records in a highly secure manner. A Subgroup member suggested that carriers participate in a unified data validation process as it relates to medical records in order to ease administrative burden on providers and carriers.

Recommendations on Non Discrimination Certification Standards

Federal Requirements

The issuer, with respect to its QHP may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.^{xv}

Existing State Requirements

Minnesota Statutes 72A.20 prohibits issuers from unfair discrimination between individuals between the same rating class in the amount of premium, policy fees, or rates charged and may not permit the rejection of an individual's coverage based on a disability.

Recommendations for 2014

Members did not identify any additional recommendations beyond what is already required under federal and state law.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Recommendations for Marketing Certification Standards

Federal Requirements

A QHP issuer and its officials, employees, agents, and representatives must comply with applicable state laws regarding marketing and may not employ marketing practices that discourage enrollment of people with significant health needs. [In addition, provisions of the federal summary of benefits and coverage \(SBC\) rules require carriers to disclose limitations and exclusions of group health plan coverage.](#)

Existing State Requirements

Marketing materials that misrepresent the terms of any policy or make any misrepresentation to a policyholder with the purpose of inducing them to drop coverage shall constitute an unfair and deceptive act or practice. No insurer may design a network of providers, policies on access to providers, or marketing strategy in such a way as to discourage enrollment by individuals or groups whose health care needs are perceived as likely to be more expensive than average. [MN. Stat. § 72A. 20] No advertisement or representation may omit information or use words, phrases, statements, references, or illustrations if the omission of the information or use of the words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. [MN Rules, 2790.0500] HMO marketing materials must also disclose exclusions and limitations including restrictions on covered services and referral requirements. [MN. Stat. § 62D.09] No health maintenance organization may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. [MN. Stat. § 62D.12]

Recommendations for 2014

Members did not identify any additional recommendations beyond what is already required under federal and state law.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Additional Topics of Interest

Recommendations on Recertification, Decertification, and Non-Renewal Processes

Federal Requirements

Federal regulations require that QHPs be certified as meeting specific criteria in order to be offered on an Exchange. Exchanges also have authority to recertify and decertify QHPs, while carriers have options to not renew a QHP in a subsequent enrollment period. Recertification, non-renewal, and decertification are briefly described below:

- Exchanges must establish a **recertification process** to ensure that QHPs continue to meet certification requirements. Exchanges have the flexibility to determine the frequency with which recertification must occur and any events that should trigger a recertification process in whole or in part. A recertification process must be complete by September 15 (or earlier as determined by the Exchange) of any applicable year so that consumers have a full range of choices available during open enrollment.
- An issuer electing **not to renew** offering of its QHP(s) must notify the Exchange of its decision prior to the beginning of the recertification process adopted by the Exchange. An issuer which chooses not to renew an existing QHP must fulfill its obligation to provide benefits through the end of the plan year and notify enrollees with a notice of QHP non-renewal.
- **Decertification** means the termination by the Exchange of the certification status and offering of a QHP. An Exchange may decertify a QHP at any time if it finds the QHP no longer meets QHP certification criteria and must provide an appeal process for the QHP issuer. Issuers may not terminate coverage until the exchange has provided notice to enrollees, HHS, and state regulatory entities (the Minnesota Departments of Commerce and Health). Enrollee notification should include detail regarding special enrollment periods permitting enrollees in a decertified plan to enroll in a new QHP. Decertification does not affect the offering of the plan outside the exchange.

Recommendations for 2014

- Subgroup members recommended the Exchange establish an annual or less frequent recertification process that relies on carriers attesting that already approved QHPs still meet certification criteria. Subgroup members were supportive of devising a recertification process that minimizes administrative work of both carriers and regulators. Regulators would still have the option to thoroughly review a component of QHP certification if they receive complaints about a QHP or if the carrier had material changes to the QHP that may affect its compliance with QHP certification criteria. It is further recommended that the Exchange should offer opportunities for consumers, providers, and other interested parties to convey concerns about QHPs to inform whether a recertification should occur in whole or in part.
- Subgroup members also suggested that changes in one aspect of a plan, such as renewing rates or periodic recalculation of actuarial value, should not trigger a full recertification process that examines all aspects of QHP certification criteria.

- It was noted that, under any circumstance in which a carrier chooses to not continue offering an existing QHP on the Exchange in a future year or an existing QHP does not meet potentially different future certification standards and is therefore not offered on the Exchange, enrollees in the QHP will face a choice: under existing state laws guaranteeing renewability of a plan, enrollees can continue to receive coverage through that product or they can choose a different QHP and receive advanced premium tax credits and cost sharing reductions for which they are eligible. Advanced premium tax credits and cost sharing reductions are only available for coverage purchased through the Exchange. Because enrollees in this situation face a very significant choice between maintaining a specific plan and remaining eligible for insurance affordability programs, it was recommended that consumers receive a clear notice advising them of these options. It was further recommended that consumers receive at least 30 days notice of a non-renewing QHP.

Recommendations For 2015 and Beyond: None.

Recommendations on Use of Tribal Addendum as a Component of QHP Certification Standards

Numerous federal laws, including the ACA, include provisions governing payment to certain Tribal providers and other provisions specific to Indians. Identification and facilitation of these Indian-specific provisions of federal law are incorporated into a draft Tribal Addendum, which is then included in contracts between Tribal providers and carriers. Tribal Addendums have been used in Medicare Part D provider contracts to clarify payment arrangements and other Indian-specific provisions in statute or regulation.

Recommendations for 2014

Work group members generally support a recommendation that the Exchange require QHPs to include the Tribal Addendum in contracts with Tribal providers. Members want to use the version of this document considered to be the most recent that has been approved by CMS and Tribes.

Recommendations For 2015 and Beyond

No specific recommendations were made.

Information on Streamlining QHP Offerings

Background: At its August 2, August 15 and August 22 meetings, Plan Certification Subgroup members discussed whether or not the Exchange should play a role in streamlining QHPs offered on the Exchange. This discussion was prompted by research which demonstrates that consumers experience challenges in comparing and choosing health plans. There are no federal QHP certification requirements related to streamlining QHPs offered on the Exchange.

Members had different opinions about whether the Exchange should play this role and also recognized the Exchange's plan choice architecture will play a critical role, along with the support of navigators and agents/brokers in helping consumers search for and compare plans that meet their needs and preferences. Members strongly supported the need for a robust plan choice architecture in helping consumers compare and choose QHPs.

While Subgroup members were divided about whether streamlining is desirable or appropriate, three potential avenues for streamlining emerged among those who expressed support for the Exchange streamlining QHP options in some way. Members also noted advantages and disadvantages associated with each of these three broad strategies:

1) Limiting numbers of plans sold on the Exchange and/or offered by a single carrier on the Exchange.

Advantages:

- Consumers may be able to make more informed choices if offered a manageable number of health plan options. A significant body of economics and consumer-experience research, as well as the concrete examples of Medicare Part D, Medicare Advantage and the Massachusetts Connector, demonstrate this.
- Consumers may feel more confident about their choice of health plan, and more positive about their shopping experience, if offered a manageable number of choices, according to the same body of research. This may enhance public trust in the Exchange.
- Offering fewer plan choices in 2014 and expanding the number in subsequent years may potentially be less disruptive than offering many choices initially and having to scale back over time.

Disadvantages:

- We are operating with a lack of information about how many QHPs carriers are likely to seek to offer on the Exchange. There is not an empirical basis on which to know whether the Exchange will have a large number of QHPs without such limits or on which establish a maximum number of plans.
- Choices are being artificially limited, when plan choice architecture will be designed to help consumers identify plans that more closely meet their preferences without limiting choices available.
- Navigators and agents/brokers will also play a critical role in helping consumers identify plans that meet their needs without limiting choices available.
- Limiting the number of plans sold on the Exchange to start may be disruptive for individuals who have coverage in the current insurance market place, but will be eligible for a subsidy in 2014. Limits reduce the likelihood that a plan option similar to the individual's current coverage is available in the Exchange, resulting in consumers having to either change coverage to access subsidies or forego subsidies to remain on their current plan outside the Exchange.
- This option would discourage innovation. Carriers would be limited in how many new products they could offer to consumers.
- This recommendation does not adequately balance the needs of currently insured consumers who have a wide variety of choices with the needs of the uninsured and underinsured.

- In the context of having the same market rules and certification requirements inside and outside the Exchange, this option would also limit plan choices sold outside the Exchange.
- Carriers would be challenged to substitute one QHP for another in order to stay within a capped number of QHPs, which would increase the number of situations in which consumers need to choose between retaining coverage through guaranteed renewability or obtaining insurance affordability assistance for which they may be eligible.

2) Standardize benefits and/or cost sharing structures beyond the standardization already required through Essential Health Benefits and limits on cost sharing.

Advantages:

- In the context of carriers being allowed to substitute levels of coverage within and possibly across essential health benefit categories as long as they maintain actuarial equivalence, standardization of benefit set limits and exclusions may promote consumer understanding of the scope and limits of their coverage.
- Reducing variation of the elements of coverage reduces the complexity of comparing and understanding plan options. This would be another way to facilitate comparisons among QHPs and reduce confusion about cost-sharing requirements.
- Standardizing benefits and cost-sharing would promote competition among carriers based on price, quality, and customer service and would reduce the potential for carriers to use benefit design to select risk.
- Standardizing benefits may provide an opportunity to promote effective care that helps achieve the Triple Aim (improve patient experience of care, improve health of population, and reduce per capita costs of health care).
- Promoting clearer consumer choices among plans and understanding of coverage scope and limitations may foster public trust in the Exchange.

Disadvantages:

- This proposal would limit innovation in product design. Carriers would be limited in their ability to experiment and create new product designs that meet evolving consumer needs.
- There are standardized plans available for purchase in the marketplace today and they are not chosen often by consumers.
- Consumers have different needs and preferences for how they want their coverage to be structured. Not all consumers would find the notion of standardized plan designs to be in their interests and instead prefer a broader variety of choices.

- This recommendation does not adequately balance the needs of currently insured consumers who have a wide variety of choices with the needs of the uninsured and underinsured.
- It isn't clear whether and how it is permissible to require more standardization in the context of federal guidance issued to date.
- Limiting the number of plans sold on the Exchange to start may be disruptive for individuals who have coverage in the current insurance market place, but will be eligible for a subsidy in 2014. Limits reduce the likelihood that a plan option similar to the individual's current coverage is available in the Exchange, resulting in consumers having to either change coverage to access subsidies or forego subsidies to remain on their current plan outside the Exchange.
- In the context of having the same market and certification rules inside and outside the Exchange, this option would also limit plan choices sold outside the Exchange.

3) Require that carriers offer products that differ from other products offered by the same carrier in some meaningful way (a "meaningful difference" standard).

Advantages:

- Will discourage a larger number of "look alike" plans being offered that do not provide substantively different coverage to consumers.
- Will encourage carriers to compete on factors that matter to consumers, such as price, benefits, and provider networks.
- Will likely encourage streamlining of plan choices without introducing more stringent limits on choices available to consumers, reducing potential for disruption to currently insured individuals eligible for a subsidy.

Disadvantages:

- Carriers have finite capacity to develop/maintain plans and do not need an external requirement to achieve this goal.
- This option may also limit some innovation in the marketplace, although to a significantly lesser degree than other options.
- It isn't readily evident how to define a standard of meaningful difference in the context of other ACA reforms.

Recommendations for 2014 (adopted at August 22 meeting)

1. The Exchange should have a robust plan choice architecture to help consumers compare options and choose a QHP. It is important for consumers to have a positive shopping experience and to understand and compare their health plan options.

All members supported this recommendation.

1.2. The Exchange should implement a "meaningful difference" standard for QHPs, beginning in 2014.

The threshold for meeting the "meaningful difference" test should include minimum defined intervals for:

* deductibles

* deviations from the federally mandated cap on annual out-of-pocket maximum

Variation on other QHP characteristics like networks and wellness programs would not be restricted.

2. Beginning in 2015, the Exchange should include a review for meaningful difference as a component of plan-level review, in order to ensure that there are no differences between QHPs that are clear and meaningful to consumers. The Exchange may use the following methods for determining meaningful difference:

1. Minimum intervals for deductibles or deviations from federally defined OOP maximums, as determined appropriate by the Exchange.
2. The tool currently being developed for determining meaningful difference among plans offered by Federally Facilitated Exchanges, when and if it becomes available to states.
3. Other criteria as determined appropriate by the Exchange.

Variation in networks, wellness programs, and value-based design should not be restricted.

There were 8 votes in favor of this recommendation and 3 abstentions.

Dissent:

- Streamlining will likely reduce choices available to consumers.
- This recommendation does not adequately balance the needs of currently insured consumers who have a wide variety of choices with the needs of the uninsured and underinsured.
- Further work will be needed to define a specific quantitative threshold for the meaningful difference standards. Carriers need to understand what the 2014 certification rules will be as soon as possible for product development purposes and there isn't sufficient time to thoughtfully develop these quantitative thresholds in this timeframe.

Recommendations for 2015 and Beyond (adopted at August 22 meeting)

31. The Exchange should conduct or commission research on the advantages and disadvantages of benefit streamlining and the advantages and disadvantages of different approaches to benefit streamlining, for possible implementation in 2015 and beyond. Research should include the following areas of consideration:

* Benefit Exclusions and Limits

* Cost-sharing

* Drug Formularies

* Out-of-Network Benefits

There were 6 votes in favor of this recommendation, 2 votes against and 3 abstentions.

Dissent:

- This recommendation presumes that Subgroup members agree conceptually with the concept of streamlining benefits rather than looking more fundamentally at both the merits and elements of benefit streamlining.
- Research that does not also include the cost/affordability impact of the possible ideas being researched does not yield meaningful results. A study on streamlining should examine estimated impacts on costs and premiums resulting from each different streamlining option.
- A study of the merits of QHP streamlining should be part of an evaluation of the entire consumer experience, including but not limited to the following:
 - Decision support tools
 - The role of assistors, including agents/brokers and navigators; and
 - Consumer comprehension of available options, regardless of the number of options available.

Recommendations for 2015 and Beyond

No specific recommendations were made.

Recommendations on Easing Transitions Between Public Programs and QHPs

Description of Issue

The Affordable Care Act expands insurance coverage by extending Medicaid eligibility and subsidizing commercial insurance for individuals and families with income at or below 400% of FPL. Changes in income, employment status, and household composition can change eligibility between Medicaid and other insurance affordability programs throughout the year, potentially disrupting continuity of care and creating the potential for gaps in coverage. Transitions between public and commercial coverage are likely, and these transitions may be disruptive and confusing for consumers. There are no QHP certification requirements related to churn or disruptions in care arising from coverage transitions. [Note: The Adverse Selection Workgroup has also considered a related issue on treatment of consumer payments toward out-of-pocket limits and deductibles for consumers transitioning between public and private coverage during the course of a single benefit year.]

Existing State Standards

Minnesota Statutes 62Q.53 provides continuity of care in limited circumstances when there are either provider contract terminations or in the small group market when an employer changes plans. This statute does not address coverage transitions between public and private coverage.

Two potential concepts were presented to Subgroup members for consideration, discussion, and feedback:

1) To consider allowing consumers transitioning from Medicaid or other public program coverage to a QHP to continue accessing the same providers available in the Medicaid network under certain circumstances (for example, such as the standards described above in Minnesota Statutes 62Q.53).

2) Another potential strategy could include auto-enrollment from Medicaid into a QHP, with the option for a consumer to change QHPs from the auto-enrolled QHP within a 60-day special enrollment period. The purpose of such a strategy would be to take a first initial step on a consumer's behalf to ensure the consumer continues to have insurance coverage during transitions off of Medicaid. Coverage would not be effective until a premium was paid.

Recommendations for 2014

None.

Recommendations For 2015 and Beyond

No specific recommendations were made.

Future Considerations

- While there is unanimous recognition among stakeholders that coverage transitions are potentially problematic, work group members have a diversity of views on how to address these transitions.
- There are significant policy and operational issues to consider related to either of these concepts. It is more viable to explore these concepts as part of the QHP certification requirements for 2015 or future years to the extent the Exchange Advisory Task Force expresses an interest in doing so.

Other Key Issues for Future Consideration

Some Subgroup members expressed interest in exploring the following topics at a future point:

- Establishing a process by which QHP certification criteria will be evaluated and revised over time.
- Discussion of how QHP certification standards may relate to evolving care delivery and payment models, such as accountable care organizations, that could potentially be offered on the Exchange.
- The Exchange should leverage existing sources of data where possible to implement the Exchange quality rating system and other Exchange requirements.
- A separate set of recommendations related to certification standards for stand-alone dental plans will be made by the Plan Certification Subgroup this fall.

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- ⁱ 42 CFR § 156.230
 - ⁱⁱ 42 CFR § 156.235
 - ⁱⁱⁱ MN Statutes § 62Q.19 and MN Rules 4688.0050. Note: Public programs serving fewer than 50,000 enrollees are exempt from this requirement.
 - ^{iv} Interview with staff at the Minnesota Department of Health, June 19, 2012
 - ^v 42 CFR § 155.1055
 - ^{vi} Minnesota Rule 4685.3400
 - ^{vii} Minnesota Rule 4685.3300
 - ^{viii} 42 CFR § 156.430
 - ^{ix} MN Statute § 62D.07
 - ^x MN Statute § 62A.04
 - ^{xi} MN Statute 72A.20
 - ^{xii} 42 CFR § 156.255
 - ^{xiii} 42 CFR § 156.200(b)(5)
 - ^{xiv} 42 CFR § 156.200(b)(7)
 - ^{xv} 42 CFR § 156.200(e)