HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 12, 2012, Minutes
- Health Insurance and Managed Care (B) Committee June 27, 2012, Minutes (Attachment One)
  - Network Adequacy Guidance White Paper June 27, 2012 (Attachment One-A)
  - Accreditation and Quality Guidance White Paper June 27, 2012 (Attachment One-B)
  - Consumer Information and Marketing Guidance White Paper June 27, 2012 (Attachment One-C)
  - Form Review Guidance White Paper June 27, 2012 (Attachment One-D)
  - Rate Review Guidance White Paper June 27, 2012 (Attachment One-E)
- Exchanges (B) Subgroup Aug. 10, 2012, Minutes (Attachment Two)
  - Exchanges (B) Subgroup June 26, 2012, Minutes (Attachment Two-A)
    - Network Adequacy Guidance White Paper June 26, 2012 (Attachment Two-A1)
    - Accreditation and Quality Guidance White Paper June 26, 2012 (Attachment Two-A2)
    - Form Review Guidance White Paper June 26, 2012 (Attachment Two-A3)
    - Consumer Information and Marketing Guidance White Paper June 26, 2012 (Attachment Two-A4)
    - Rate Review Guidance White Paper June 26, 2012 (Attachment Two-A5)
- Limited Medical Benefit Plan (B/D) Working Group June 8, 2012, Conference Call Minutes (Attachment Three)
- Limited Medical Benefit Plan (B/D) Working Group May 9, 2012, Conference Call Minutes (Attachment Four)
- Health Care Reform Regulatory Alternatives (B) Working Group (Attachment Five)
  - Health Care Reform Regulatory Alternatives (B) Working Group Charge (Attachment Five-A)

© 2012 National Association of Insurance Commissioners

Draft: 8/21/12

Health Insurance and Managed Care (B) Committee
Atlanta, GA
August 12, 2012

The Health Insurance and Managed Care (B) Committee met in Atlanta, GA, Aug. 12, 2012. The following Committee members participated: Sandy Praeger, Chair (KS); Joseph Torti III, Vice Chair, represented by Christopher Koller (RI); Dave Jones (CA); Jim Riesberg (CO); Adam Hamm (ND); Benjamin M. Lawsky represented by Robert Easton (NY); Michael F. Consedine (PA); Julie Mix McPeak (TN); Neal T. Gooch (UT); Jacqueline K. Cunningham represented by Althelia Battle (VA); Mike Kreidler represented by Leslie Krier (WA); Ted Nickel and Dan Schwartzer (WI); and Michael D. Riley (WV). Also participating were: Jim L. Ridling and Steve Ostlund (AL); Bret Kolb (AK); Mike Rothman (MN); Monica J. Lindeen (MT); Scott J. Kipper (NV); and Randy Moses (SD).

1. Presentation on Robert Wood Johnson Foundation State Network Program

Heather Howard (Princeton University) and Mila Kofman (Georgetown University Health Policy Institute) briefed the Committee on the State Health Reform Assistance Network (State Network) program. Ms. Howard said the State Network is a Robert Wood Johnson Foundation–funded program providing technical assistance to the states to maximize coverage expansions under the federal Affordable Care Act (ACA). She said the program is focused on providing 10 diverse states (Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia) with the technical assistance they need to successfully implement the coverage provisions of the ACA.

Ms. Howard outlined the program's technical assistance strategies, which include: 1) a multi-disciplinary team providing operational-level technical assistance; 2) meeting each state where they are; 3) deploying a team of technical experts outside state procurement; and 4) facilitating peer-to-peer learning. She said the program has four focus areas related to ACA coverage expansion: 1) the development of health insurance exchanges; 2) streamlining eligibility and enrollment systems; 3) planning for Medicaid expansion; and 4) private insurance market reforms. Ms. Howard provided examples of the type of technical assistance the program provides to the states, including: 1) regulatory analyses of federal proposed rules on health insurance exchange implementation and reinsurance, risk corridors and risk adjustment; 2) assisting the states to establish timelines and work plans; and 3) holding webinars on the basic health program option and essential health benefits (EHBs).

Ms. Kofman detailed the activities of the technical team of multi-disciplinary experts providing assistance to the states. She emphasized that the assistance provided is driven by requests from the states themselves. Ms. Kofman highlighted the tools developed by the team that can be used by the states, such as self-audit checklists, strategic planning assistance and "cheat sheets."

2. Consider Adoption of June 27 Meeting Minutes

Commissioner Gooch motioned, and Health Insurance Commissioner Koller seconded, to adopt the June 27 meeting minutes (Attachment One). The motion passed unanimously.

3. Consider Adoption of Subgroup, Working Group and Task Force Reports

a. Exchanges (B) Subgroup

Commissioner Lindeen said the Exchanges (B) Subgroup met Aug. 10. During this meeting, the Subgroup heard an update on the activities of the Center for Consumer Information and Insurance Oversight (CCIIO) related to health insurance exchanges. She said the Subgroup heard three state perspectives (West Virginia, Rhode Island and Nebraska) on health insurance exchange implementation. She said the Subgroup also heard an update on the SERFF Plan Management Project, which will assist state insurance departments in carrying out their health insurance exchange plan management functions. Commissioner Lindeen said the Subgroup discussed its next steps for assisting states regarding health insurance exchanges, regardless of whether an exchange is a state-based Exchange (SBE), state partnership federally facilitated Exchange (PFFE) or federally facilitated Exchange (FFE). Those next steps include developing a series of decision point documents related to Exchange implementation issues if a state plans to operate an SBE, pursue a PFFE or default to an FFE. In addition, the Subgroup may consider developing a best practices paper related to consumer education and outreach. Commissioner Lindeen said the Subgroup adopted its June 26 meeting minutes.

© 2012 National Association of Insurance Commissioners

Commissioner Riesberg motioned, and Mr. Easton seconded, to adopt the Exchanges (B) Subgroup report (Attachment Two). The motion passed unanimously.

b. Limited Medical Benefit Plan (B/D) Working Group

Jolie Matthews (NAIC) said the Limited Medical Benefit Plan (B/D) Working Group met via conference call June 8 (Attachment Three) and May 9 (Attachment Four). During these meetings, the Working Group discussed its 2012 Charge and priorities. Ms. Matthews noted that the Working Group was charged with reviewing issues related to limited medical benefit plans, including those dealing with misrepresentation in sales and marketing as well as product utility. Related to this charge, the Working Group developed a consumer alert on limited medical benefit plans that was adopted by the Executive (EX) Committee and Plenary at the Spring National Meeting. Ms. Matthews noted that the Working Group received a letter from the NAIC funded consumer representatives requesting the Working Group to consider amending the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The consumer representatives' letter also requested including excepted benefits in the Working Group's charges. Ms. Matthews said the Working Group decided that, while Model #171 could benefit from updates, such a charge was likely outside the Working Group's current charges and was premature due to the then-pending U.S. Supreme Court ruling on the constitutionality of the ACA's individual mandate. She said the Working Group agreed to work with this Committee and the Market Regulation and Consumer Affairs (D) Committee on this issue and request clarification regarding the scope of the Working Group's charges.

Commissioner Jones asked if a decision had been made regarding the NAIC funded consumer representative's request that the Working Group consider expanding its charge to include reviewing issues related to excepted benefits. He said that, if clarification is needed, a decision should be made as soon as possible. Mr. Schwartzer said he participated on the Working Group conference calls where this issue was discussed, and it was decided that this issue would be discussed at the Summer National Meeting, but no decisions would be made. Commissioner Praeger agreed that the issue of excepted benefits was an important issue that should be reviewed. However, the Committee anticipates deciding what group—which could be this Working Group, another existing Committee group or a D Committee group—will carry out that task when it considers its 2013 Proposed Charges. Timothy Jost (Washington and Lee University School of Law) clarified what issues related to excepted benefits the NAIC funded consumer representatives wanted addressed. He said a decision on which group will be tasked with such a review did not need to be decided during this meeting, but such a review needs to be done.

Commissioner McPeak motioned, and Commissioner Gooch seconded, to adopt the Limited Medical Benefit Plan (B/D) Working Group report. The motion passed unanimously.

c. Health Actuarial (B) Task Force

Mr. Ostlund said the Health Actuarial (B) Task Force met Aug. 10. During this meeting, the Task Force received an update from the American Academy of Actuaries (AAA)/Society of Actuaries (SOA) Long-Term Disability Work Group concerning its progress on developing a Group Long-Term Disability Valuation Table. Mr. Ostlund said the Task Force also received an update from the AAA/SOA Cancer Claim Cost Table Work Group. He noted that this Work Group received a high response rate to its request to companies for information. Mr. Ostlund attributed this to the Task Force, on behalf of the NAIC, encouraging companies to participate in the data call conducted by Milliman in support of the Work Group's project to develop the new valuation table.

Mr. Ostlund said the Task Force also adopted its 2013 Proposed Charges. He said that, with respect to proposed charge #3, the Committee approved the Task Force's model law development request June 27, which was approved by the Executive (EX) Committee Aug. 12, for revising the *Health Insurance Reserves Model Regulation* (#10). Mr. Ostlund said the Task Force has heard from industry that perhaps this work was moving too quickly. He said that, given this, the Task Force would work on Model #10 and the valuation table on a parallel track to provide industry and other interested parties ample time to provide comment.

Mr. Ostlund said the Task Force also received reports from the SOA Health Section and the AAA Health Practice Council on their work related to various Task Force projects. Mr. Ostlund said the Task Force also received reports from its subgroup and working groups as to their activities: 1) the Medicare Supplement Refund Formula (B) Subgroup; 2) the Health Care Reform Actuarial (B) Working Group; and 3) the Long-Term Care Actuarial (B) Working Group.

Mr. Ostlund noted that the Long-Term Care Actuarial (B) Working Group met Aug. 10. During that meeting, the Working Group received a report from the AAA/SOA Long-Term Care Valuation Work Group. The Working Group discussed a proposal by the Long-Term Care Rate Stability (B) Subgroup of the Senior Issues (B) Task Force to amend the *Long-Term*

Care Insurance Model Regulation (#641). Mr. Ostlund said the Working Group also discussed its 20% required adverse development threshold and the 2011 long-term care reserve memorandum.

Commissioner Hamm motioned, and Commissioner McPeak seconded, to adopt the Health Actuarial (B) Task Force report. The adoption of the report did not include the Task Force's 2013 Proposed Charges. The Committee will consider adoption of the 2013 Proposed Charges at the Fall National Meeting. The motion passed unanimously.

d. Regulatory Framework (B) Task Force

Mr. Moses said the Regulatory Framework (B) Task Force met Aug. 11. During this meeting, the Task Force adopted its June 26 meeting minutes. Mr. Moses said the Task Force discussed comments received on drafts of proposed new NAIC models: Individual Market Health Insurance Coverage Model Act and Small Group Market Health Insurance Coverage Model Act. These proposed models incorporate the ACA's Sept. 23, 2010, immediate reform and 2014 market reform provisions. Mr. Moses said the Task Force set an Aug. 24 deadline for comments to be submitted on these drafts. The Task Force plans to hold a conference call after this comment deadline to review possible revisions to these proposed models that would reflect the discussion at this meeting and the additional comments received by the Aug. 24 deadline.

Mr. Moses said the Task Force also continued its discussions on revising the *Coordination of Benefits Model Regulation* (#120) to address issues related to medical benefits (med pay) coverage in automobile "no fault" and traditional automobile "fault" type contracts and, as provided in Section 2714 of the federal Public Health Services Act (PHSA), the extension of dependent coverage to age 26. He said that, as part of this discussion, the Task Force reviewed a discussion draft prepared by NAIC staff that included proposed revisions for addressing the issue of the extension of dependent coverage to age 26. Mr. Moses said the Task Force decided to prepare an official draft of revisions based on this discussion draft and set an Aug. 24 deadline to receive comments on the draft. The Task Force plans to continue discussion of the med pay coverage issue during an interim conference call. Mr. Moses said the Task Force adopted the ERISA (B) Working Group report.

Commissioner Consedine motioned, and Mr. Easton seconded, to adopt the Regulatory Framework (B) Task Force report. The motion passed unanimously.

e. Senior Issues (B) Task Force

Commissioner Kipper said the Senior Issues (B) Task Force met Aug. 12. During this meeting, the Task Force adopted a Model Law Development Request to amend the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* to make revisions to the rate stability provisions. Commissioner Kipper said the Task Force heard an update from NAIC staff regarding long-term care insurance consumer complaints. The Task Force also received an update from the Long-Term Care Shopper's Guide (B) Subgroup, which is continuing its work to update the statistics in the Shopper's Guide and create a one-page summary document to accompany the Shopper's Guide.

Commissioner Kipper said the Task Force also received an update from the Medigap PPACA (B) Subgroup. He said the Subgroup is continuing its work to implement section 3210 of the ACA and is developing standards for additional cost sharing for Medigap Plans C and F.

The Task Force received an update from the Health Actuarial (B) Task Force on issues of interest to the Task Force. It also received an update from the federal Centers for Medicare & Medicaid Services (CMS). Commissioner Kipper said the Task Force discussed a proposal being considered by the Long-Term Care Rate Stability (B) Subgroup to make improvements to Model #640 and Model #641 to address problems in the market relating to pricing and rating. He said the Subgroup plans to continue its work.

Commissioner Kipper said the Task Force discussed the need to more broadly examine the long-term care insurance market and the way it is regulated. He said the Task Force plans to conduct an in-depth examination of the changes to this product, changes in the way that it is being marketed and sold, and the evolving needs of consumers.

Commissioner Gooch motioned, and Commissioner Jones seconded, to adopt the Senior Issues (B) Task Force report, which included approving the model law development request to revise the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641) to make revisions to the rate stability provisions. The motion passed unanimously.

4. CCIIO Discussion of ACA Implementation

Mike Hash (CCIIO) said that, with respect to health insurance exchanges, CCIIO wants to ensure that consumers have access to affordable health insurance coverage. He noted CCIIO's issuance in May of the Exchange Blueprint for the states to use to demonstrate how their Exchange will work to offer a wide range of competitively priced private health insurance options. The Blueprint also sets forth the application process for states seeking to enter into an FFPE. If a state chooses to operate its own SBE or an FFPE, the U.S. Department of Health and Human Services (HHS) will review and potentially approve or conditionally approve the Exchange no later than Jan. 1, 2013, so it can begin offering coverage on Jan. 1, 2014. Mr. Hash said CCIIO is still soliciting comments on its FFE white paper and its proposal for a streamlined application for consumers. He also noted that CCIIO issued in June a federal opportunity announcement (FOA) providing states with 10 additional opportunities to apply for funding to establish an SBE, FFPE, or to prepare state systems for a FFE.

Commissioner Nickel said Wisconsin has already implemented many of the ACA-type reforms without federal grants and other assistance. He said he hopes CCIIO will provide the flexibility it has said it would to states like Wisconsin that already have robust marketplaces and have taken the lead toward reform already. Mr. Hash said he appreciates the comments and wants to hear from states such as Wisconsin that can be an example to other states and assist them in their reform efforts.

Commissioner Consedine asked for specifics related to the timeframe within which CCIIO will be able to provide more information related to EHBs. He also asked about the status of CCIIO's information technology (IT) system designs related to Medicaid eligibility. Mr. Hash said CCIIO is close to releasing the information related to the benchmark plans. He said he hopes that information can be released by the end of August. He said CCIIO has entered into contracts regarding the building of the necessary data hub related to determining Medicaid eligibility and eligibility for federal subsidies, which is being designed for use by both FFEs and SBEs. He said there has already been some testing of this system. Health Insurance Commissioner Koller urged CCIIO to issue guidance and regulations as soon as possible regardless of the current political climate in order for the states to move forward with their activities for operating an SBE or pursuing an FFPE.

5. Discuss Establishment of Health Care Reform Regulatory Alternatives (B) Working Group

Commissioner Consedine said a number of NAIC members have found themselves considering paths other than establishing an SBE. He said some states have already stated that they do not intend to establish an SBE, while others have found themselves by circumstance not able to establish one. Commissioner Consedine said these NAIC members need guidance and information on the options before them. He said the Executive (EX) Committee approved Aug. 12 the establishment of a new working group under the Committee—the Health Care Reform Regulatory Alternatives (B) Working Group. The Working Group's charge is to: 1) provide a forum for discussion of and guidance on the alternatives to implementing an ACA-compliant state-based Exchange and the implications of such alternatives to NAIC member regulatory authority; 2) identify and assist NAIC members in resolving open issues that need to be addressed with regard to non-state Exchange ACA alternatives; 3) analyze the impact of the ACA on existing NAIC member regulatory authority both inside and outside of a federal Exchange as well as the impact on NAIC model laws; and 4) identify opportunities for NAIC members to continue to innovate and regulate outside of a federal Exchange. Commissioner Consedine stressed that the Working Group would not be used as a forum for criticizing health care reform.

Commissioner Praeger said Commissioner Consedine has agreed to chair the Working Group and Commissioner Nickel will be vice chair. Commissioner Consedine said the Working Group will hold its first meeting Aug. 13 (Attachment Five). He motioned, and Commissioner Nickel seconded, to ratify the establishment of the Health Care Reform Regulatory Alternatives (B) Working Group to carry out the charge as adopted by the Executive (EX) Committee. The motion passed unanimously.

Commissioner Praeger said the white papers adopted by the Committee at its June 27 meeting would not be considered for adoption by the Executive (EX) Committee and Plenary. She said that, because of the evolving nature of the issues discussed in the papers, they would remain under the Committee's jurisdiction in order for them to be more easily updated as additional guidance from HHS and federal regulations are released. She said the white papers would be made available on the Committee's Web page on the NAIC website for NAIC members and this new Working Group to use as guidance, as appropriate.

6. Discussion of Financial Reporting of Health System Improvement Expenses

Health Insurance Commissioner Koller asked the Committee to consider making a request to the Executive (EX) Committee to establish a joint Health Insurance and Managed Care (B) Committee and Financial Condition (E) Committee working group to carry out a charge to clarify that insurers' health system improvement expenses should be reported on the annual

statement as medical, not administrative, expenses. He explained that health system improvement expenses are those made by insurers for the purpose of improving the quality, accessibility and efficiency of the health care system. The benefits of these expenses do not accrue to the insurer, the health care provider or an individual consumer, but to the health care system as a whole. Examples of such expenses include health information exchanges, clinical practice improvement initiatives and electronic health records technical assistance.

Health Insurance Commissioner Koller said the issue is how these expenses should be classified for financial reporting purposes. He said federal guidance is clear that for purposes of the medical loss ratio (MLR) calculation, these expenses are added to the numerator of MLR. However, the NAIC's statutory accounting principles do not address the issue. Health Insurance Commissioner Koller said Rhode Island has taken the position that such expenses are not administrative expenses because their benefits do not accrue to the insurer, but to the general population. He said Rhode Island will be directing its domestic health insurers to report these expenses on the annual statement as "aggregate write-ins for other hospital and medical," line 14. He said that, because it is not clear how other state insurance regulators will address this issue, there is a potential for a lack of uniformity in financial reporting that deserves consideration by the appropriate NAIC committees.

Mr. Ostlund said he believed that this issue is more of an E Committee issue than a B Committee issue. Commissioner Praeger said the Committee would review this issue and decide what action to take at the Fall National Meeting.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

W:\National Meetings\2012\Summer\Cmte\B\08-Bmin.docx

Draft: 7/26/12

Health Insurance and Managed Care (B) Committee
Washington, DC
June 27, 2012

The Health Insurance and Managed Care (B) Committee met in Washington, DC, June 27, 2012. The following Committee members participated: Sandy Praeger, Chair (KS); Joseph Torti III, Vice Chair, represented by Christopher F. Koller (RI); Jim Riesberg represented by Peg Brown (CO); Adam Hamm (ND); Benjamin M. Lawsky represented by Troy Oechsner (NY); Michael F. Consedine represented by Peter Camacci and Franca D'Agostino (PA); Julie Mix McPeak and Chlora Lindley-Myers (TN); Neal T. Gooch represented by Tanji Northrup, Paul Anderton and Nancy Askerlund (UT); Jacqueline K. Cunningham (VA); Mike Kreidler represented by Beth Berendt (WA); Ted Nickel (WI); and Michael D. Riley and Jeremiah Samples (WV). Also participating were: Steve Perry (DC); Linda Sheppard and Cindy Hermes (KS); Emma Fontenot (LA); Molly White (MO); Monica J. Lindeen and Christina Goe (MT); Jean Holliday (NC); Alex Feldvebel (NH); Susan Dobbins (OK); and Randy Moses (SD).

1. Adoption of Uniform Fraud Reporting Form

Mr. Perry, Vice Chair of the Antifraud (D) Task Force, said that, last May, the Task Force received an assignment from the Committee to create a Uniform Fraud Reporting Form and Instructions. He said the assignment stemmed from a letter received by the Committee from Secretary Kathleen Sebelius at the U.S. Department of Health and Human Services (HHS) requesting the NAIC to provide a Form and Instructions for using the Form in accordance with section 6603 of the federal Patient Protection and Affordable Care Act (ACA). This Form would be available for use by insurers submitting suspected fraud referrals to state regulators. Mr. Perry said, that, at the time the Task Force received this assignment, it had already begun work on updating the existing Form. He said the Task Force wanted to update the existing Form to reflect current trends and information requirements, as well as ensure the hardcopy Form collected the same information as the NAIC's Online Fraud Reporting System (OFRS).

Mr. Perry said the Task Force held several conference calls and meetings since it received its assignment. The Task Force received input from state insurance regulators, the U.S. Centers for Medicare & Medicaid Services (CMS) staff, interested parties and industry representatives. He said the Form reflects the information and input the Task Force received from all parties. Mr. Perry said there were some initial discussions suggesting a separate health-related form should be created. He said the Task Force felt it was important not to split the Form into separate forms for each line of insurance business. It was best to have one form for everyone to use and to keep all referrals uniform. He said the Form is clear on what information applies to property and casualty insurance as opposed to health insurance. Mr. Perry said eventually most industry representatives agreed it was best for insurers as well, especially those reporting on multiple lines, to have one uniform Form. He said the Task Force held open conference calls April 4 and June 14 to discuss and vote on both the Form and the Instructions for using the Form. The Task Force passed both unanimously. Commissioner Cunningham motioned, and Commissioner McPeak seconded, to adopt the Uniform Fraud Reporting Form and Instructions (Refer to Market Regulation and Consumer Affairs (D) Committee Minutes, NAIC *Proceedings* – Summer 2012). The motion passed unanimously.

2. Adoption of Exchanges (B) Subgroup Report

Commissioner Lindeen said the Exchanges (B) Subgroup met June 26. During this meeting, the Subgroup adopted five white papers concerning Exchange plan management functions. She said each of the co-leads for the teams that developed the white papers would provide an overview of their white paper and discuss any additional amendments the team wished the Committee to consider.

a. Network Adequacy Team

Mr. Moses, as the Network Adequacy Team co-lead with Ms. Berendt, said that, in drafting the white paper, the Team kept in mind throughout the process that the purpose of the white paper was to provide a framework for the states to consider when developing or, in some cases, reviewing their existing network adequacy standards to meet the ACA network adequacy requirements as further outlined in the Exchange final rules. He said the Team believes that it struck the appropriate balance between what is required under the ACA and what is required in the NAIC's *Managed Care Plan Network Adequacy Model Act* (#74). Mr. Moses said that, after the Subgroup's June 26 adoption of *Plan Management Function: Network Adequacy White Paper*, the BlueCross and BlueShield Association (BCBSA) submitted comments regarding their concerns with the

© 2012 National Association of Insurance Commissioners

white paper's treatment of the requirements. He said he and Ms. Berendt reviewed those comments and suggest the Committee consider adopting some of them when it adopts the white paper. After discussion, the Committee agreed to include the suggested revisions in the white paper, as part of its adoption of the white paper.

b. Accreditation and Quality Team

Ms. White, as the Accreditation and Quality Team co-lead with Ms. Lindley-Myers, said the Subgroup adopted the *Exchanges Plan Management Function: Accreditation and Quality* white paper June 26. She said that, in drafting the white paper, the Team held several education sessions and webinars with the National Committee for Quality Assurance (NCQA) and URAC. Ms. White said the Team also held weekly conference calls during which it discussed comments received on the white paper drafts from the accrediting entities, the health industry, consumer groups and state insurance regulators. She noted that the changes discussed during the June 26 Subgroup meeting were included in the version of the white paper being considered for Committee adoption.

c. Marketing and Consumer Information Team

Ms. Dobbins, as the Marketing and Consumer Information Team co-lead with Ms. Hermes, said the *Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage* was adopted by the Subgroup June 26. It explores the issues and options for the states related to the implementation of certain provisions of the ACA and regulations issued to-date regarding the management of marketing, the summary of benefits and coverage (SBC) required to accompany each policy beginning in September, and how agents, brokers and Navigators will be regulated and managed in regard to the ACA. She said the white paper does not address issues concerning consumer outreach in general, nor does it address the many facets of issues surrounding agents, brokers and Navigators that do not directly involve how state insurance departments will manage these individuals. She said comments were received on the white paper from the Independent Insurance Agents and Brokers of America, Inc. (IIABA). Ms. Dobbins said she reviewed those comments and felt that they were not within the scope of the white paper. Commissioner Praeger said she believed that some of the IIABA's comments are, perhaps, more appropriate for future work as part of a best practices document.

Lynn Quincy (Consumers Union) pointed out some technical corrections that needed to be made to the white paper. Claire McAndrew (Families USA) said the white paper did not include any discussion on how consumers are to be made aware of the Navigator program. Commissioner Praeger said that, as described by Ms. Dobbins, the white paper was developed with a specific goal and scope in mind, which did not contemplate the inclusion of such information. She said outlining options for the states to consider for such consumer outreach and education could be the subject of future Committee work.

Wes Bissett (IIABA) reiterated IIABA's concerns with certain provisions in the white paper. He explained some of IIABA's major concerns, which included the language in the Considerations and Options for State Officials: Licensing and Certification provision. Mr. Bissett said it should be revised to define what a licensing scheme would look like, because the final Exchange regulations said the states could require Navigators to be licensed. Candy Gallaher (America's Health Insurance Plans—AHIP) restated AHIP's concerns with the footnote related to specialty health plans in the white paper concerning what should be included in Navigator training. She suggested language to address those concerns. Robert Holden (National Association of Specialty Health Organizations—NASHO) said he would like to review Ms. Gallaher's suggested language before the Committee takes any action related to it. The Committee agreed, but decided to move forward with considering adoption of the white paper and, if necessary, revisiting whether to include Ms. Gallaher's suggested language in the white paper at a later date.

d. Form Review Team

Ms. Holliday, as the Form Review Team co-lead with Althelia Battle (VA), said the *Form Review White Paper* discusses the changes to the form review process in response to provisions of the ACA that are effective in 2014. She said the white paper also identifies resource implications for state insurance regulators as a result of these anticipated changes. Ms. Holliday said the most significant change will be the need for state insurance regulators to consider some elements of form filings at a plan level, instead of the product-level review that is typical today. She said the Team held six open conference calls and five regulator-to-regulator conference calls. The Team solicited and considered comments from interested parties on each draft of the white paper. Ms. Holliday said the Team adopted the white paper during a conference call June 8. The Subgroup adopted the white paper June 26. Ms. Holliday said the white paper being considered for Committee adoption includes the revisions discussed at the Subgroup's June 26 meeting.

e. Rate Review Team

Ms. Sheppard, as Rate Review Team co-lead with Mr. Anderton, said the Team developed the *Rate Review White Paper* to assist state policymakers with the implementation of the ACA's provisions related to health insurance rating, rate filing and rate review. She said the white paper's focus is on the rate review requirements related to Exchange qualified health plan (QHP) certification. Ms. Sheppard noted, however, that many of the ACA provisions impacting rate review apply to all plans in the individual and small group markets. She said that, from the beginning of its work, the Team agreed that the purpose of the white paper was not to tell the states how they should fulfill their rate review responsibilities. Instead, the white paper lays out the provisions in the ACA and the changes in the regulatory environment that will impact rates and the rate review process. Ms. Sheppard said the white paper being considered for Committee adoption does not include "best practices," given the state-specific process of rate review, but she said the Committee might want to consider developing such a best practices document in the near future.

Health Insurance Commissioner Koller said that, when thinking about best practices, it will be important to communicate to stakeholders the changes in rating rules. Therefore, it would be beneficial to state insurance regulators if a best practices document could include information on what other states are doing in this area and any best practices.

Commissioner Hamm motioned, and Ms. Berendt seconded, to adopt the *Plan Management Function: Network Adequacy White Paper* as revised (Attachment One-A); the *Exchanges Plan Management Function: Accreditation and Quality* white paper (Attachment One-B); the *Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage*, as revised (Attachment One-C); the *Form Review White Paper* (Attachment One-D); and the *Rate Review White Paper* (Attachment One-E). The motion passed unanimously.

3. Adoption of Regulatory Framework (B) Task Force Report

Mr. Moses said the Regulatory Framework (B) Task Force met June 26. During this meeting, the Task Force discussed comments received on drafts of proposed new NAIC models: *Individual Market Health Insurance Coverage Model Act* and *Small Group Market Health Insurance Coverage Model Act*. Mr. Moses said the Task Force adopted the ERISA (B) Working Group report, which included adopting the Working Group's decision to move forward with guideline amendments to the *Stop Loss Insurance Model Act* (#92) related to revising the attachment points.

The Working Group is revising the attachment points of the *Stop Loss Insurance Model Act* (#92) in accordance with its charge to review and revise the model to take into account medical inflation. Ms. Northup said Utah believes the Working Group should consider revising the model in its entirety, not just the attachment points. She said, however, that considering such revisions is appropriate for another charge, which could be discussed at a later date.

Ms. Berendt motioned, and Commissioner Hamm seconded, to adopt the Regulatory Framework (B) Task Force report. The motion passed unanimously.

4. Adoption of Health Actuarial (B) Task Force Model Law Development Request

Jolie Matthews (NAIC) said the Health Actuarial (B) Task Force had approved unanimously a model law development request to update Appendix A in the *Health Insurance Reserves Model Regulation* (#10). She said the Task Force intends to revise Appendix A to reference a new table for the valuation of group long-term disability liabilities.

Commissioner McPeak motioned, and Ms. Berendt seconded, to adopt the Health Actuarial (B) Task Force's model law development request to update Appendix A in the *Health Insurance Reserves Model Regulation* (#10) (Attachment One-F). The motion passed unanimously.

© 2012 National Association of Insurance Commissioners

5. SERFF Update Related to Health Insurance Exchange Plan Management

Julie Fritz (NAIC) updated the Subgroup on SERFF's efforts to-date to assist NAIC members who choose to assume certain Exchange plan management functions. She reiterated that because product form and rate filing remains the responsibility of state insurance regulators, both inside and outside of an Exchange, state insurance regulators have the opportunity to play a key role in the operation of Exchanges as related to Exchange plan management functions. Ms. Fritz said that, generally, the goal in using SERFF for some pieces of Exchange plan management is to refine and supplement, as opposed to expanding significantly into other areas. She cited the example of accreditation, which is already handled by other third parties and embedded in many state and company processes. For this particular Exchange plan management function, rather than try to reinvent the wheel, SERFF expects to leverage these existing resources. Ms. Fritz again emphasized that SERFF is not intended to serve as an Exchange, nor is it intended to support all Exchange plan management functions. She noted that over the last 14 years, SERFF has become the tool for both states and insurers to facilitate product compliance. Ms. Fritz said that is SERFF's driving force in tackling this project.

Ms. Fritz provided an overview of SERFF's activities related to Exchanges since last summer. She noted that, due to uncertainty over the constitutionality of the individual mandate, many states have not decided whether they will establish a state-based Exchange (SBE), participate in a Partnership Exchange or default to a federally facilitated Exchange (FFE). Ms. Fritz said SERFF is prepared to support all three Exchange models. She emphasized that SERFF remains relevant even in those states that default to an FFE because state insurance regulators will have regulatory responsibilities related to QHPs.

Ms. Fritz said SERFF has held four Health Insurance Exchange Plan Management Forums—November 2011, December 2011, March 2012 and May 2012. She said the next Forum is Aug. 9 immediately preceding the Summer National Meeting. Ms. Fritz said SERFF has established a Technology Study Group and a User Interface Group to gather feedback from stakeholders concerning system needs. She detailed the specific activities of each of these groups to plan the workflow modifications for SERFF, including holding conference calls with about a dozen states to develop a proposed workflow that contains enough flexibility for SERFF to support the three Exchange models.

Ms. Fritz said that, to enhance communication with various stakeholders about SERFF's plan management activities, SERFF created the Health Insurance Exchange Plan Management (HIX) Bulletin, which is distributed monthly by email to all relevant stakeholders. She said SERFF created a new Web page within the SERFF website to make it easier to follow SERFF's plan management activities. Ms. Fritz noted that, during her report to the Exchanges (B) Subgroup at the Spring National Meeting, she had stated that one of SERFF's biggest challenges was the lack of communication with the Exchange establishment bodies in those states where the state insurance department is not setting up the SBE. She had requested state insurance regulators in those states to bring other state agencies into the discussion. She said that, since then, significant progress has been made in this area. However, she believes there are many more states where SERFF needs to expand its communication. Ms. Fritz said it is important to reach out to these other states to obtain information from them as soon as possible as to their needs and what Exchange model they intend to operate. She noted the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) Nov. 16 deadline for states to submit a Declaration Letter as to which Exchange model they intend to operate.

Ms. Fritz described SERFF's collaboration efforts with accreditation vendors to assist SERFF with supporting this portion of QHP certification. She said similar efforts are beginning with network adequacy vendors. Ms. Fritz said SERFF has also continued its communication and collaboration efforts with CCIIO to minimize duplicative efforts, both in the development process and software solutions that will play a significant role for state insurance regulators and industry. She said that, as part of this collaboration, the NAIC and CCIIO have established basic operating principles, all of which are designed to promote the development of effective Exchanges, regardless of Exchange model.

Ms. Fritz detailed SERFF's upcoming planned activities, which include its work on a proposed data dictionary and release of SERFF 5.16, which will include state configuration tools for essential health benefits (EHBs) in anticipation of the release of final regulations on EHBs.

Ms. Fritz said the project is huge and complex with many stakeholders. She asked Committee members and other state insurance regulators, if their state Exchange project team is not fully engaged in this portion of the Exchange, to contact her in order to help ensure that their state Exchange project planning and SERFF project planning mesh in order to ensure success. She reiterated that there are Exchange plan management functions that SERFF cannot directly support, such as licensing, solvency, producer/Navigator licensing/registration/certification, market conduct and consumer assistance. She noted, however, that the NAIC has several other existing systems that could easily and effectively support these functions,

© 2012 National Association of Insurance Commissioners

but the discussion needs to take place. Ms. Fritz stated that identifying non-insurance department state agency contacts, engaging them and collaborating with them is critically important to the success of this project. Commissioner Praeger urged state insurance regulators to communicate with SERFF about their state's plans regarding Exchanges as soon as possible.

Commissioner Praeger asked whether the NIPR could be leveraged to assist the states with any Exchange licensing or registration requirements for navigators. Ms. Fritz said there have been some limited discussions about this and about whether SBS resources similarly could be leveraged. She said she has been looking at SBS as a possible tool for use by those states that might choose to license Navigators. She said there could be some problems with using SBS if a state imposes registration or certification requirements. She said that, given the fact that not all of the states participate in SBS, using SBS would not be a solution for all of the states.

Mr. Samples asked whether SERFF has had any discussions with CCIIO regarding the ability to access the actuarial value (AV) calculator through SERFF. Ms. Fritz said she is not sure how it will be done, but there will be access to the AV calculator through SERFF. Mr. Samples asked about the planned tools for determining discriminatory plan benefit designs and whether these tools will be available through SERFF. Ms. Fritz said that, because CCIIO has not issued any guidance or other information related to discriminatory benefit plan designs, there have been no specific discussions on this issue with CCIIO.

Health Insurance Commissioner Koller suggested that some Exchange QHP issuer certification requirements, such as NAIC accreditation requirements, could overlap with SBS requirements. Ms. Fritz said she believes some overlap is inevitable. She said that, particularly for FFEs, SERFF is discussing this issue with CCIIO to try to streamline the process and reduce as much overlap as possible. Ms. Fritz noted that SERFF has the same issues raised by Ms. Holliday concerning product filing versus plan filing with respect to form filing. She reiterated that SERFF is exploring working with NCQA and URAC regarding accreditation. Ms. Fritz said she envisions a data feed coming into SERFF. She said, however, that SERFF needs to know what the states expect on Day 1—data or just a confirmation of accreditation. Ms. Fritz said SERFF is exploring the same process for the network adequacy QHP certification requirement.

6. Federal Legislative Update

Brian Webb (NAIC) said that, after the U.S. Supreme Court issues its opinion on the constitutionality of the individual mandate June 28, he expected CCIIO to issue a flood of ACA implementation-related guidance and regulations that it had been holding back in anticipation of the decision. He described the activities of the various Committee groups working on ACA implementation and described possible next steps for these groups after they complete their current projects, such as developing best practices documents on issues such as rate and form filing and Navigator training requirements.

Beth Abbott (Health Access) said that, as the Committee considers its next steps, the NAIC consumer representatives urge the Committee to consider a new charge to revise and expand the *Managed Care Plan Network Adequacy Model Act* (#74) in light of the changes in the marketplace and consumer needs since it was adopted in 1996. She said such a charge is relevant whether or not the ACA is upheld. Commissioner Praeger said the Committee would consider this request when it reviews its charges for 2013.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

W:\National Meetings\2012\Summer\Cmte\B\6-27-12-Bmin.docx

© 2012 National Association of Insurance Commissioners

Draft: 6/27/12
As adopted by Health Insurance and Managed Care (B) Committee, 6/27/12

Plan Management Function: Network Adequacy White Paper

I. Introduction

The federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA) provides for the establishment of American Health Benefit Exchanges to facilitate the purchase of health insurance by qualified individuals and qualified employers.[1] Under the Affordable Care Act, states electing to establish an Exchange must do so and meet certain minimum requirements by Jan. 1, 2014.[2] For states that do not establish a qualifying Exchange, the ACA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an Exchange, known as a federally facilitated Exchange (FFE), for the residents of that state.[3]

In the proposed rules on "Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" published in the *Federal Register* July 15, 2011, HHS announced the State Partnership Federally Facilitated Exchange (PFFE) model. Under this model, both HHS and the states will operate functions of the Exchange. HHS, however, will remain responsible and accountable to ensure the Exchange meets all of the standards and requirements under the ACA. As stated by HHS, the PFFE model is intended to give the states another option to tailor their Exchange to accommodate local needs and market conditions. In addition, the PFFE model is a way for states to transition into fully operating their own state-based Exchange (SBE).

On Sept. 19, 2011, at a State Exchange Grantee meeting, HHS' Center for Consumer Information and Insurance Oversight (CCIIO) provided additional information to the states on PFFEs.[4] As provided at this meeting, states entering into a PFFE must agree under the terms of their grants to ensure state insurance department, Medicaid and Children's Health Insurance Program (CHIP) cooperation to coordinate business processes, systems, data/information and enforcement. Also, as part of a PFFE agreement, a state may choose to operate plan management functions and/or some consumer services—such as consumer assistance programs—using Exchange grant funding to establish functionality, thereby maintaining existing relationships and allowing for easier transitions to SBEs in future years.

Specifically, under the proposed PFFE, CCIIO stated that a state may choose to operate the following Exchange functions:

- Option 1 – Plan management functions, such as collection and analysis of plan information and plan monitoring and oversight.
- Option 2 – Selected consumer assistance functions, such as Navigator management and in-person application and other assistance.
- Option 3 – Both selected consumer assistance and plan management functions.

Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options.

These plan management and consumer assistance functions can be further defined as including: 1) licensure and solvency; 2) network adequacy; 3) rate and form review; 4) benefit design standards; 5) marketing and consumer information, which includes reviewing marketing materials and overseeing Navigators; 6) accreditation; and 7) quality ratings, quality improvement strategies and enrollee satisfaction surveys.

On May 16, 2012, CCIIO issued additional guidance, "General Guidance on federally facilitated Exchanges."[5] The guidance outlined HHS' approach to implementing an FFE in any state where an SBE is not operating. It also described more specifically HHS' approach on how the states can partner with HHS to implement select functions in an FFE. Consistent with

[1] Pub. L. 111-148 (ACA), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010).
[2] ACA §1311(b).
[3] ACA §1321 (c).
[4] http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf.

[5] http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

© 2012 National Association of Insurance Commissioners

the information provided at the State Exchange Grantee meeting in September 2011, the guidance provides that the states will have the option to enter into a PFFE under which the state may assume primary responsibility for the plan management function; in-person consumer assistance functions, including oversight and management of Exchange Navigators; or both. The guidance requires those states that decide to assume primary responsibility for plan management under the PFFE to conduct all plan management activities. In addition, the state will collect and transmit necessary data to HHS in a specific format and manage certified QHPs. The guidance also details responsibilities for the states that enter into a PFFE to assume primary responsibility for in-person consumer assistance functions.

The purpose of this white paper is to provide a framework for the states to consider for ensuring compliance with the network adequacy requirements (both statutory and regulatory) for both inside an Exchange for qualified health plans (QHPs)—whether a state is implementing an SBE, FFE or PFFE—and outside an Exchange for managed care plans.

Section II. Background

The Affordable Care Act requires the Secretary of HHS to establish, by regulation, criteria for the certification of health plans as QHPs.[6] The regulations must include certain specified criteria that a plan must satisfy in order to be certified as a QHP and, as such, eligible to be offered on an Exchange. Some of those criteria are related to plan network adequacy requirements. Specifically, the ACA requires the certification criteria to:

> 1) Ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act (PHSA)) and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.
>
> 2) Include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the PHSA and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure (*see* Appendix A for the full text of Section 1311(c)(1)(B) and (C) of the ACA).[7]

In the March 27, 2012, *Federal Register*, the Secretary of HHS published the final rules, "Exchange Establishment Standards and Other Related Standards under the Affordable Care Act."[8] The final rules set out the minimum requirements for network adequacy that a plan must meet to be certified as a QHP. Subpart C – Qualified Health Plan Minimum Certification Standards, section 156.230 Network Adequacy standards, states that a QHP issuer must ensure that the provider network of each of its QHPs meets these standards:

> 1) Include essential community providers in accordance with §156.235.
>
> 2) Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.
>
> 3) Is consistent with the network adequacy provisions of section 2702(c) of the PHSA.

In addition, the final rules require a QHP issuer to make its provider directory for a QHP available to the Exchange for publication online and to give to potential enrollees upon request. The provider directory must identify providers that are not accepting new patients (*see* Appendix B for the full text of 45 CFR §156.230).

Section 156.235 of the final rules sets out the requirements related to the inclusion of essential community providers in a QHP provider network (*see* Appendix B for the full text of 45 CFR §156.235). As defined in §156.235(c), essential community providers, including providers that meet specified criteria, serve predominately low-income, medically underserved individuals. This section includes an alternative standard for meeting this requirement for QHP issuers that

[6] ACA §1311(c)(1).
[7] ACA §1311(c)(1)(B) and (C).
[8] *www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf*.

provide a majority of their covered professional services through physicians employed by the issuer or through a single contracted medical group.

In developing the language for the final rules, HHS reviewed many comments concerning the network adequacy standard initially included in the proposed 45 CFR §155.1050. As noted in the preamble to the final rules, many commenters supported the flexibility provided to the states in the proposed rules, noting that such flexibility could facilitate the alignment of markets inside and outside of an Exchange. Other commenters suggested that HHS establish a national, uniform network adequacy standard. Among the standards suggested was the NAIC *Managed Care Plan Network Adequacy Model Act* (Model #74). Again, as noted in the preamble, in balancing the competing policy goals and considerations that come into play with examinations of network adequacy (that QHPs must provide sufficient access to providers; that Exchanges should have discretion in how to ensure sufficient access; that a minimum standard in this regulation would provide consistent consumer protections nationwide; that network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions; and that a standard in regulation could misalign standards inside and outside of the Exchange), HHS modified the language in 45 CFR §155.1050, as reflected in 45 CFR §156.230(a)(2) in the final rules, to better align with the language used in the NAIC Model.

Specifically, the final rules establish a minimum standard for QHP issuers as to QHP network adequacy requirements while also providing sufficient discretion to Exchanges to structure network adequacy standards that are consistent with standards applied to plans outside an Exchange and are relevant to local conditions. HHS notes in the preamble that placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current state practice.

While the Affordable Care Act and the final rules prescribe that mental health providers be incorporated into networks for plans inside the Exchange, it must be recognized that mental health is covered under many circumstances outside the Exchange such as federal mental health parity, state-specific mental health mandates and plans that choose to cover mental health. Therefore, mental health providers should be a component of networks inside and outside the Exchange.

To the extent that a state already has network adequacy standards, it would make sense for the state to extend those requirements to QHPs to minimize adverse selection against the Exchange. However, in some cases, the ACA's network adequacy standards may go beyond a state's existing requirements, particularly as related to its requirement that essential community providers be included in the QHP's provider network. Whether a state has existing network adequacy standards or not, each state will need to consider whether to apply the same standards for QHP certification to the outside market; the potential for adverse selection against the Exchange if they choose not to require the same standards; and the cost to issuers in the outside market to comply if they choose to require the same standards.

For a comparison of the language in the final rules and the NAIC Model, please see Appendix C.

III. Network Adequacy Regulatory Standards

The final rules provide the states with considerable flexibility in fashioning network adequacy standards for QHPs that wish to participate in an Exchange. One of the ways that the states can put into place network adequacy standards that, with the following exceptions, would be sufficient to meet the final rules would be the adoption of the NAIC Model. While some states have adopted the NAIC model in a manner such that it only applies to HMOs, it and the final rules are designed so that these standards apply to all network plans, including PPOs and any plan that either requires enrollees to use—or creates incentives, including financial incentives, for enrollees to use—the plan's participating provider network.

Areas in which the NAIC Model can be enhanced to ensure compliance with §156.230 include: 1) inclusion of essential community providers, as defined in §156.235(c), in networks; and 2) inclusion of mental health and substance abuse providers in networks.

Regardless of whether a state has adopted the NAIC Model, general regulatory authority should be applied to ensure that the network is adequate to deliver the services promised under the benefit contract. Further, if financial incentives are provided for the use of certain preferred providers, a sufficient number of the preferred providers must be made available in a given

© 2012 National Association of Insurance Commissioners

service area. In addition, some carriers[9] may be required under state law to deliver prepaid health services through contracts with participating providers. An insufficient number of providers in any given service area may prevent the carrier from selling or renewing benefit plans in that area.

National accreditation entities such as the National Committee for Quality Assurance (NCQA)[10] and URAC[11] have established provider network criteria that measure network adequacy and provide guidance for reviewing networks. States may also refer to standards established by the federal government for Medicaid managed care or Medicare programs. States could consider relying on a QHP plan's accreditation for network adequacy as a complementary tool—but not as a replacement for regulatory oversight—for assessing compliance with the ACA and the final rules network adequacy standards for QHP certification.

Section 5B of the NAIC Model requires a carrier to file an "access plan" with the state insurance commissioner. The review of a carrier's "access plan" is one component of determining compliance with the NAIC Model's requirements and is part of a process known as "Network Adequacy Analysis." This analysis typically is performed by state insurance department personnel, and also involves the review of the carrier's actual networks in order to confirm that there is adequate access to all providers and facilities in a carrier's service area without unreasonable delay or the need to travel an unreasonable distance. The process also accounts for differences in provider availability, capacity to treat patients, provider types (specialties), facilities and practice referral patterns. Although general guidelines—including ratios of patients to providers, distance traveled and waiting times for appointments—can be helpful measures in this process, effective analysis also generally accounts for differences between suburban, urban and rural areas. General provider availability and the interrelationship between various providers in treatment of a patient requires a more complete analysis of the network to ensure that there are no direct or indirect barriers to access. States with existing network adequacy standards, in reviewing a carrier's access plan, may need to consider the impact on network adequacy given the expected increase in enrollees.

When developing a network analysis approach, regulatory staff should have a general familiarity with or request information about:

1. General provider availability in a given geographic area. Consideration should be given to what providers and facilities are located in a given area. General availability will vary depending on population, urban density and the provider's willingness to enter into provider contracts under reasonable terms and conditions. It should also be kept in mind that, as part of the network analysis, network adequacy considerations may have to be modified, depending on a state's specific geographic makeup.

2. Medical care referral patterns and hospital admission privileges. Network analysis must include a review of the hospital admission privileges of providers as well as typical referral patterns for a given community or area. This information may be obtained from the state's health department. Hospital admission privileges are typically gathered as part of the carrier's provider credentialing process. Analysis must confirm that providers requiring the use of facilities—including hospitals, ambulatory surgical centers or specialty treatment facilities—are able to admit their patients to network facilities. As an example, obstetricians must have admitting privileges to network hospitals for delivery services.

3. Hospital-based providers—such as radiologists, pathologists and emergency room physicians—may not be part of the same network as the facility, or may not be in any network. Absence from the network may result in an inadequate network for these services. This is particularly the case if the hospital providers hold an exclusive contract with the facility.

[9] The ACA uses the term "issuer" instead of "carrier." The term "carrier" used in this white paper is consistent with the term "issuer" used in the ACA.
[10] For more information about NCQA's health plan accreditation standards related to network adequacy, please see its website at: www.ncqa.org.
[11] For more information about URAC's health plan accreditation standards related to network adequacy, please see its website at: www.urac.org.

© 2012 National Association of Insurance Commissioners

4. Geographical barriers may exist that impede access to care, and the analysis should not rely on a simple mileage factor to determine accessibility. Examples of geographical barriers include mountain ranges and rivers or other bodies of water.

5. The location and availability of essential community providers as well as mental health and substance abuse providers is not addressed in the NAIC Model. However, as previously mentioned, inclusion of essential community providers is required for QHP certification in §156.230(a)(1) of the final rules.

6. The availability and access to centers of excellence for transplants and other medically intensive services as well as the availability of critical care services such as advance trauma centers, burn units, etc. If a carrier does not have such providers in their networks, then arrangements must be made by the QHP issuer to ensure access to these specialized services.

7. The availability of provider types as well as the capacity of providers to accept new patients is a critical component of understanding the network. It is also imperative to recognize that different health plans may be including the same provider or facility in a network, thereby reducing the overall capacity to accept new patients from a single QHP issuer.

In-depth review of network adequacy should occur at the time a network is established and at least annually. In addition, issuers should be required to submit notification at least quarterly of general changes in their network, as well as prompt notice of a potential loss of a material provider such as a hospital or multi-specialty clinic. An overarching goal of network review is to ensure that the network provides access to the participating providers in order to deliver the services promised under the benefit contract. If such access is not available, then the carrier must make arrangements acceptable to the state insurance department or other accountable entity that the services are provided at no greater out-of-pocket expense to the enrollee. Because non-participating providers may balance-bill their patients for the amount of charges in excess of the carrier's allowed amount, any alternative arrangement must recognize the possibility of greater out-of-pocket expense, resulting in the possibility of issuers basing their payments on billed charges rather than "allowed amounts" or usual and customary fees.

IV. Minimum Network Adequacy Processes

The network adequacy processes outlined in this white paper are designed so that either an Exchange or a state insurance department can perform those functions. However, where a state insurance department either has or will be implementing network adequacy standards for the outside market, for purposes of administrative efficiency and consistency between the markets, a state insurance department performing functions for both the Exchange for QHP certification and the outside market would be desirable.

A. Review of Health Carrier's Provider Networks

i. Timing

A health carrier shall seek approval of a service area when initially entering into a new service area market. Once approved, a health carrier must maintain an adequate network. A state shall perform regular reviews of the carrier's approved network to ensure adequacy. The state shall have the flexibility to determine the frequency of a network adequacy review, performing network service area reviews when regulatory concerns arise due to consumer complaints, market conduct activities and other department regulatory functions.

ii. Areas of Network Adequacy Review

A health carrier shall maintain a network that is sufficient in number and types of providers to ensure all services will be accessible without unreasonable delay. In a state's review of an adequate network, it must also ensure the inclusion of the following within the network:

- Essential community providers.
- Mental health and substance abuse providers.
- Providers that offer essential health benefit services.

However, this requirement should not be interpreted as an "any willing provider" requirement.

Other state considerations could include:
- Geographic distribution of providers within a service area.
- The area's population density.
- Time and/or distance to access providers.
- Location of predominantly low-income, medically underserved individuals population.

States may consider using tools that measure network adequacy, such as OptumInsight (formerly GeoAccess) or Quest Analytics, checklists, time travel analysis, critical care hospital locations, U.S. Census and all other applicable tools. The initial implementation of the new ACA and PHS Act network adequacy rules may gain efficiencies with the use of a state-specific streamline review process that includes for QHP certification specific review criteria pertaining to essential community providers and mental health and substance abuse providers for network-based carriers with previous state approval.

Given that network adequacy evaluation is a component of the QHP certification process, states may also want to consider the potential to leverage the NAIC's System for Electronic Rate and Form Filing (SERFF), which is being modified with the intent to be able to support plan management for Exchanges. There are plans under way to enable the ability to submit network adequacy data through SERFF, either through a third-party submission or by the carrier during the plan filing submission process.

iii. Adequacy Standards

The burden of network sufficiency shall lie with the health carrier requesting the new service area or certification as a QHP for the Exchange. The health carrier shall demonstrate its adequacy by providing supporting documentation that demonstrates its network sufficiency. A health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees.

States may determine sufficiency by using reasonable criteria that may include but are not limited to: provider-covered person ratios by specialty; rural/urban geographic accessibility; appointment waiting times; hours of operation; primary care provider (PCP) covered person ratios; availability of PCPs and high-utilization provider specialties; provider acceptance of new patients; hospital access; and patient referral patterns in the requested service area.

There are no specific requirements in either the NAIC Model or the final rules that specify the minimum distances for access to providers or minimum time frames in which to access the providers. Due to the geographic variability of many states, a standard distance or timing may prove to be difficult. States may consider using urban and rural access time standards when reviewing provider access. If no statewide standard exists, measuring adequacy may be accomplished by comparing the health carrier's network to the geographic region served by the applicable provider types. States may give consideration of the relative availability of health care providers in the service area. When considering access to rural geographic areas, states may consider a health carrier's adjacent service area networks that may augment providers if a provider deficiency exists within the service area.

If a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the state insurance commissioner.

To ensure that a health carrier possesses an adequate network within a requested service area, the states may require that carriers submit a detailed listing of their network provider specialties, locations, acceptance of new patient status, total unduplicated providers, and all other applicable categories using electronic filings. These requirements should be applied uniformly to all health carriers offering QHPs on an Exchange.

B. Review of Contracts Between Health Carrier and Providers/Intermediaries

As part of the processes considered in determining network adequacy, states should consider reviewing the contracts that carriers have with providers and intermediaries to create and maintain their provider networks. These reviews may entail new, additional filing and review responsibilities.

Section 6 of the NAIC Model sets forth requirements that a carrier must address in its contractual and other dealings with participating providers. These include the requirement of a "hold harmless" provision in the carrier's contract with providers to ensure that providers will not seek payment from enrollees if the carrier or intermediary should become insolvent or fail to pay the provider for any reason. This section also requires a continuation of care provision in the contract between the carrier and the participating provider. The contract provision must set forth the arrangements for continuing covered services to enrollees for a specified period if the health carrier or the intermediary should become insolvent or cease operations. States should note that for individuals who have exhausted the ACA's grace period for nonpayment of premiums, the final rules allow carriers to minimize costs on other consumers by paying, pending or denying a claim under certain circumstances. Specific to these circumstances it is important to note also that the NAIC Model's proposed contract provision allows a provider and an enrollee to agree to continue services solely at the expense of the enrollee.

Among the other provisions in Section 6 of the NAIC Model that the states, as part of their review, should consider having carriers include in their contracts are provisions:

1) Prohibiting providers from attempting, under any circumstances, to collect from an enrollee any money owed to the provider by the carrier.

2) Prohibiting carriers from using standards to select providers that would allow the carrier to avoid providers serving potentially high-risk populations.

3) Requiring carriers to make their provider selection standards available for review by the state insurance commissioner.

4) Prohibiting a carrier from penalizing a provider for reporting in good faith to state or federal authorities any act or practice by the carrier that jeopardizes patient welfare.

Although not expressly included in the NAIC Model, given the shared responsibility of providers to report timely to carriers of any changes in office locations, their capacity to no longer accept new patients and other pertinent information related to network adequacy, states may also want to permit carriers to include such reporting requirements in their provider contracts. States may also want to permit the inclusion of continuity of care commitments to accept plan payment for courses of treatment in process until completed if the provider leaves the network.

The NAIC Model defines an intermediary as "a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network." Section 7 of the NAIC Model sets out the contracting requirements between a carrier and intermediary. One important provision in that section is a requirement that intermediaries and participating providers comply with all of the NAIC Model's applicable requirements for the relationship between carriers and providers. Another important provision in this section of the NAIC Model specifies that the carrier retains the statutory responsibility for monitoring the provision of covered benefits to enrollees and that the carrier cannot assign or delegate that legal responsibility to the intermediary. Other provisions of this section establish record keeping and related requirements intended to ensure that the carrier and the state insurance commissioner have appropriate access to the books and records of intermediaries.

C. Review of Access Plans

Subsection A above outlines processes and standards for review of a carrier's network adequacy. Those regulatory processes are intended to incorporate the review criteria for purposes of this component of overall network adequacy. Incorporating the network adequacy review, as outlined in Subsection A above, within the access plan filing allows a panoramic view of the carrier's overall network adequacy. Those items in the access plan for review on an annual basis, at a minimum, should include the following:

i. Health carrier's network

While the access plan should have the provider network information, additional items should be reviewed in addition to the count of the number and type of providers in the network. Even where the network has sufficient numbers and types of providers overall, individual situations of a lack of network adequacy can occur. Those circumstances can include a hospital or other facility being in-network, but particular providers treating patients at those facilities being non-network (anesthesiologists, for example); the person's provider of choice leaving the network during the course of treatment or during

a period in which choice of primary care providers is not available; and geographic disparities in the availability of providers. Regulatory options for dealing with a lack of adequacy in these narrower circumstances may include in-network coinsurance and copayments and allowing for the provider to continue under the network contract for the course of treatment for affected enrollees.

ii. Provider network types

Determinations on network adequacy generally consider both the number of providers and specialties as well as the provider network types. HMOs may provide in-network-only coverage, except in the case of emergencies. PPOs may provide coverage for both in-network and out-of-network coverage, with the higher level of coverage provided when obtained in-network (or in the case of an emergency). Other network arrangements have evolved; for example, HMO issuers offering Point of Service (POS) plans that provide for coverage outside of the network, and PPOs offering Exclusive Provider Organizations (EPOs), which provide for in-network coverage only, except in the case of emergency.

Network adequacy determinations focus on an adequate number of network providers to address the health needs of the enrolled or prospective enrolled members. So in the case of HMOs, PPOs, POS plans and EPOs, the analysis is to ensure adequacy of those networks. When the plan includes one of those network types in a tiered network arrangement—and only if the same network providers are included—no additional network adequacy analysis should be required. If the tiered network contains different providers in each tier, then it is important that the network analysis focus on the preferred tier to ensure that there are a sufficient number of providers in the tiers to provide adequate access.

Tiered network arrangements may encourage enrollees to utilize the highest-tier providers for services or key services, such as "Centers of Excellence."

iii. Health carrier's procedure for making referrals

The NAIC Model contemplates a review of the carrier's procedures for both in-network and out-of-network referrals and stipulates that the review of the access plan should involve determining what processes and procedures are in place to carry out this requirement. It does not provide any specific standards as to what processes and procedures should be required. In order to determine whether the procedures are appropriate, it is necessary to understand the plan requirements for referrals. If, for example, a primary care provider referral is required, then the procedures that the enrollee must use to obtain the referral must be outlined. Likewise if there are differences in out-of-network and in-network referrals, those differences need to be specified. Finally, a review should identify how enrollees are notified of the referral requirements and a determination as to whether those methods of notification are adequate.

iv. Health carrier's process for monitoring and assuring ongoing network sufficiency

A health carrier's network is never static. In order to ensure it meets the minimum standards for network adequacy on a consistent basis, a carrier must maintain a system for monitoring its network and develop procedures to react to impending and existent changes in its network that impair adequacy. This would entail a regulatory review of the procedures for monitoring as well as what procedures are in place as to when and how to take corrective action as it applies to its network.

v. Health carrier's efforts to address enrollees with special needs

The NAIC Model requires as part of the access plan that the carrier develop a process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of the enrolled population. In addition to looking at the needs from an overall enrollee population standpoint, the access plan review should include a review of the carrier's efforts to address the needs of those with limited English proficiency and literacy. This would of necessity include providing the services of professionals who can communicate to and for the enrollees with special needs. The review would involve determining what processes and procedures are in place for those with special needs and specificity as to what services are available to such enrollees.

vi. Health carrier's methods for assessing enrollee satisfaction

There are two common measures of assessing enrollee satisfaction with their plan—enrollee complaints and enrollee satisfaction surveys. The review should entail a determination as to how the carrier reviews and maintains enrollee complaints and how it uses this information to measure satisfaction. In addition to determining if and how often a carrier

© 2012 National Association of Insurance Commissioners

surveys satisfaction and how it uses the results to determine enrollee satisfaction, the regulatory review might include an examination of the survey document and the survey results.

vii. Health carrier's method for informing enrollees of plan features

Section 5 the NAIC Model contemplates the following as it relates to methods of informing covered persons:

> *"The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care."*

Therefore, not only must there be the existence of a grievance system, processes for changing providers and approval of emergency and specialty care, but there must also be a review of how the carrier notifies enrollees of those features. At a minimum, the existence of the right to file a grievance, change providers in certain circumstances, and when and how emergency or specialty care may be accessed should be incorporated into the carrier's policy form. Additional information relating to these processes should be available upon request and accessible via the carrier's website.

Although not in the NAIC Model, but required under the Exchange final rules in45 CFR §156.230(b), QHP issuers must make their provider directories for a QHP available to the Exchange for publication online and to potential enrollees in hard copy upon request. The provider directory must also specifically identify those participating providers not accepting new patients. States should ensure compliance with these requirements as part of their review. States may consider relying on standards set by national accreditation entities, such as NCQA[12] and URAC,[13] for addressing provider directory information in the Exchange. In addition, for compliance with this requirement and the requirement under 45 CFR §155.205(b)(1)(viii) that the provider directory be made available to the Exchange as part of the comparative standardized information on each available QHP required to be on an Exchange website, the states may want to consider providing a direct link on the Exchange website to the QHP issuer's provider directory.

viii. Health carrier's system for ensuring coordination and continuity of care

One aspect of coordination and continuity of care that presents unique challenges in the Exchange environment is the transition between Medicaid and QHPs. Due to Medicaid eligibility guidelines, certain enrollees will frequently be in a transition mode between the two types of coverage. The provider of choice that the enrollee sought care from while on Medicaid may or may not be part of a QHP carrier's network. If not a part of the QHP network, enrollees who are in the course of treatment are especially vulnerable when considering what level and type of coordination and continuity of care should be utilized. Strategies designed to minimize disruptions in the care provided to such enrollees are critical to enhancing the quality of care intended for coverage in the Exchange. Strategies may include requiring in-network benefits while a new enrollee is in the course of treatment and a limited based network agreement for treatment of specified enrollees.

ix. Health carrier's procedure enabling enrollees to change primary care providers

One of the challenges for enrollees is the protean nature of provider networks. Their provider of choice may for various reasons leave the network. Furthermore, an enrollee's provider preference may change over time. If the carrier's plan requires use of a primary care provider as a gatekeeper, then allowing enrollees to switch primary care providers is an important provision in any network arrangement.

In the access plan filing, a review of the carrier's procedures relating to changing primary care providers is normally within the scope of review. The NAIC Model includes a general provision requiring carriers to disclose their process for enabling enrollees to change primary care providers, but does not specify what procedures would be acceptable. At a minimum, in

[12] For more information about NCQA's health plan accreditation standards related to network adequacy, please see its website at: www.ncqa.org.

[13] For more information about URAC's health plan accreditation standards related to network adequacy, please see its website at: www.urac.org.

implementing this standard, states may want to considering applying a reasonableness test to determine if the procedures are designed to allow enrollees to switch based upon designated circumstances (such as a provider leaving the network) or at designated time intervals (such as annually upon open enrollment). States also may want to consider conducting a regulatory review of consumer complaints and consumer satisfaction surveys to help determine if the process is, in practice, performing as outlined in the procedures.

x. Health carrier's plan for providing continuity of care in the event of provider contract termination

Continuity of care, depending upon the nature of the care needed, may be critical for an enrollee's health. Provider disruption can also be very problematic when the course of treatment does not involve an immediate life threatening situation but involves very strong enrollee provider preference, such as pregnancy.

At a minimum, a carrier must provide notice to enrollees of provider terminations. In addition, specific regulatory standards may be appropriate to allow for the enrollee to continue care with the provider for a specified period of time, such as 90 days, with the applicable provisions of the terminated provider contract applying to care for the affected enrollee. Another option would be to allow the enrollee in the case of pregnancy to continue treatment through postpartum care with the provider once a certain stage of the pregnancy has been reached, such as the second trimester.

The access plan review would take into account specific standards required for continuity of care and review the carrier's plan to determine if it is reasonably designed to meet those standards for continuity of care.

D. Enforcement

There are multiple regulatory responses, as outlined in the NAIC *Market Regulation Handbook*, available to regulators when identifying compliance issues associated with network adequacy. The regulatory response chosen may vary depending upon the severity and nature of the problem, the preferred regulatory strategy or strategies of the state, and the nature of the state's health care delivery system. No one response will necessarily fit every state or fit a particular state for all circumstances. This multivariate approach is contemplated by the general nature of the enforcement section of the NAIC Model. Specifically, Section 10 of the model includes the following: "The commissioner may institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act." Therefore, each of the following approaches or methods should be not be viewed as separate and distinct alternatives for a state to adopt to the exclusion of other options, but rather a list of regulatory options available depending upon the facts and circumstances of each particular situation.

i. Notice and an opportunity to correct

A lack of network adequacy can in some circumstances be correctable. There may be additional providers that can be added to the network to provide the desired level or type of provider availability to enrollees. This method would typically involve a regulatory notice, either formal or informal, to the carrier specifying how the carrier's network is inadequate and request that the carrier take appropriate remedial steps. That notice could contain a timeline for bringing the network's adequacy into compliance.

ii. Restricting the carrier's service area

This approach may be appropriate in circumstances where notice and opportunity to correct has not brought about the desired level of network adequacy, or where a review of the availability of providers in the area in question may make a viable network unworkable in a particular area. This approach is prospective and would specify that the carrier would not be able to continue to sell the network product(s) in question in the areas where the network is no longer determined to be adequate. Depending upon the nature of the state's authority, this could be accomplished by a notice of withdrawal of approval of the network in part or in whole or it could involve a hearing process under the state's administrative procedures act.

iii. Requiring in-network benefits

For particular areas or for particular types of providers where the network is inadequate, the state's regulatory response may be that the carrier is required to base an enrollee's responsibility for any coinsurance, deductibles or copayments related to such treatment on in-network benefits. This may be an appropriate regulatory response in instances where particular types of providers are unavailable due to either inadequate numbers of providers accepting patients or an unwillingness to contract.

iv. Disapproval of policy forms containing the inadequate network

If a carrier's network proves to be inadequate on a state-wide basis, an option may be to withdraw approval or disapprove the carrier's network policy forms, effectively precluding the sale of new policies.

v. Formal administrative penalties

There may be more acute problems related to network adequacy, such as intentional violations or a pattern and practice of noncompliance. In such circumstances, a state may wish to initiate more formal administrative action. Many states have authority to issue temporary cease and desist orders. If the actions of the carrier are particularly egregious, a state may wish to consider whether the action in question warrants a monetary penalty or even revocation or suspension of the carrier's license.

V. Conclusion

As noted in this white paper, the Exchange final rules provide the states with considerable flexibility in fashioning network adequacy standards for QHP certification, whether a state decides to establish an SBE or enter into a Partnership Exchange with HHS to carry out the plan management functions in a FFE. This white paper provides a framework that the states may consider in fashioning their network adequacy standards and in developing procedures and processes for implementing those standards.

© 2012 National Association of Insurance Commissioners

APPENDIX A

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

****

(c) Responsibilities of the Secretary-

(1) IN GENERAL- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum--

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION- Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

****

APPENDIX B

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

Subpart C – Qualified Health Plan Minimum Certification Standards

*****

§156.230 Network adequacy standards.

(a) General requirement. A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards –

(1) Includes essential community providers in accordance with §156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) Access to provider directory. A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

§156.235 Essential community providers.

(a) General requirement. (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act[14]; and

[14]Section 340B(a)(4) of the PHSA (Prescription Drug Pricing program, which provides drugs at deeply discounted prices to certain health care providers) defines those entities qualified to receive discounted drugs, which includes federally-qualified health centers, family planning projects receiving grant funds under Title X of the PHSA, Ryan White Care Act providers furnishing HIV/AIDS services, state AIDS drug purchasing assistance (ADAP) programs, black lung clinics, hemophilia diagnostic treatment centers, urban Indian health clinics, Native Hawaiian Health Centers, STC and tuberculosis treatment clinics, public hospitals receiving disproportionate share adjustment payments under Medicare, children's hospitals, critical

(2) Providers described in section 1927(c)(1)(D)(i)(IV)[15] of the Act as set forth by section 221 of Pub. L. 111-8.

(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) Payment of federally-qualified health centers. If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

****

access hospitals, and rural referral centers and sole community hospitals meeting disproportionate share adjustment payment thresholds. See 42 USC §256(a)(4): www.law.cornell.edu/uscode/text/42/256b.

[15]See 42 USC §1396r-8 – Payment for covered outpatient drugs: www.law.cornell.edu/uscode/text/42/1396r-8.

Appendix C

COMPARISON OF

NAIC MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT AND EXCHANGE ESTABLISHMENT FINAL RULE

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
Section 4. Applicability and Scope	**Subpart C – Qualified Health Plan Minimum Certification Standards**
This Act applies to all health carriers that offer managed care plans. The term "managed care plan" is defined broadly in section 3O to mean a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. As defined, a "managed care plan" would include HMOs as well as PPOs.	Applies to qualified health plans (QHPs).
Section 5. Network Adequacy	**§ 156.230 Network Adequacy standards.**
	(a) A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards –
No equivalent provision.	(1) Includes essential community providers in accordance with § 156.235.
A. A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services covered persons will be accessible without unreasonably delay. For emergency services, covered persons shall have access 24/7. Sufficiency shall be determined in accordance with this section, and may be established by reference by any reasonable criteria used by the carrier, including: provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technology advanced or specialty care. (1) In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the	(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
commissioner. (2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration. (3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons.	
N/A	(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.
B. Access plan. A health carrier shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the managed care plans that the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following: (1) The health carrier's network; (2) The health carrier's procedures for making referrals within and outside its network; (3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans; (4) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities; (5) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services; (6) The health carrier's method of informing covered persons	No equivalent provision

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care; (7) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning; (8) The health carrier's process for enabling covered persons to change primary care professionals; (9) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and (10) Any other information required by the commissioner to determine compliance with the provisions of this Act.	
No equivalent provision.	(b) A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP must identify providers that are not accepting new patients.
	§ 156.235 Essential community providers.
No equivalent provision.	(a) (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. (2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section. (3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.
No equivalent provision.	(b) Alternate standard. A QHP issuer described in

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
	paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.
No equivalent provision.	(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law: (1) Health care providers defined in section 340B(a)(4) of the PHS Act; and (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111-8.
No equivalent provision.	(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.
No equivalent provision.	(e) Payment of federally-qualified health centers. If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.
Section 6. Requirements for Health Carriers and Participating Providers	No equivalent provision
A health carrier offering a managed care plan shall satisfy all the requirements contained in this section.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services. B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary. D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section. E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier. F. (1) Health carrier selection standards for participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act]. Selection criteria shall not be established in a manner: (a) That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization. G. A health carrier shall make its selection standards for participating providers available for review by the commissioner. H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs. I. A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to a covered person. J. A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier. K. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records. L. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of a termination within fifteen (15) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier. N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions. O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services. P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare. Q. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier. R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier. S. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this Act.	
Section 7. Intermediaries	No equivalent provision.
This section describes the requirements that must be contained in a contract between a health carrier and an intermediary. The term "intermediary" is defined in section 3N to mean a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
Section 8. Filing Requirements and State Administration	No equivalent provision.
A. A health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries. B. A health carrier shall submit material changes to a contract that would affect a provision required by this statute or implementing regulations to the commissioner for approval [cite period of time in the form approval statute] days prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection. C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved. D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.	
Section 9. Contracting	No equivalent provision.
A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations. B. All contracts shall be in writing and subject to review. C. All contracts shall comply with applicable requirements of the law and applicable regulations.	
Section 10. Enforcement	No equivalent provision.
A. If the commissioner determines that a health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner may institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	***ACA Establishment of Exchanges and Qualified Health Plans Final Rule***
B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination.	

W:\National Meetings\Summer\2012\Cmte\B\Network Adequacy White Paper Adopted by B Committee 6-27-12 Final.docx

© 2012 National Association of Insurance Commissioners

Draft: 6/27/12
As adopted by the Health Insurance and Managed Care (B) Committee, 6/27/12

Exchanges Plan Management Function: Accreditation and Quality White Paper

1. Introduction

The federal Patient Protection and Affordable Care Act (ACA) provides for the establishment of American Health Benefit Exchanges (Exchanges).[1] An Exchange must offer only qualified health plans (QHPs) certified by the Exchange to qualified individuals and qualified employers. To participate in an Exchange, QHPs are required to meet accreditation standards and must implement a quality improvement strategy. The ACA addresses the obligations of the Secretary of the U.S. Department of Health and Human Services (HHS), the Exchange, the state, the issuer and the QHP itself.

As part of a national quality strategy, Exchanges will have a significant role in: 1) ensuring that QHPs become accredited and implement quality improvement strategies; 2) providing plan ratings based on quality and cost; and 3) providing patient satisfaction data. The purposes of these requirements are to improve the quality of health care, ensure that QHPs are focused on promoting quality improvement, and improve transparency so that consumers can compare plans based on quality as well as price.

This paper is intended to be a resource to help the states understand the obligations of the Exchange with regard to accreditation and quality. The paper also addresses situations where the states have options, including situations where options may exist but federal guidance on specifics is not yet available.

2. Summary of Federal Requirements

The ACA quality and accreditation requirements are excerpted at the end of this paper for easy reference. Federal law obligates the Exchange to be responsible for certain quality and accreditation elements. The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes. The Exchange website must provide standardized comparative information on each QHP, including quality ratings and results of enrollee surveys.

QHP issuers must be accredited by an accrediting entity that meets HHS standards and reflects a variety of quality parameters, such as clinical quality, access and satisfaction, among others. A QHP issuer must receive such accreditation within a time period established by an Exchange, if not already accredited. A QHP issuer must adopt a quality improvement strategy that incorporates increased reimbursement or other incentives for improved health outcomes, prevention of hospital readmissions, improved patient safety, reduced medical errors, wellness and reduced healthcare disparities. An accredited QHP issuer is required to authorize its accrediting entity to share information with HHS and the Exchange. An accredited QHP issuer must maintain its accreditation for as long as it offers QHPs on the Exchange.

3. Accreditation Requirements

a. Requirement to Oversee Assessment of Health Care Quality and Outcomes

An Exchange must oversee assessment of health care quality and health outcomes. This requirement is at least in part fulfilled by ensuring that QHPs are accredited. Accreditation is an obligation of the QHP issuer.[2] If the QHP issuer does not become accredited within the specific time frame or the QHP issuer does not remain accredited, the QHP will not be certified. An issuer that is not accredited by a recognized accrediting entity on the basis of local performance of its QHP will not be certified to sell coverage through the Exchanges. Exchanges are obligated to oversee this assessment of health care quality and outcomes.[3]

[1] Pub. L. 111-148, as amended by Pub. L. 111-152.
[2] ACA, Section 1311(c)(1)(D)(i).
[3] 45 CFR §155.200(d). "The Exchange must…oversee implementation of…"assessment and ratings of health care quality and outcomes in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act."

© 2012 National Association of Insurance Commissioners

The ACA does not name a specific accrediting entity, but requires that the accreditation must be awarded by an organization that is formally recognized by HHS. There are currently two nationally recognized organizations, the National Committee for Quality Assurance (NCQA) and URAC, which have evolved over the past 20 years for the express purpose of accrediting health plans.[4] The Accreditation Association for Ambulatory Health Care (AAAHC) is another organization that has focused primarily on accrediting ambulatory care facilities, but also has more than 30 years of experience with accrediting health plans and is recognized by U.S. Centers for Medicare & Medicaid Services (CMS) as a deemed accrediting organization for Medicare Advantage plans.[5] As of the drafting date of this paper, other accrediting entities have not been recognized by HHS or made themselves known to state insurance regulators.

On June 5, 2012, HHS published a proposed rule on recognition of entities for the accreditation of QHPs.[6] This paper references information from the proposed rule in order to provide the most current regulatory guidance. However, the states should be aware that the final rules may include substantial changes from the proposed regulations. On May 16, 2012, HHS issued guidance on federally facilitated Exchanges. State insurance regulators should also be aware that HHS has welcomed comments on this guidance and intends to issue subsequent guidance with additional policy and operational details.

In the proposed rule, HHS announced a two-step process for recognizing accrediting entities. In phase one, HHS proposes to recognize NCQA and URAC on an interim basis, subject to certain conditions.[7] In phase two, HHS intends to establish an application procedure, standards for recognition, a criteria-based review of applications, public participation, and public notice of the recognition for entities seeking to become a recognized accrediting entity.[8] If an accrediting entity is not included in the final regulation on recognition of accrediting entities, it is anticipated that they would need to go through the federal recognition process described in the phase two process.

The states may wish to consider whether there is a role for state recognition of accrediting organizations. Although HHS intends that, for purposes of certification as a QHP, accreditation must be made by an HHS-recognized entity. However, it is unclear whether there could also be some type of role for state recognition. Allowing federal and state recognition under uniform federal standards may be a desirable way to balance the goals of ensuring that all accrediting entities meet the same standards, while also allowing state flexibility to recognize accrediting entities that may be state-specific or otherwise better suited to state, rather than national, recognition. This could potentially serve the goal of giving issuers more choices in accrediting entities and preserve the role of the states in selecting accrediting entities.

The ACA does not preclude the possibility of the recognition of organizations other than NCQA and URAC, including AAAHC, state-recognized entities or state-specific organizations to fulfill the accreditation purposes. It appears possible that a state could have a unique state-specific accreditation body that could seek HHS or state recognition.

In order to earn accreditation from an HHS recognized accrediting entity, a QHP issuer is evaluated in a review that includes quality improvement activities, credentialing of providers, network adequacy standards, utilization management practices, providing information to consumers, enrollee satisfaction surveys, and assessment and ratings of health care quality and outcomes. Accrediting entities typically evaluate health plans in an initial application process, an ongoing oversight process, and a recertification process.

In overseeing this process, State-Based Exchanges (SBEs) could consider adopting a similar approach as HHS in allowing a choice of qualified accreditation entities, including those designated now and in the future by CMS. Such an approach would allow QHP issuers flexibility to choose an accreditation entity that best meets their needs and could reduce costs for issuers because there would be competition between accreditors. Numerous states now recognize multiple accreditors through their health and insurance department regulations. Alternatively, the states may want to consider whether it would be permissible for the states to choose one accreditation program, as a number of the states do for their Medicaid programs. If permissible, this could allow for consistency in evaluation, quality measure collection and approach to scoring plans. It should be noted, however, that the states are able to require uniform measure sets, even if multiple accrediting bodies are operating in a state.

[4] For more information about the history and activity of each of these organizations, visit *www.ncqa.org* and *www.urac.org*.
[5] For more information about the history and activity of the AAAHC, visit *www.aaahc.org*.
[6] Proposed Rule, 77 Fed. Reg. 33133 (June 5, 2012).
[7] The conditions are specified in §156.275(c)(2)–(4) of the Proposed Rule on Recognition of Entities. The Proposed Rule noted that NCQA meets, and URAC is planning to meet, these conditions.
[8] This future rulemaking will be 45 CFR §156.275(c)(1)(ii).

© 2012 National Association of Insurance Commissioners

Additionally, there are objections that limiting a QHP's choice of accreditors would be costly to issuers, particularly for those that would be forced to seek re-accreditation by a different entity.

A key question to be addressed is how well current accreditation processes fulfill ACA requirements. Both NCQA and URAC have provided crosswalk materials outlining where their specific accreditation standards correlate to ACA requirements. Similar crosswalk information is available from AAAHC. The states may wish to consider an arrangement where accreditation by one or more of the national organizations will be presumed to show compliance with additional QHP requirements beyond the baseline requirement that all QHPs be accredited. However, in allowing this presumption, the states should not cede regulatory authority, so they can take action if they determine that additional oversight is required.

Although the ACA requires an Exchange to address certain quality-related issues (including evaluating quality improvement strategies, overseeing implementation of enrollee satisfaction, assessments, comparative ratings and outcomes), there may be an opportunity to realize considerable administrative savings, as well as valuable consumer protection, by deferring to the accrediting entities that already address these dimensions as part of their accreditation programs, and have decades of experience, as well. Accreditors report that currently as many as 41 states have some level of accreditor recognition. State certification of accrediting entities, if utilized, should be limited, however, to the state in which it is granted.

Exchanges should also align and prepare to be able to receive and evaluate the data that would be necessary to fulfill accrediting and quality obligations (as established by future guidance on quality reporting by HHS). Accreditation is a tool for regulators and purchasers that does not serve as a replacement for regulatory oversight, but is a complement to state regulatory review. It offers an objective evaluation of critical quality activities (e.g., quality improvement, credentialing or provider directories) not currently included in a state's plan audit processes. For areas where accreditation overlaps with existing state requirements (e.g., utilization management/review) the review can help Exchanges and their state regulatory partners in the assessment of initial and ongoing qualification.

Those states that decide to use the results of accreditation to satisfy some state or federal requirements may wish to be careful to ensure that QHP certification processes do not duplicate the activities of accrediting entities or establish differing regulatory requirements, which could add to administrative costs. The states should consider the extent to which data submitted on the accreditation survey may be used to fulfill other quality reporting standards, and it is anticipated that HHS will issue future guidance to establish when accreditation can fulfill federal quality reporting requirements.

b. Quality Reporting Requirements of QHP Issuers

While quality reporting requirements for QHP issuers and Exchanges will be the subject of future federal rulemaking, HHS has indicated support for an approach that allows for harmonization of measures across programs. In guidance on federally facilitates Exchanges, HHS stated that they intend "…to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the Public Health Service Act (PHSA)), and quality reporting requirements under Medicare and Medicaid."

In the interim, the ACA and the final Exchange rule require that QHP issuers must "be accredited on the basis of local performance by an accrediting entity" recognized by HHS in the following nine categories:

(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set [HEDIS].
(ii) Patient experience ratings on a standardized CAHPS survey.
(iii) Consumer access.
(iv) Utilization management.
(v) Quality assurance.
(vi) Provider credentialing.
(vii) Complaints and appeals.
(viii) Network adequacy and access.
(ix) Patient information programs.

Accreditation programs must include clinical quality measures. In recent proposed rules, CMS put forward the following criteria that clinical measures must meet to satisfy the accreditation clinical quality measure requirement.

- Span a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care and acute care.

- Include measures that are applicable to adults and separate measures that are applicable to children.
- Align with the priorities of the National Strategy for Quality Improvement in Health Care.
- Only include measures that are either developed or adopted by a voluntary consensus standards-setting body (such as those described in the National Technology and Transfer Advancement of Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A-119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards.
- Be evidence based.

While the clinical quality measures for NCQA and URAC have similarities and differences, both have undergone initial review by the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) and, thus far, it appears that they will meet HHS requirements. Prior to issuing this proposed rule and identifying NCQA and URAC for potential recognition, CCIIO has worked to become fully aware of the current standards and clinical quality measures employed by both NCQA and URAC. A final review and approval of both URAC's and NCQA's programs, including measures, will be performed by HHS prior to announcing formal recognition in a final rule to be published in the *Federal Register*.

The following chart summarizes the measure set domains for the two accrediting entities, NCQA and URAC, which were named in the proposed rule.

URAC Measures	**NCQA (HEDIS®[9]) Measures**
• Patient centeredness • Coordination of care • Care efficiency • Effectiveness of care • Patient safety • Health plan management and administration • Systemness or health information technology integration • Health care disparities	Measures scored in accreditation: • Prevention and screening • Respiratory conditions • Cardiovascular conditions • Diabetes • Musculoskeletal conditions • Behavioral health

Detailed clinical quality measure sets for both URAC and NCQA are available at their respective websites: *www.ncqa.org* and *www.urac.org*. In addition, information about the AAAHC quality measure sets can be obtained by contacting AAAHC at *info@aaahc.org*.

It should also be noted that, while NCQA has developed and maintained the HEDIS measure set, URAC's program can also accept HEDIS measures for issuers already using that system of reporting. NCQA also can collect and audit non-HEDIS quality measures.

Under the ACA, the states may require quality measures in addition to those required by the accrediting entities. URAC's program allows for the states to supplement its requirements in this manner. The states may also be interesting in asking plans to address certain state-specific data that is not included in reports from accreditors. For example, those states with a significant mining industry may ask health plans in that state to report data and improve the quality of health care services related to illnesses and injuries associated with mining activities. However, the states should consider balancing the imposition of any new quality measures with increased compliance costs, and consider that federal standards will be established in this future.

c. Sharing of Accreditation Information on QHP Issuers with Exchanges

45 CFR §156.275(a)(2) requires QHP issuers to "authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, **together with any survey related information that HHS may require** [emphasis added], such as corrective action plans and summaries of findings." NCQA provides the states with quality measure results. On the other hand, URAC routinely provides the states with a copy of the accreditation summary report, and gives them an opportunity to receive additional information. The accrediting entities recognize that the

[9] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

© 2012 National Association of Insurance Commissioners

ACA requires an increased level of information-sharing than has occurred in the past, and goes beyond what the accrediting entities currently make publicly available.

In their proposed rule, HHS proposes that, when authorized by an accredited QHP issuer, the accreditation entities provide certain data elements to the Exchange during the annual certification period or as changes occur to the data throughout the coverage year. These data elements include: name, address, Health Insurance Oversight System (HIOS) issuer identifier, unique accreditation identifier(s) of the QHP issuer and its accredited product(s) and type(s) that have been released. In addition, for each accredited product type: the HIOS product identifier; accreditation status, survey, type or level; accreditation score; expiration date of accreditation; and clinical quality measure results and CAHPS measure survey results (for example, QHP product or plan level).[10]

The accrediting entities have expressed interest in working with the federal government, the NAIC and state Exchanges to provide necessary plan accreditation information with the QHP issuer's authorization. In doing so, it is anticipated that the accrediting entities will put in place any necessary data agreements before sharing the information.[11] The proposed rule also provides that Exchanges will be permitted to enter into these types of data-sharing agreements if they choose to require additional information, and asks for additional comment on whether accrediting entities should be required to provide this additional information upon request from an Exchange.

At a minimum, state insurance regulators should receive sufficient information to ensure ACA compliance.

Even if an Exchange is able to use the results of accreditation to satisfy some of the oversight requirements, the Exchange should arrange to have access to the data sets that are collected for accreditation purposes. In doing so, Exchanges should ensure the protection of confidential or proprietary data.

The states should also consider which state agency is appropriate to receive such information, because it might not always be the state insurance department. State insurance regulators are likely already familiar with the NAIC's System for Electronic Rate and Form Filing (SERFF). The NAIC is currently in ongoing discussions with NCQA and URAC regarding SERFF's role as a data conduit in order to present data in a way that is helpful for state review. Those states in full federally facilitated Exchanges may also utilize the HIOS for data exchange. The NAIC's Market Conduct Annual Statement (MCAS) may also be a potential data-sharing platform in the future if large data sets are involved. However, because MCAS is not currently used for health insurance, the development and refinement of a health application for MCAS could be a lengthy endeavor.

Both SERFF and MCAS are tools well known to state insurance regulators, but for those states where the Exchange is not overseen by the insurance department, or in those states where there is a federally facilitated Exchange, these platforms might not be the obvious first choice of the Exchange. HHS has a growing familiarity with SERFF, although state Medicaid and public health agencies are unlikely to be familiar with SERFF. The states may wish to consider the use of these platforms as a means to harmonize with overlapping insurance department and Exchange activities.

d. Requirement to Establish Time Frames for Accreditation

For QHP issuers that are not already accredited, Exchanges are required to establish a uniform period following certification of a QHP within which the issuer must become accredited.[12] The accreditation requirement depends on the timeline set by an Exchange.

In determining a time frame to achieve accreditation, state insurance regulators should be aware of the reasons that some health plans are not currently accredited. Accreditation has traditionally been driven by public and private purchasers requiring accreditation of plans in order for plans to participate in the market, for plans to receive preferential contracts and to provide or supplement oversight. Prior to enactment of the ACA, some plans decided not to pursue accreditation due to cost. State or regional provider-sponsored plans are less likely to have the preferential contract opportunities or market incentives to dedicate resources to earning formal accreditation. These plans may be aware of accreditation evaluation standards and

[10] Proposed Rule on Recognition of Entities, §156.275(c)(5).
[11] The type of data agreement may vary depending on the use of the information. For example, if a state Exchange intends to publicly report information from an accreditation review, a different data agreement may be needed than if a state were intending to use the information solely for QHP certification purposes.
[12] 45 CFR §155.1045.

© 2012 National Association of Insurance Commissioners

measures, and strive to comport themselves following those standards, although it is not possible to determine whether the non-accredited plans are, in fact, meeting industry standards and measures and monitoring quality.

The states may wish to analyze the status of their non-accredited issuers to determine if sufficient criteria exist (based on the plan's documented efforts to operate like an accredited plan) to provide some kind of monetary or technical assistance for those plans to get them to formal accreditation. This may be an especially important consideration for the new Consumer Operated and Oriented Plans (CO-OPs), which have no previous experience operating as a health plan, let alone an accredited health plan.[13] It is reasonable that the states may be concerned about providing assistance to such smaller and newer plans. However, more established insurers that are already accredited and issuers currently undergoing the accreditation process may have objections to the competitive disadvantage posed by assistance to newer and smaller issuers. In addition, state Exchanges should carefully consider, if such an issuer does not have the resources to complete initial accreditation, whether they would have difficulty funding the ongoing costs of maintaining the operational infrastructure to meet the accreditation standards and cost of renewal accreditation fees. In addition, Exchanges may want to weigh this expense against other more pressing needs, given scarce resources.

The accrediting entities are also aware of the challenges facing new plans, such as the CO-OPs, and plans that are not currently accredited but are interested in pursuing accreditation. New issuers will not have a history of complex case management files that can be reviewed or a history of claims that can be used to report clinical quality measures. All three known accrediting entities (NCQA, URAC and AAAHC) have provisional or interim accreditation programs to accommodate these types of situations.[14] It is also anticipated that accreditation standards for multi-state plans, including an accreditation timeline, will be included in future federal rules for multi-state plans.

In guidance on federally facilitated Exchanges, HHS announced accreditation requirements for QHP issuers. In coverage years 2014 and 2015, a QHP issuer will receive an interim accreditation that reflects policies and procedures, not performance. If a QHP issuer has an existing health plan accreditation on a commercial line of business in the same state as the Exchange, and only one product type is accredited (e.g., commercial HMO), that accreditation will apply to all Exchange product types (HMO, PPO, POS) if the policies and procedures that were accredited for the commercial HMO are the same across all product types. If a QHP issuer has no existing accreditation, then the QHP issuer will need to get an interim accreditation in 2014 and 2015. This timeline will also be enforced in Exchange Partnership states.

The guidance also indicates the federally facilitated Exchange will accept NCQA or URAC accreditation of a commercial or Medicaid QHP in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification. This approach is designed to accommodate the needs of new entrants and Medicaid QHPs seeking certification as a QHP.

In establishing a timeline or grace period, the states should be aware that the accrediting entities have indicated that the typical accreditation process for a previously unaccredited issuer takes an average of 18 months to prepare and an additional three months for the accreditor review process. For issuers not already accredited, the January 1, 2014, time frame is achievable because URAC and NCQA both offer provisional or interim accreditation that could be granted in that time frame. However, issuers not currently accredited do not necessarily need to achieve accreditation by January 1, 2014.

As of the date of this paper, several of the states have already established Exchanges, and have had varying experience in establishing time frames for accreditation. For example, the Arizona Health Insurance Exchange allows issuers to have one year from the date of application to sell a product in their Exchange to demonstrate accredited status. Arizona's decision was

[13] 45 CFR §156.515(c)(2) states: "Loan recipients must offer a CO-OP qualified health plan … in every individual market Exchange ... If offering at least one plan in the small group market, loan recipients must offer a CO-OP qualified health plan in each SHOP ..."

[14] URAC grants provisional accreditation if the plan meets standards for policies and procedures, but does not yet have sufficient operational experience or consumer enrollment to receive full accreditation. Once the plan does have operational experience with enrolled consumers, URAC will conduct an on-site review to validate compliance with accreditation standards. NCQA has created interim and first accreditation programs for new or currently unaccredited issuers and will first review policies and procedures, then review plan files and performance once the plan builds a history of enrollment. AAAHC's Early Options Survey (EOS) program is for plans in operation for six months or less, and plans are granted accreditation but must then undergo an additional interim survey during the accreditation term.

based on informal work with health plans and consumer advocates and was informed by the fact that most non-accredited issuers were already well on their way toward accreditation.

The states also will need to determine the manner in which they establish the time frame, including whether it will require a rule or statute. Arizona simply published its decision. Exchanges in other states might find it necessary to establish the time frame in a more formal manner, such as via bulletin, regulation or statute.

The states may also need to consider what will occur if an issuer attempts but fails to achieve accreditation by the expiration of the required time frame. Historically, the formal accreditation process was sufficiently resource-intensive that issuers would not pursue accreditation if they were not reasonably confident they would succeed. Issuers may also have feared negative publicity resulting from an accreditation denial. URAC has corrective-action requirements for organizations undergoing accreditation review and NCQA provides feedback to plans on areas with poor performance and allows plans second review if plans are denied accreditation initially. There are some built-in measures to manage situations of denied accreditation; however, the states should consider ramifications if decertification is required. For example, if denied, an issuer can have an additional six months to correct its performance and then undergo an expedited review by the accreditor.

A related topic the states should consider is what types of consequences should result from decertifying a QHP due to failure to achieve accreditation within the specified time period. For example, while an individual may still have guaranteed renewability rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if their plan is decertified for failure to achieve accreditation, their plan would no longer be available on the Exchange. Similarly, issues surrounding state subsidies should be considered. If an enrolled individual's chosen plan is decertified, subsidies are not available outside the Exchange, even though HIPAA gives those individuals a right to guaranteed renewability. The states may also want to consider implications for small employers purchasing coverage in the Small Business Health Options Program (SHOP) Exchanges.

The states may wish to inquire with accrediting entities about timing based on the volume of issuers in their states that have approached them about accreditation since enactment of the ACA. In those states that currently have many of the plans accredited for other commercial, Medicaid or Medicare products, there will not be a large influx of plans, and the accrediting entities may perform a shorter and limited review of those plans that are currently accredited. State insurance regulators may also want to keep in mind that additional accreditation entities may seek to play a larger role in accreditation of issuers to meet demand and preserve competition (although under the proposed rule, only specific named accreditors will be recognized by HHS on an interim basis).

e. How Well Does Accreditation Line Up with Policy Forms?

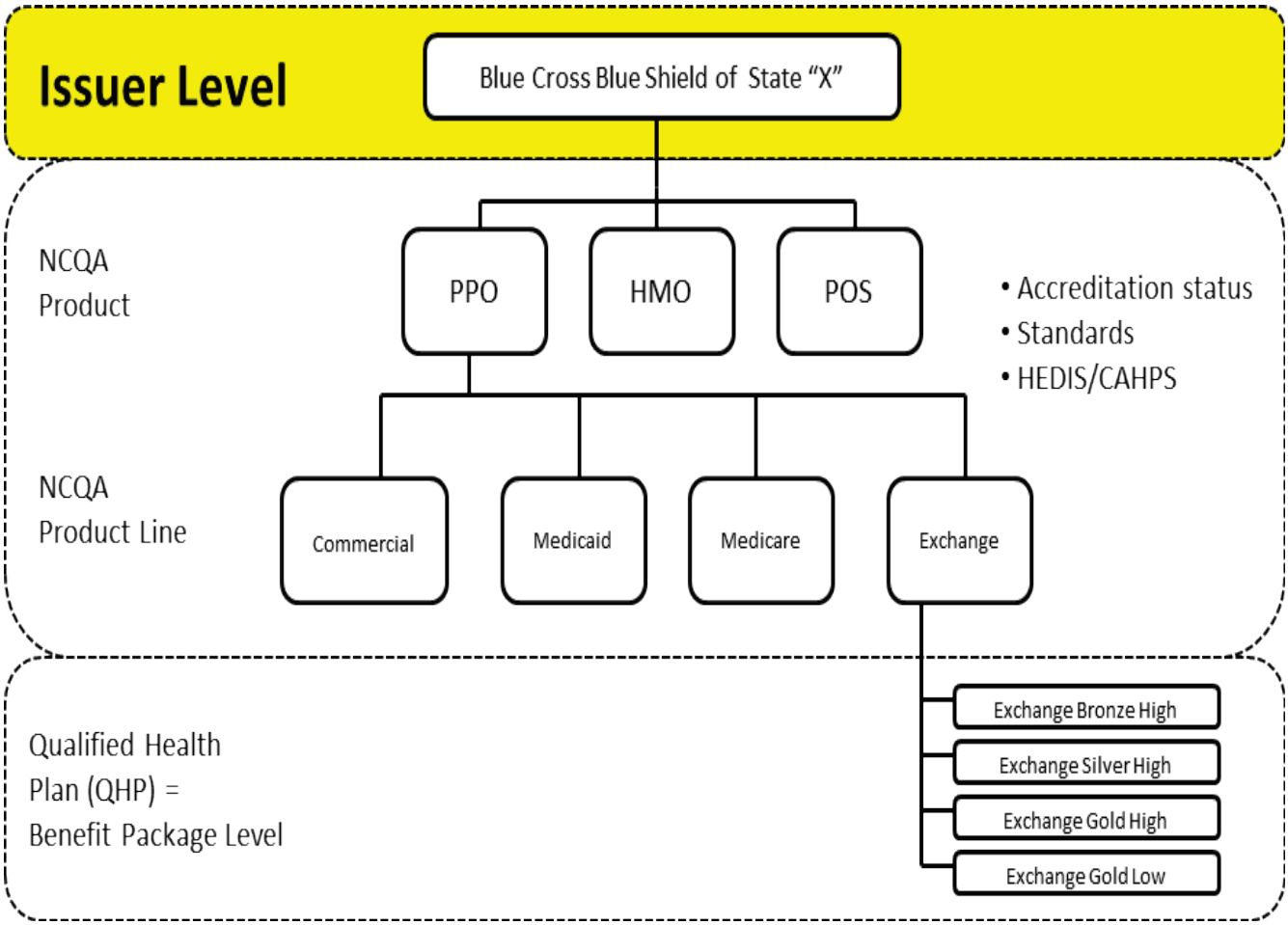
There is considerable confusion in the ACA, related to federal regulations and various external information sources in how the terms "plan" and "product" are defined and used. For state insurance regulators, there may not be much, if any, distinction for regulatory purposes between these terms. Existing federal laws — such as HIPAA, Mental Health Parity and Addiction Equity Act (MHPAEA) and ERISA, and now the ACA — attach different meanings to these terms. To complicate matters, URAC and NCQA accreditation status is awarded to entities that may or may not be recognizable to state insurance regulators. It is clear from materials available from URAC and NCQA that accreditation could be issued in a variety of ways: to an insurance company, a holding company, a single product or product line within a company but NOT the whole company, one geographic part of a company's total geographic territory, etc. Accrediting entities have expressed interest in working with the NAIC to match levels of accreditation to NAIC codes.

Currently, each URAC accreditation attaches directly to a state-licensed issuer and applies to all lines of the issuer's business in a given state (e.g., QHP, commercial, Medicaid). So, for example, in the case of a national insurer that operates QHP issuers in multiple states, a URAC accreditation certificate number is not issued to the parent company. Instead, each state-licensed QHP issuer operated by the parent company receives a separate on-site review by URAC and receives its own unique URAC accreditation certificate.

In conducting the on-site review, URAC verifies that the name of the legal entity seeking accreditation is directly matched to a state insurance license. URAC also conducts a review to ensure that each product offered by the issuer (e.g., HMO, PPO, POS) and every product line (QHP, commercial, Medicaid) meets URAC accreditation standards, as well as any state-specific requirements. When URAC issues an accreditation certificate, it is specific to a state-licensed issuer and the certificate lists each product and product line that is included in the accreditation. URAC has indicated that they could also

list on the certificate the state license identifier and NAIC code for the accredited entity. However, the states should verify that the accreditation achieved is the appropriate level for qualification for the Exchange.

The following chart, supplied by NCQA, demonstrates what level NCQA accreditation and quality data-collection occurs.



The challenge with this approach, for state insurance regulators, is that it does not resemble or correlate to state licensure, market regulation or solvency laws, which are the general parameters by which state insurance regulators recognize a "plan." For example, in many of the states, licensure as an insurance company precludes the sale of HMO products, and vice versa. Licensure as an HMO precludes the sale of insurance products. That is, there would not be one company delivering both PPO and HMO products under the same license. Therefore, the accreditation that NCQA's chart indicates actually would apply to at least two separately licensed entities in the eyes of the state insurance regulators. Yet only one accreditation has been awarded from NCQA.

In many cases, it may not be easy for the states to identify which insurance policies or products or plans line up with an accreditation and which ones do not. This is an area where SERFF might be useful. SERFF staff have worked closely with state and federal officials to adapt SERFF to meet new needs under the ACA. When making a policy form filing in the SERFF system for state-approval purposes, the SERFF system could be adapted to reflect whether the company proposes to use the form(s) in that filing in or out of the Exchange, or both, as well as the evidence of accreditation status necessary if the form is for purposes of supporting plans sold through the Exchange. If necessary, the states could establish state-specific submission requirements in SERFF, although doing so might create a lack of uniformity across the states.

© 2012 National Association of Insurance Commissioners

In their June 1, 2012, proposed rule, HHS proposed that accreditation should be done for each product type offered by a QHP issuer in each Exchange, based on data submitted by the issuer that is representative of the population of each QHP in that Exchange product type.[15]

Consumer groups note that QHP accreditation, rating and reporting should tied as closely as possible to the particular plan in which an individual is enrolling, in order to permit consumers to make plan comparisons based on quality and the most transparency. They oppose accreditation at the holding company level.

Both NCQA and URAC have demonstrated unhesitating willingness to work closely with state and federal regulators to ensure smooth implementation of the ACA requirements. This cautionary note is simply to advise state insurance regulators to pay close attention to the details of accreditation awards.

f. Dental Plans

Stand-alone dental plans offered in an Exchange are considered to be a type of QHP. These plans must meet consumer protection standards, such as offering benefits without annual and lifetime limits.[16] However, the federal rule recognizes the unique nature of stand-alone dental plans and permits Exchanges to establish standards that are specific to stand-alone dental plans. The final rule also establishes that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the plans covers only pediatric dental benefits. To the extent that accreditation standards specific to stand-alone dental plans do not exist, such plans would not have to meet the requirement that QHPs not already accredited must become accredited within the uniform period established by Exchanges.[17]

There are currently no accreditation standards specifically for dental plans. It does not appear that such standards are likely to be developed by the health plan accrediting entities specifically for dental plans. Dental plans believe, and urge, that accreditation standards should not be applicable to dental.

The states should be aware that URAC does currently accredit a few dental plans to varying degrees. URAC's accreditation is offered in modular format, for specified activities (such as utilization management, for example). These can be applied to a broad range of entities that perform utilization management, including dentistry. Therefore, some of URAC's accreditation awardees are dental plans that have earned accreditation in a module applicable to the business of operating a dental plan (such as utilization management). The states may wish to consider if a particular URAC module is reasonable to expect a certified dental plan to obtain. In considering this option, however, the states should keep in mind that extremely few dental plans have any accreditation, and that for pediatric-only dental plans, the costs and administrative burden of accreditation may outweigh any benefit.

g. CO-OPs

Neither the ACA nor federal regulations regarding CO-OPs provide an exception for CO-OPs in terms of obtaining accreditation for their QHPs, or for complying with quality reporting requirements. Because CO-OPs are intended to have no connection to any existing insurance plans, CO-OPs will, therefore, have no experience, no maturity with data-collection and reporting, and no statistically valid pool to sample, or from which to pull data. The federal regulations establish a phase-in time frame for new plans to earn accreditation. However, given CO-OPs' lack of claims experience, the application of the accreditation and quality requirements to CO-OPs will be particularly challenging. URAC's modular options for accreditation, as discussed above in relation to dental plans, may be a suitable and appropriate route for CO-OPs.

[15] 45 CFR §156.275(c)(2)(iii).
[16] 45 CFR §155.1065.
[17] Exchanges Final Rule, Provisions of the Proposed Regulation and Analysis and Response to Public Comments, p. 18412 describing §155.1065 and §155.1045.

4. Quality Elements in the Exchanges

The federal regulation requires Exchanges to evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures and data-reporting.[18]

a. Requirement to Evaluate Quality Improvement Strategies

The ACA requires QHP issuers to implement a quality improvement strategy. This is a requirement separate from the accreditation process. Exchanges are required to evaluate these quality improvement strategies.[19] As of the date of this paper, HHS has not issued additional guidance, although such guidance is anticipated. At present, this paper will assume that Exchanges will collect data from QHP issuers that shows health status and health outcomes.

HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that state-based Exchanges may adopt a similar approach prior to final regulatory standards. It is anticipated, for example, that HHS will propose that reporting requirements related to all QHP issuers will start in 2016. It is also anticipated that HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The QHP-specific quality rating would be available for display in 2016 open enrollment for the 2017 coverage year. In the interim, a federally facilitated Exchange will display existing CAHPS data that are available for the same QHP product types and adult/child populations from existing accreditation data.[20] Federally facilitated Exchanges will not display other data drawn from the accreditation data, such as clinical measures results.

HHS intends to engage in rulemaking for quality reporting and disclosure requirements for all Exchanges. HHS also intends to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, Section 2717 of the PHSA, and quality reporting requirements under Medicare and Medicaid).

The statutory language regarding quality improvement strategies refers to "market based incentives." These are defined as "increased reimbursement" or other incentives for specified outcomes or implementation of certain activities. Therefore, it appears that, at a minimum, "quality improvement" means more money for achieving outcomes or implementation activities. The use of the term "reimbursement" appears to assume the incentive is aimed at those who are reimbursed by health plans. In most cases, medical providers are reimbursed by health plans. It appears that the intent of the ACA is that QHP issuers will pay providers more if providers demonstrate achievement of desired outcomes. "Other incentives" can certainly mean almost anything, including, but not limited to, reduced out-of-pocket costs for health plan members.

Although accreditation programs could be used to demonstrate how plans are meeting quality improvement strategies, it is unclear, pending further federal guidance, whether accreditation will be considered sufficient to meet such quality improvement strategies. Both URAC's and NCQA's health plan accreditation programs include standards related to operation of an effective internal quality improvement program which, in part requires analyzing performance based on quality measures, and conducting corrective action and follow-up based on these findings.

Consumer groups suggest that the goal of establishing quality improvement strategies is to help provide incentives for providers to provide, and for consumers to choose, the highest quality, highest value health plans and providers. For providers, these may include incentives to implement patient-centered care initiatives that focus on improving health outcomes, preventing readmissions, improving care coordination, advancing patient safety, reducing medical errors and reducing disparities in care. For consumers, this would encourage the use of services and programs that improve health and may include the use of patient-centered tools designed to discourage utilization of expensive services that do not add value when good alternatives exist. QHPs may be able to demonstrate quality improvement strategies by making a commitment to higher reimbursement for primary care, increased access to primary care services, and adopting strategies toward achieving a coordinated, patient-centered, value-based delivery system.

[18] ACA, Section 1311(c)(1), 1311(c)(3) and 1311(c)(4).
[19] 45 CFR §155.200(d) states: "*Quality activities:* The Exchange must evaluate quality improvement strategies…in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act."
[20] For example, HMO Adult CAHPS results for HMO QHPs, or Child CAHPS results for child-only QHPs.

© 2012 National Association of Insurance Commissioners

The states may want to address state-specific health issues in their review of QHPs' quality improvement strategies, and to ensure that the strategies are consistent with the three-part aim identified in the National Quality Strategy: better care, healthy people and communities, and affordable care.[21]

Consumer groups have suggested that HHS establish a standardized set of metrics that the NAIC can adopt to ensure comparability across QHPs and state Exchanges. However, insurers have raised concerns that quality improvement strategies will not be comparable across plans because of population differences and socioeconomic factors and, therefore, would not be an accurate reflection of the effectiveness of such programs. One potential challenge to quality reporting in the Exchange relates to the expected influx of individuals who have not previously had access to coverage. These individuals will likely have unmet health needs that will affect initial efforts to improve quality. At least initially, measurements of quality improvement are expected to be unreliable as a significant volume of previously uninsured people are introduced into the system. Guidance related to federally facilitated Exchanges provides for a phase-in of quality reporting requirements to account for this initial instability.

In order to assist state Exchanges in evaluating quality improvement strategies, the states may also want to consider some potential tools such as SERFF, all-payer claims databases and MCAS (described earlier in this paper).

1. SERFF

SERFF is an NAIC-owned, Internet-based tool used by 49 states, the District of Columbia and Puerto Rico, as well as more than 3,400 insurers, for purposes of submitting, receiving, reviewing and approving insurance company product filings (e.g., rate, form, rule and advertising). The SERFF system has automated the historically manual, paper-intensive filing process. Today, it is estimated that more than 95% of all product filings travel through the SERFF system. NAIC SERFF staff have been actively working with state insurance regulators, insurers, the federal government and other third parties, such as URAC and NCQA, to explore adaptations that would support health plan management functions that the states may elect to perform in a health insurance Exchange, regardless of the Exchange model implemented (state-based, Partnership or federally facilitated exchange). State insurance regulators and the health insurance industry agree that they would benefit significantly in terms of administrative consistency and support if the SERFF system could be modified to support QHP issuer accreditation and quality improvement data. SERFF staff have already proven that they are willing and able to modify the SERFF system to support new functions related to the federal health insurance reforms in other areas, notably in support of health insurance rate review functions and data reporting to the federal government.

Current plans are under way to ensure that SERFF will serve a role in the new Exchange environment. Details related to the role of SERFF, as the primary plan management tool, have been evaluated. Phase 1 of this initiative was approved as part of the NAIC's 2012 budget process and Phase 2, while currently under way, will be formally approved in the upcoming 2013 budget process. Modifications to the SERFF system will be funded by the states through their federal grant funds, either for exchanges or rate review.

2. All-Payer Claims Databases

Some states have implemented an all-payer claims database (APCD) that could potentially be used to evaluate quality improvement strategies and oversee plan quality.[22] APCDs are enjoying some popularity among policymakers because of the potential to gather, control, analyze and manipulate a tremendous amount of public health information.

However, it is important to note that, thus far, APCDs are claims databases and do not collect information on quality initiatives or outcomes. For purposes of this paper, both the medical provider community and the health insurance industry have expressed significant concern with the state of development of APCDs and the use of APCDs in the 14 states that have enacted legislation to collect claim or remittance information.

To address some of the complex data challenges, the Accredited Standards Committee X12 and the APCD Council are currently attempting to develop a national standard (or standards) for reporting from APCDs. Though the X12 standards may clarify some reporting issues, these standards might not address other issues, such as inconsistent data definitions among payers, which is one of the major impediments to using APCDs' information for comparative quality reporting purposes. The

[21] For more information about the National Quality Strategy, visit *www.ahrq.gov/workingforquality/nqs*.
[22] More information about APCDs is available at *www.apcdcouncil.org* and *www.x12.org*.

technology is considered to be still under development and it may be many years before APCDs can be expected to serve a significant role in state health planning.

b. Requirement to Oversee Implementation of Enrollee Satisfaction Surveys

It is anticipated that HHS will issue further guidance on implementation of enrollee satisfaction surveys, which are intended to survey consumer satisfaction with QHPs in Exchanges. Specific reference in the ACA is made to Consumer Assessment of Healthcare Providers and Systems (CAHPS) and HHS plans to develop an enrollee satisfaction survey based on CAHPS.[23] CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The survey is a set of instruments established and maintained by the federal Agency for Healthcare Research and Quality (AHRQ). However, AHRQ does not administer the survey. It is publicly available and is nationally recognized as a valid and uniform instrument for surveying consumer satisfaction with health care service delivery and financing systems.

NCQA currently uses CAHPS surveys. URAC has routinely accepted CAHPS data as part of meeting is standards and, with the release of the current URAC Health Plan Accreditation Program (Version 7, 2011), URAC now requires CAHPS reporting.

The ACA requires Exchanges to "oversee implementation of enrollee satisfaction surveys."[24] The Exchange must also post enrollee satisfaction survey results on the Exchange website so that the public can compare satisfaction across plans. The states can elect to deem an accredited plan to meet any state-specific standards for surveying consumer satisfaction.

Several different survey instruments are available, including "Health Plan," "Clinician and Group," "Hospital" and others. One survey instrument that does not currently exist is "Exchange." Therefore, where the ACA and associated regulations require state Exchanges to "oversee" surveys of consumer satisfaction, it appears this refers to surveys of consumer satisfaction with the health plans specifically sold as QHPs through the Exchanges. It does not appear that Exchanges must directly administer such surveys, but Exchanges are responsible for overseeing surveys administered by QHPs on their own membership. This is another area, however, where it would be questionable for Exchanges to duplicate the work already being carried out by the accrediting entities. To the extent permitted by future federal guidance, Exchange activity in this area should defer to accreditation standards. Exchanges may want to consider whether they want to voluntarily undertake their own customer satisfaction surveys, specifically because there is currently no CAHPS instrument specific to "Exchange." However, the states should keep in mind that HHS will be implementing a survey for all QHPs.

c. Requirement to Support a Website that Provides Standardized Comparative Information on Quality Ratings

It is anticipated that further regulatory guidance will be issued before Exchanges are required to implement a quality rating system. It is anticipated that HHS intends a phased approach to the quality rating provisions in which quality ratings in 2014 would be predicated on generally available and collected metrics and measures, and moving to a QHP-specific rating in 2016. Once implemented, it is part of the obligation of Exchanges to oversee implementation of "assessment and ratings of health care quality and outcomes, information disclosures and data reporting."[25]

Numerous organizations across the country have websites providing comparative information on health plans. Quality reporting information on such comparative websites, in conjunction with cost information, will assist consumers in making decisions based on value. The Massachusetts Health Connector website, which includes data on accreditation and quality, is one resource the states may wish to look at as they design and implement a quality rating system.[26] Another helpful example may be the Getinsured.com website, which also displays accreditation information.[27] A third useful tool is the Consumers CHECKBOOK plan compare tool.[28]

[23] For more information, visit *www.cahps.ahrq.gov*.
[24] 45 CFR §155.200(d) and ACA Section 1311(c)(4).
[25] 45 CFR §155.200(d).
[26] *www.mahealthconnector.org/portal/site/connector*.
[27] *www.getinsured.com*.
[28] *www.checkbook.org/plancompare*.

There are additional requirements in the ACA and Exchange regulations on what the Exchange website should support, but, for purposes of this paper, the focus is on allowing consumers to compare plans on a quality and price basis, where certain minimum required plan features are expected to be the same across all plans, such as coverage for preventive services and essential health benefits. State Exchanges may want to develop their quality initiatives closely in concert with the development of the Web portal and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

When thinking about providing quality information to Exchange enrollees on websites, NCQA has suggested two phases of presenting this type of information. In the early years, there will be limited quality information available because there is no Exchange population to measure. In this first phase of the Exchange, the websites can report how a plan performed on accreditation. URAC urges that, because access to health plan quality information is essential to consumers, this information would be the most widely available to consumers when provided through the Exchange websites.

d. Quality Best Practices and Related Issues

The states have a variety of options to evaluate and adopt best practices in health care and health plan quality oversight.

There are a number of organizations devoted to improving quality in the health care context. AHRQ, described above, is the lead federal agency responsible for improving the quality, safety, efficiency and effectiveness of healthcare for Americans. Other federal agencies, as well as some state-based organizations and private and public-private partnerships, are also involved in quality-related activities.

While this paper is focused on accreditation and quality requirements relating to Exchanges, state insurance regulators have other responsibilities related to insurer quality and reporting under the ACA. Implementation of these related areas should be carefully coordinated. Section 2717 of the PHSA requires HHS to develop reporting requirements for plans regarding coverage provisions and provider reimbursement structures intended to improve outcomes, reduce hospitalizations and improve patient safety, among other goals. Section 2715(a) of the PHSA, Section 1311(e) of the ACA and Section 2718 of the PHSA require issuers to report data to the Exchange, the state insurance department and HHS. State insurance departments may also want to carefully monitor quality improvement activities for which carriers claim expenses in the numerator of their medical loss ratio (MLR) calculations under Section 2718 of the PHSA.

Accrediting entities offer information and guidance on best practices. According to NCQA, 41 states currently use its accreditation information in their oversight of health plans. Of those, 37 apply it to commercial plans and 29 apply those requirements for Medicaid-contracted plans. Commercial state regulators vary in their use of accreditation, but the most commonly recognized standards include the areas of utilization management and credentialing.

There is an NAIC *Quality Assessment and Improvement Model Act* (#71). One state (Nebraska) has adopted it in total, and 26 states are identified as having adopted it in part, although, in some cases, the requirements only apply to HMOs.

Many of the states have a long history of using elements (e.g., utilization management and credentialing) of or whole quality programs (health plan accreditation) from accreditors. State Medicaid programs have historically been more active in the review of health plan quality than state insurance regulators, through state Medicaid managed care programs. The states can tap their Medicaid managed care programs for guidance and support in developing quality oversight programs applicable to commercial health insurance.

In Tennessee, the TennCare program participated in a webinar with Academy Health and NCQA regarding quality. While the states should consider the differences between Medicaid and commercial insurance markets, the TennCare officials offered the following items as important “lessons learned” in their 15+ years of overseeing a state-wide effort at improving quality for Medicaid beneficiaries:

1. Access to reliable encounter data as quickly as possible is extremely important. Hard data is needed to dispel misinformation.
2. Quality requirements should be spelled out for health plans; e.g., accreditation requirements and timelines and performance measure reporting requirements. Accreditation takes time, so clear milestones should be established to assess progress toward the goal. Consider a pay-for-performance arrangement to reward plans for the accreditation level received.
3. Independent, external review (an external quality review organization (EQRO) or an accrediting entity like NCQA or URAC) goes a long way to quelling stakeholder concerns.

4. Required reporting of standardized, evidenced-based performance measures for managed care organizations (MCOs) allows tracking trends over time and for comparison to national norms (e.g., HEDIS).
5. Consider developing a state-level survey that will allow the tracking of issues of interest to the state over time. This would be in addition to MCO-level surveys like CAHPS.
6. Pay-for-performance incentives tied to specific performance measures can be used effectively to target attention to the state's highest priorities.
7. Network monitoring should include three components:
    - Establishment of network standards for various provider types (e.g., geographic, appointment time).
    - Tracking compliance with standards based on network information self-reported by MCOs.
    - An audit process to validate MCO self-reported information
8. Tracking and analysis of enrollee appeals can be an important quality monitoring tool.

The Medicaid Health Plans of America (MHPA) offers guidelines for Medicaid managed care programs in specific clinical issues to enhance the overall health of Medicaid populations. Their website also offers access to a wide range of clinical, administrative and policy publications, many at no cost. Other public and private organizations, from consulting firms to research organizations to advocacy groups, offer a wide range of papers, discussions, research articles, webinars and other resources for little or no cost, exploring a wide range of issues in health plan quality improvement strategies. Common themes that appear to recur in much of this literature include:

- The importance of data-collection and state-of-the-art data systems that can support powerful analysis.
- An emphasis on clinical quality measures, with somewhat less information and guidance on administrative quality improvement approaches.
- An emphasis on behavioral incentives for medical providers and patients, beyond clinical excellence. In other words, the best clinical care can be ineffective if not accompanied by incentives that remove administrative barriers to delivery. Proper and timely communication between providers and patients is an important goal.
- Achieving an appropriate balance between data reporting and collection and minimizing unnecessary and unhelpful administrative burdens. The public wants standardized, comparable health plan information, often in highly specialized areas, such as treating children with autism or longevity following cancer treatment. The public also wants privacy protection and affordable care. These two things actually work against each other and will require constant monitoring and perpetual rebalancing.

5. Distinctions Based on Exchange Status

Exchanges may be entirely state-based, or the states may develop a Partnership Exchange with HHS to share certain Exchange responsibilities. Even if the Exchange is entirely federally facilitated, the states should be aware of the quality and accreditation issues. Those states with existing state law requirements for health plan accreditation and quality may be well positioned to manage Exchange operations related to these requirements.

Regardless of the Exchange status, state insurance regulators will play a modified role in health plan oversight. Where the Exchange is operated by the state, the role of state insurance regulators will not change much, as might be the case with a federally facilitated Exchange, but there will still be a change. For example, in areas of market conduct and consumer support, state insurance regulations may be superseded by new Exchange requirements. Insurance regulatory interactions with Medicaid managed care plans and state Medicaid agencies will be dramatically different. Even in the area of health plan solvency, state insurance regulators will be dealing with the financial impacts of new plan growth, new plans in the market place (particularly CO-OPs with no prior insurance experience), and large numbers of new entrants into the insurance market. Although the ACA includes no new financial solvency requirements, state insurance regulators will be wise to keep close track of the financial stability of health plans operating in a fundamentally different market than has existed prior to the ACA.

In those states where there is a Partnership Exchange, state insurance regulators will develop new relationships with their federal partners for the exchange of information and resources. In addition to supplying information to federal partners, state insurance regulators will have a new opportunity to receive information from federal partners regarding the behavior of health plans in the new marketplace. The history of state insurance regulators working together will serve the states well in designing relationships with federal partners that are both responsive to unique needs from state to state, and also uniform where necessary and appropriate.

Finally, state insurance regulatory relationships with regulated health plans, and with consumers, will continue to be critical. Particularly with regard to the role of accreditation, the ability of state insurance regulators to evaluate health plan quality,

and the impact of new reporting requirements, the states' ongoing communication with industry and consumers will remain a significant component and will continue to demand significant resources from state insurance regulatory agencies. This will be true, regardless of which type of Exchange is established in a particular state.

ACA Quality and Accreditation Requirements Related to Exchanges

Note: Critical "musts," "shalls" and "requireds" are highlighted in the excerpts below from ACA and from subsequent federal regulations, related to Exchanges and QHP accreditation and quality. The highlighted excerpts formed the basis for the organization of this paper.

SEC. 1311

...
(c) Responsibilities of the Secretary-
(1) IN GENERAL- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—
...
(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or
(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;
(E) implement a quality improvement strategy described in subsection (g)(1);
...
(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable; and (I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act. *As added by section10203(a)*.
***
(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).
(4) ENROLLEE SATISFACTION SYSTEM.—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.
(5) INTERNET PORTALS.—The Secretary shall—
(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist states in developing and maintaining their own such portal; and
(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices. Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.
***
(d) REQUIREMENTS.—
***
(4) FUNCTIONS.—An Exchange shall, at a minimum—
***
(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);
***
(g) Rewarding Quality Through Market-Based Incentives-
(1) STRATEGY DESCRIBED- A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for--

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
(D) the implementation of wellness and health promotion activities; and
(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).
(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1)....

---

§ 155.1045 Accreditation timeline.
The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

§ 156.275 Accreditation of QHP issuers.
(a) *General requirement.* A QHP issuer must:
(1) Be accredited on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:
(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;
(ii) Patient experience ratings on a standardized CAHPS survey;
(iii) Consumer access;
(iv) Utilization management;
(v) Quality assurance;
(vi) Provider credentialing;
(vii) Complaints and appeals;
(viii) Network adequacy and access; and
(ix) Patient information programs, and
(2) Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange 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.
(b) *Timeframe for accreditation.* A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with § 155.1045 of this subchapter. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.

§ 155.200 Functions of an Exchange.
***
(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.
***

§ 155.205 Consumer assistance tools and programs of an Exchange.
***
(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:
(1) Provides standardized comparative information on each available QHP, including at a minimum:
***
(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;
(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;

§ 156.200 QHP issuer participation standards.
***
(b) *QHP issuer requirement.* A QHP issuer must—
***
(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;
***

General Guidance on Federally-facilitated Exchanges, CCIIO (May 16, 2012)

Note: Only a portion of the references to accreditation and quality in this guidance are included in this excerpt.

****
Accreditation and Quality Reporting
The Affordable Care Act includes several provisions to improve the quality of care delivered by QHPs and increase the availability of quality data that can inform plan selection. Specifically, the Affordable Care Act requires QHP issuers to implement quality improvement strategies, enhance patient safety through certain contracting requirements, and publicly report quality data. In addition, the Affordable Care Act directs the Secretary to develop and administer a rating system and an enrollee satisfaction survey system, the results of which will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements.

QHP issuers participating in an FFE will be required to be accredited by an accrediting entity and comply with quality reporting requirements that HHS will specify in future rulemaking. HHS intends to propose a phased approach to accreditation and quality data reporting and display in an FFE to accommodate new QHP issuers and Medicaid plans without Exchange or accreditation experience.

HHS also intends to propose a phased process for recognizing accrediting entities. In phase one, the entities that HHS believes will be equipped to provide the statutorily required accreditation review by 2013 certification – the National Committee for Quality Assurance (NCQA) and URAC – would be recognized as accrediting entities on an interim basis subject to conditions. In phase two, we would adopt an application and review process for the recognition of additional accrediting entities.

We intend to propose that an FFE will accept existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification (for example, 2016 certification for the 2017 coverage year). HHS intends to propose that QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification. By the fourth year of certification, all QHP issuers must be accredited on the QHP product type having fulfilled the requirements to submit performance data to the accrediting entity.

Similarly, HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that State-based Exchanges may adopt a similar approach prior to final regulatory standards. For example, HHS intends to propose that reporting requirements related to all QHP issuers will start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The QHP-specific quality rating would be available for display in 2016 open enrollment for the 2017 coverage year. In the interim, an FFE will display existing Consumer Assessments of Healthcare Providers and Systems (CAHPS) results from accredited commercial and/or Medicaid product lines when these existing CAHPS data are available for the same QHP product types and adult/child populations (for example, HMO Adult CAHPS results for HMO QHPs, Child CAHPS results for child-only QHPs). FFEs will not display other data drawn from the accreditation data, such as clinical measures results.

HHS intends to engage in rulemaking for quality reporting and disclosure requirements for all Exchanges. HHS also intends to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the Affordable Care Act, and quality reporting requirements under Medicare and Medicaid).

Proposed Rule on Recognition of Entities for the Accreditation of Qualified Health Plans, CMS-9965-P, 77 Fed. Reg. 33133-142 (June 5, 2012)

*****

§ 156.275 Accreditation of QHP issuers.

*****

(c)(1) *Recognition of accrediting entity by HHS.*

(i) Effective upon completion of conditions listed in paragraphs (c)(2) through (4) of this section, at which time HHS will notify the public in the **Federal Register** that the National Committee for Quality Assurance (NCQA) and URAC are recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs meeting the requirement of this section. Such recognition is effective until rescinded or recognition is required to be made by the process identified in paragraph (c)(1)(ii) of this section.

(ii) [Reserved]

(2)(i) *Scope of accreditation.* Subject to paragraphs (c)(2)(ii) through (iv) of this section, recognized accrediting entities must provide accreditation within the categories identified in paragraphs (a)(1) of this section.

(ii) *Clinical quality measures.* Recognized accrediting entities must include a clinical quality measure set in their accreditation standards for health plans that:

(A) Spans a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care.

(B) Includes measures that are applicable to adults and measures that are applicable to children.

(C) Aligns with the priorities of the National Strategy for Quality Improvement in Health Care issued by the Secretary of HHS and submitted to Congress on March 12, 2011;

(D) Only includes measures that are either developed or adopted by a voluntary consensus standards setting body (such as those described in the National Technology and Transfer Advancement of Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A–119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards; and

(E) Is evidence-based.

(iii) *Level of accreditation.* Recognized accrediting entities must provide accreditation at the Exchange product type level.

(iv) *Network adequacy.* The network adequacy standards for accreditation used by the recognized accrediting entities must, at a minimum, be consistent with the general requirements for network adequacy for QHP issuers codified in § 156.230(a).

(3) *Methodological and scoring criteria for accreditation.* Recognized accrediting entities must use transparent and rigorous methodological and scoring criteria.

(4) *Documentation.* An accrediting entity must provide the following documentation:

(i) To be recognized, an accrediting entity must provide current accreditation standards and requirements, processes, and measure specifications for performance measures to demonstrate that each entity meets the conditions described in paragraphs (c)(2) and (3) of this section to HHS at a time period specified by HHS.

(ii) Recognized accrediting entities must provide any proposed changes or updates to the accreditation standards and requirements, processes, and measure specifications for performance measures with 60 days notice prior to implementation.

(5) *Data sharing requirements between the recognized accrediting entities and Exchanges.* When authorized by an accredited QHP issuer pursuant to paragraph (a)(2) of this section, recognized accrediting entities must provide the following QHP issuer's accreditation survey data elements to the Exchange in which the issuer plans to operate one or more QHPs during the annual certification period or as changes occur to these data throughout the coverage year—the name, address, Health Insurance Oversight System (HIOS) issuer identifier, and unique accreditation identifier(s) of the QHP issuer and its accredited product line(s) and type(s) which have been released; and for each accredited product type:

(i) HIOS product identifier (if applicable);

(ii) Accreditation status, survey type, or level (if applicable);

(iii) Accreditation score;

(iv) Expiration date of accreditation; and

(v) Clinical quality measure results and adult and child CAHPS measure survey results (and corresponding expiration dates of these data) at the level specified by the Exchange.

© 2012 National Association of Insurance Commissioners

Draft: 6/27/12
As adopted by Health Insurance and Managed Care (B) Committee, 6/27/12

Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage

Introduction
The federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA) provides for the establishment of American Health Benefit Exchanges to facilitate the purchase of health insurance by individuals and employers. Under the ACA[1], states electing to establish a state-based Exchange (SBE) must do so and meet certain minimum requirements by Jan. 1, 2014.[2] For states that do not establish a state-based Exchange, the ACA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an Exchange, known as a federally facilitated Exchange (FFE), for the residents of that state.[3]

In the proposed rules on "Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" published in the *Federal Register* July 15, 2011, HHS announced the state Partnership federally-facilitated Exchange (PFFE) model. Under this model both HHS and the states will operate functions of the Exchange. HHS, however, will remain responsible for ensuring that the Exchange meets all of the standards and requirements under the ACA. As stated by HHS, the PFFE model is intended to give the states another option to tailor their Exchange to accommodate local needs and market conditions. In addition, the PFFE model is a way for states to transition into fully operating their own SBE.

On Sept. 19, 2011, at a State Exchange Grantee meeting, HHS' Center for Consumer Information and Insurance Oversight (CCIIO) provided additional information to the states on PFFEs.[4] As provided at this meeting, states entering into a PFFE must agree under the terms of their grants to ensure state insurance department, Medicaid and Children's Health Insurance Program (CHIP) cooperation to coordinate business processes, systems, data/information and enforcement. Also, as part of a PFFE agreement, a state may choose to operate plan management functions and/or some consumer services—such as consumer assistance programs—using Exchange grant funding to establish framework, thereby maintaining existing relationships and allowing for easier transitions to SBEs in future years.

Specifically, CCIIO indicated that, under a PFFE, a state may choose to operate the following Exchange functions: Option 1) plan management functions, such as collection and analysis of plan information and plan monitoring and oversight; Option 2) selected consumer assistance functions, such as Navigator program management or other in-person consumer function; or Option 3) both selected consumer assistance and plan management functions.

HHS has indicated that, in a PFFE, states must, in general, take an all-or-nothing approach to the plan management and consumer assistance functions. That is, a state must agree to take on all duties outlined under plan management and/or consumer assistance (with a few exceptions), or none of them.

Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options. In an FFE, consumer assistance and plan management functions will be performed by HHS.

The plan management and consumer assistance functions that may be performed by the state in a PFFE were further defined in the May 16, 2012, guidance as including: 1) licensure and solvency; 2) network adequacy; 3) rate review; 4) benefit design standards; 5) marketing and consumer information, which includes oversight of Navigators, review of marketing materials and the summary of benefits and coverage; 6) accreditation; and 7) quality ratings, quality improvement strategies and enrollee satisfaction surveys.

Scope
This paper is intended to explore the issues and options for implementation of certain provisions of the law and regulations issued to date. These provisions include the management of marketing; the summary of benefits and coverage required to

[1] Pub. L. 111-148 (ACA).
[2] ACA Sec. 1311(b).
[3] ACA Sec. 1321(c).
[4] http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf.

© 2012 National Association of Insurance Commissioners

accompany each policy beginning in September 2012; and how agents, brokers and Navigators will be regulated and managed in regard to the ACA. This paper will not address issues concerning consumer outreach in general, nor will it address the many facets of issues surrounding agents, brokers and Navigators that do not directly involve how state Departments of Insurance (DOIs) will manage these individuals. Those issues may be addressed at a later date when more information has been released by HHS.

This paper expands on the white paper developed by the NAIC in April 2011 concerning agents and brokers and their involvement in the ACA, and includes final regulations on SBEs and the most recent guidelines released by HHS on May 16, 2012. Where this paper uses the term "regulation," it is referring to the final regulations regarding SBEs.

The issues and options identified in this paper will be useful to all states, but how the state addresses the issue will depend on whether the state decides to implement an SBE, an FFE or a PFFE. Whenever possible, this paper will highlight the possible differences in approach a state may take depending on what type of Exchange is established, including all issues that implicate the involvement of the DOIs.

This paper is not intended to be used as a "best practices" guide, but rather a paper that outlines issues and options that states may face when establishing an Exchange. States should evaluate the needs and requirements of their local population and market condition when deciding how best to establish an Exchange.

This paper includes four topical sections: Navigators, agents and brokers, marketing, and Summary of Benefits and Coverage. Each section will first summarize the requirements and responsibilities found in the ACA and final regulations, then will discuss issues and options for states to consider when planning an Exchange. When applicable, the paper will outline the differences between states considering an SBE, an FFE or a PFFE.

Navigators

Background information
The ACA requires Exchanges to establish Navigator programs through which entities that receive financial grants will conduct public education activities, distribute fair and impartial information, and perform related duties set forth in the law. The federal law and regulations provide some basic details about the responsibilities and roles of Navigators, but state policymakers have considerable flexibility and discretion to structure these programs in the manner they deem most appropriate.

The law and regulations do not specify the type or contents of the contractual agreements between Exchanges and Navigators. However, at a minimum, Navigators must carry out the following duties:

- Maintain expertise in eligibility, enrollment and program specifications for the Exchange as well as public coverage options, and conduct education activities to raise public awareness of the Exchange.
- Provide information and services in a fair and impartial manner (including information about the costs of coverage and advance payments of premium tax credits and cost-sharing reductions), acknowledging other health programs.
- Facilitate selection of a qualified health plan (QHP), initiating the enrollment process.
- Provide referrals to any applicable office of health insurance consumer assistance, ombudsman or other appropriate state agency for any enrollee with a grievance, complaint or question regarding their health plan, coverage or a determination under that plan.
- Provide information in a manner that is culturally and linguistically appropriate, and ensure accessibility and usability of Navigator tools and functions in accordance with the American Disabilities Act (ADA).

The Exchange is free to require that Navigators meet additional standards and carry out additional duties consistent with the listed minimum duties.

Who can be a Navigator?
The law and regulations list the types of entities that may be Navigators. The regulations clarify that the Exchange must select entities from at least two of the following categories to serve as Navigators:

- A community- and consumer-focused nonprofit group
- A trade, industry or professional association
- A commercial fishing industry, ranching and farming organization

- Chambers of commerce
- Unions
- Resource partners of the Small Business Administration
- Licensed agents and brokers
- Other public or private entities or individuals that meet the requirements, such as Indian tribes, tribal organizations, urban Indian organizations, and state or local human service organizations

One of the two entities selected from the above list must be a community- and consumer-focused nonprofit group.

In order to be eligible to receive a grant from the Exchange, an entity must:

- Be capable of carrying out the minimum duties required by federal law and regulation.
- Demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP.
- Meet any licensing, certification or other standards that are prescribed by the state and/or the Exchange.
- Not have a conflict of interest that bars the person from carrying out the duties of a Navigator.
- Comply with the privacy and security standards established by the regulation.

Individuals and entities who do not receive grant funding might not be considered qualified to be a Navigator, as per HHS guidance.

Funding the Navigator program
Federal law requires that all funds for Navigator grants must come from the Exchange's operation funds generated through non-federal sources. The preamble of the final regulation dealing with SBEs notes that operational funds of the Exchange may be revenue received by the Exchange through user fees or other revenue sources, so long as the Exchange is self-sustaining. HHS also observes that public or private grants may be available to support certain Exchange functions, such as education and outreach, and indicates that such grants will be considered to be operational funds of the Exchange once they are received. The preamble also indicates that, to the extent that Navigators assist with Medicaid and Children's Health Insurance Program (CHIP) administrative functions, such as assisting eligible individuals with enrollment in coverage, the Medicaid or CHIP agencies are permitted to claim federal funding for their share of expenditures incurred for such activities.

Prior to the establishment of Exchanges, states may use Exchange planning and establishment grants to fund activities related to the development of the Navigator program, such as:

- Conducting a needs assessment to identify populations that are likely to use Navigators.
- Identifying potential Navigator entities.
- Engaging stakeholders in the development of Navigator standards, grant guidelines and plans for public education and outreach.
- Designing Navigator training and certification programs.

The preamble to the final regulations encourages states with SBEs that are approved or conditionally approved by January 1, 2013, to have Navigator programs operational with services available to consumers by October 1, 2013, and guidance from HHS indicates that Navigators in the FFE will also be operational by that date.

Licensing, Certification and Training
The federal regulations require an individual or entity to satisfy any licensing, certification and training standards established by the state or the Exchange in order to operate as a Navigator and receive Navigator funding. It is the responsibility of the states and the Exchanges to develop training standards to ensure the competency of Navigators, but the regulations do impose certain minimum requirements. Specifically, training standards must ensure that Navigators understand the following:

- The needs of the underserved and vulnerable populations.
- The rules and procedures for eligibility and enrollment.
- The range of public programs and QHP options available through the Exchange.
- How to appropriately handle tax data and other personal information and comply with the regulations' privacy and security standards.

Although it is not required, the preamble to the final regulations strongly encourages Exchanges to implement ongoing and recurring training, as well as regular reviews and assessments of their Navigators. In addition, HHS has indicated that it may provide further guidance in the future.

The preamble also states that an Exchange may NOT require that any Navigators hold an agent or broker license, or maintain errors and omissions (E&O) coverage.

Prohibitions on Navigator Conduct and Conflicts of Interest
The federal law includes prohibitions on Navigators that are intended to prevent, minimize and mitigate possible sources of conflicts of interest, and the regulation further provides that a Navigator *must not*:

- Be a health insurance issuer, a subsidiary of a health insurance issuer or an association that includes members of, or lobbies on behalf of, the insurance industry.
- Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees in a QHP or a non-QHP.

The preamble to the regulations notes that HHS intends for these prohibitions to apply broadly, including to any staff of an entity serving as a Navigator or entities that serve as Navigators for one Exchange while simultaneously serving in another capacity for another Exchange. The preamble also expresses concern that grants and other considerations provided by health insurance issuers to Navigators for activities unrelated to enrollment in health plans may present a significant conflict of interest for Navigators, although such grants are not inherently prohibited. Finally, HHS indicates in the preamble that "consideration," as used in connection with these prohibitions, should be interpreted to mean both (1) financial compensation, including monetary and in-kind compensation and grants, and (2) any other type of influence that a health insurance issuer could use, including gifts, free travel and other items that may result in steering consumers to particular plans.

Exchanges must develop and publicly disseminate conflict of interest standards to ensure the appropriate integrity of all entities and individuals carrying out Navigator functions. The preamble to the regulations urges states to craft conflict of interest standards that address areas such as:

- Financial considerations.
- Non-financial considerations.
- The impact of a family member's employment or activities with other potentially conflicted entities.
- Navigator disclosures regarding existing financial and non-financial relationships with other entities.
- Exchange monitoring of Navigator-based enrollment patterns.
- Legal and financial recourses for consumers who have been adversely affected by a Navigator with a conflict of interest.
- Applicable civil and criminal penalties for Navigators that act in a manner inconsistent with the conflict of interest standards set forth by the Exchange.

The preamble also clarifies HHS' view that conflicts of interest arise when a Navigator has a private or personal interest sufficient to influence, or appear to influence, the objective exercise of his or her official duties. HHS plans to release model conflict of interest standards in future guidance.

Considerations and Options for State Officials

Who are the best candidates to become Navigators?
As stated in the regulations, each Exchange must fund at least one Navigator entity that is a community- and consumer-focused nonprofit group. States might consider a range of community-based organizations, such as Kiwanis, parent-teacher associations, community health organizations, faith-based organizations, churches, earned income tax credit (EITC) assisters, peer-run nonprofit organizations (such as addiction and mental health help groups), and state Senior Health Insurance Information Programs (SHIIPs)—which could include institutions with consistent interaction with the public, provided that such entities also meet the eligibility criteria necessary to receive a grant from the Exchange, as set out earlier in this paper.

Information gathered as part of the Navigator application process can help states determine which entities and individuals would be most instrumental in reaching all populations of the state. This information might include what types of services the

entity currently provides, what populations they interact with most often, what methods they use to reach consumers (e.g., telephone, home visits, in-person appointments and which geographic areas of the state they will serve.

Some states are considering allowing "safety net providers," including federally qualified health clinics and health departments, to be part of the Navigator program. States that choose to include these organizations may wish to define what constitutes a "safety net clinic" and should ensure that Navigators will provide unbiased information and do not act in a way that violates the rules set out by HHS regarding conflict of interest for Navigators.

The relationship between the Navigator entity and Navigator individual
States will need to determine the relationship that will exist between a Navigator entity and a Navigator individual, and what the state's involvement in that relationship will be. Some states are planning to require the Navigator entity to apply for and receive the grant. The entity then may be responsible for the training and conduct of each individual Navigator, and will decide whether/how that grant money will be distributed.

Who will be responsible for training Navigator individuals?
States will need to decide what methods for training Navigator individuals are most feasible for the population and geography of their state, taking consistency of that training into consideration. Some states are using their state SHIIP program as a model to address these issues. For example, Kansas is planning to centralize the training process, ensuring that all Navigator entities and individuals receive the same training from the same Exchange-approved individual or group. This will eliminate problems of inconsistency that can sometimes be found in a "train the trainer" process. However, states with a larger number of Navigators or a larger geographical area may need to consider other ways to ensure consistency while still being accessible in all areas of the state—perhaps via videos or online training programs. North Carolina plans to provide uniform training at designated sites across the state, similar to SHIIP training sites, and will also develop an online course to ensure that Navigator entities and individuals get the same training regardless of where they are located in the state.

What should be included in Navigator training?
States may need to evaluate the Navigator individuals in their state, including the specialized knowledge they already have, and identify the gaps in knowledge that exist. Navigator individuals should be trained on how to help consumers through the entire process of finding, evaluating and choosing a QHP in the Exchange marketplace (both electronically and on paper), including issues that may arise with the Web portal and electronic enrollment process. Some issues that states have identified as possible training topics include:

- Content knowledge
    - Basic health insurance concepts
    - QHP details
    - Non-Exchange plans
    - Specialty health plans[5]
    - Exemptions from the individual mandate
    - Premium tax credits and other tax considerations
    - Subsidies
    - Other affordability programs
- Eligibility issues
    - Assessing information about eligibility and enrollment status
    - Eligibility for public assistance programs
    - Employment eligibility issues
    - Changes in eligibility (transition risk)[6]
    - How to help consumers with complex or mixed eligibility
- Enrolling consumers

[5] Specialty health plans include coverage such as vision, dental, hearing, chiropractic, behavioral, alternative medicine and cancer. As some specialty pediatric essential benefits differ from adult benefits under the ACA, some coverage coordination will be necessary.

[6] Transition risk is the tendency for some segments of the population to switch eligibility between Medicaid, premium tax credits and subsidies within the policy year. Navigators should be trained on how to provide enrollment and information to individuals that fall into this category, including: access to care; continuity of care; continued eligibility or ineligibility for Medicaid, premium subsidies and tax credits; exposure to tax liability for some portion of previous subsidy payments; exposure to higher costs of premiums, deductibles and out-of-pocket expenses; and exposure to changes in coverage.

© 2012 National Association of Insurance Commissioners

  - Comparing plan options
  - Applying online (how to use the Exchange online portal)
  - How to apply via paper applications
  - Renewing coverage and re-enrolling consumers with lapsed policies
  - Changing plans when appropriate
- Counseling skills
  - Ethics
  - Cultural competency
  - Privacy and security for handling personal information
  - Communication skills
  - Evaluating the level and type of assistance the consumer needs
  - Assisting individuals with disabilities, including addiction or mental health issues
  - Making referrals and finding community resources
  - Conflict of Interest requirements

States may wish to consider setting up a resource center with a "1-800" number for Navigators to call for assistance, especially at the beginning of implementation of the Navigator program.

Licensing and Certification
States cannot require Navigators to be licensed insurance agents or brokers. However, HHS regulations permit states to develop Navigator-specific licensing or certification requirements. This certification or licensure should occur after fulfilling Navigator training requirements, and after demonstrating a command of the information and skills required to perform Navigator duties. States may wish to evaluate the process to ensure that potential Navigators do not face overly burdensome requirements. Some states may wish to allow Navigators to be certified based on competency alone, not based on hours of training. If a state chooses to have Navigator individuals complete different types of duties (e.g., distinguishing Navigators on an individual Exchange and Navigators on the Small Business Health Options Program (SHOP) Exchange), that state may wish to vary the requirements based on the functions that particular Navigator will be responsible for. States may wish to evaluate what continuing education requirements they will provide for Navigators, including specialized topics, policy updates and strategies for conducting Navigator duties.

Kansas plans to certify Navigator individuals who successfully complete training. Navigator entities will apply for grant funds from the Exchange, and Navigator individuals will be trained and certified. They will require an initial 24 hours of face-to-face training and an additional four hours of online training, including pre- and post-testing. After the initial training and first year of work, Navigator individuals will be required to complete eight hours of face-to-face training and four hours of online training annually to maintain their certification.

Monitoring Navigator Behavior and Performance
States will need to determine who will be responsible for monitoring Navigator behavior and performance. In some states Navigators may report directly to the Exchange, to the DOI, or to another organization altogether. Some states may wish to require Navigators to sign a code of conduct or ethics statement regarding the appropriate and fair delivery of service.

States may also wish to monitor Navigator conduct by requiring Navigators to report data on a defined set of measures, which might include: the number of individuals assisted; how many of those individuals were eligible for public programs or subsidies; which programs or plans consumers were enrolled in; demographic information; insurance history; and what level or type of assistance was required, including whether and where they were transferred for additional assistance. Keeping a record of this information may help the Exchange keep track of the work each Navigator is doing and ensure proper oversight of duties. The Community Service Society of New York is an example of an organization that currently practices this oversight process; the primary contractor in the consumer assistance program reviews a case sample from each contracting entity to monitor behavior and performance.

In Kansas, the Navigator entity will be responsible for ensuring that all individuals are trained properly. Any Navigator misconduct could result in the individual losing certification status and the entity losing its grant money. Complaints concerning Navigators would be monitored by the DOI through consumer complaints filed electronically, by telephone, by mail or in person. States with SBEs could consider providing Navigators with a portal that is separate from the portal used directly by consumers, and assigning each Navigator an individual unique number which would be recorded when signing into that portal. The Navigator can use that identifying number to submit enrollment applications on behalf of the consumers

and/or small businesses they assist and track eligibility and enrollment information. If a consumer reports misconduct, that individual could be traced through the Exchange through that identifying number.

There may be entities in the marketplace that will use Navigator names or create copycat Exchange websites to defraud and mislead consumers. States need to remain vigilant in identifying and disabling these entities in order to protect consumers.

Conflict of Interest Standards
HHS will provide states with a conflict of interest statement template that can be used when certifying or licensing Navigators. States may also wish to consider whether they should incorporate additional or existing state laws or standards that govern Navigator conflicts of interest. States should consider establishing a standard procedure to prevent and mitigate conflicts of interest, such as an annual disclosure requirement and/or ongoing obligations to disclose new or actual conflicts. States may also wish to adopt measures to prevent the appearance of impropriety, and outline procedures for the review of possible conflicts of interest.

Massachusetts has decided to incorporate its conflict of interest law and financial disclosure law into the operation of their Exchange, The Connector.

Recourse for Consumers
States should consider what recourse a consumer might have if he or she is harmed by a Navigator's actions. While states are prohibited from requiring Navigators to purchase Errors and Omissions (E&O) insurance, states may wish to determine ways in which consumers harmed by Navigator entities may seek redress. Navigator entities may wish to voluntarily purchase an overarching liability insurance policy that would protect them and the consumer in the event of an error.

States may need to develop a process for handling Navigator-related complaints from consumers, with the ability to take appropriate action against Navigators when fraud or other improper conduct occurs. States may also wish to establish a process for reviewing awarded Navigator grants to detect and protect against malfeasance, waste, fraud and abuse.

Navigator Compensation
States will need to decide how Navigator entities will be awarded grant money, and whether that process will include a performance-based system. States should consider establishing Navigator compensation that ensures proper linkage of performance and results. Some factors that states may want to consider when evaluating Navigator performance include:

- The number of consumers assisted.
- The actual services provided to consumers.
- The time intensity of the service provided.
- The geographical location in which the Navigator is located.
- Whether the Navigator serves a specific population (including populations of consumers with limited English proficiency, mental illnesses or disabilities).

In Kansas, compensation of Navigator individuals will be left up to the discretion of the Navigator entity.

Individual Exchange vs. SHOP Exchange
States may choose to fund different Navigators that specialize in providing services to the SHOP and individual Exchanges, or may choose to have Navigators with different roles in the individual and SHOP Exchanges. States should consider the necessity of having some Navigators familiar with both markets to serve populations that may be interconnected (for example, if members of one family have varying coverage needs and eligibility statuses that are divided between the SHOP and individual Exchange). States should also decide if they plan to include Navigators in both markets. Maryland, for example, is planning to focus Navigators on the individual market and utilize agents and brokers to assist in the SHOP Exchange.

Considerations for SBEs, FFEs and PFFEs
States that choose to run an SBE will have full control over Navigators within the parameters of the law and regulations. These states will determine training standards, hand out Navigator grants, and oversee the entire Navigator program, including what financing mechanisms will be used for funding Navigator grants.

States with an FFE must await further guidance from the federal government on many aspects of the Navigator program.

Currently there is not a clear answer as to what will happen to Navigator programs in a PFFE. A state that chooses to run the Consumer Assistance option may determine some aspects of the program, including training standards and who will conduct the training. HHS has indicated that they may retain control of Navigator grants in a PFFE since the money would be coming from the federal government. States should consult directly with HHS about this issue and come to an agreement that will work for the individual state.

Agents and Brokers

Background
Under federal law, Exchanges have a great deal of flexibility to determine the role of agents, brokers and Web-based entities in the marketplace.

The federal regulations make it clear that, with proper training, agents and brokers can enroll individuals, employers and employees in QHPs through the Exchange, as well as outside the Exchange.

The Exchange may also provide information regarding agents and brokers on its website. The regulations permit states with SBEs to allow agents and brokers to assist individuals in applying for advance payment of the premium tax credits and cost-sharing reductions for plans offered through the Exchange (comments have been requested on this aspect of the regulations). The regulations make it clear that agents or brokers that enroll individuals in a QHP or assist individuals in applying for subsidies must comply with applicable state law related to agents and brokers, including state law related to confidentiality and conflicts of interest, in addition to the federal standards.

Agents and brokers who assist individuals in enrolling in QHPs or applying for subsidies must have entered into an agreement with the Exchange, the terms of which require agents or brokers to, at least:

- Register with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange.
- Receive training in the range of QHP options and insurance affordability programs.
- Comply with the Exchange's privacy and security standards adopted consistent with the regulations.

The regulations allow agents or brokers to use their own website to complete the selection of a QHP, as long as the website, at a minimum:

- Meets all the standards for disclosure and display of QHP information set out in law and regulations.
- Provides consumers the ability to view all QHPs offered through the Exchange.
- Does not provide financial incentives, such as rebates or giveaways.
- Displays all the QHP data provided by the Exchange.
- Maintains audit trails and records in an electronic format for a minimum of 10 years.
- Provides consumers with the ability to withdraw from the process and use the Exchange website instead at any time.

In addition, the regulations provide that a consumer may be enrolled in a QHP through the Exchange with the assistance of an agent or broker if the agent or broker ensures that the consumer is eligible for coverage and completes an application. The application must then be properly transmitted to the insurer through the Exchange website.

In order to receive a subsidy, consumers must enroll in coverage through the Exchange. As long as the agent or broker is certified to sell products through the Exchange, the consumer may receive that subsidy when enrolling with an agent or broker.

Considerations and Options for State Officials

Agents and Brokers as Navigators
Agents and brokers may be Navigators if they are not compensated directly or indirectly from health insurance issuers for their work. States may wish to evaluate how this will affect their unique insurance environment and agent requirements.

Agents Selling on the Exchange
States should evaluate what training should be required of agents and brokers who wish to sell QHPs through the Exchange, including training on public affordability programs, subsidy eligibility, and use of the Web portal. Additionally, states will need to consider how agents and brokers serving Exchange consumers will be compensated, and how the pricing of QHPs

will remain the same both inside and outside the Exchange, whether or not an agent or broker was involved. Both the individual Exchange and the SHOP Exchange should be taken into consideration when making these decisions.

How Consumers will find Exchange-Approved Agents and Brokers
State Exchanges and DOIs will need to decide whether to provide consumers with a list or database of agents and brokers approved to sell on the Exchange. Maryland is planning to make a list of agents and brokers approved to sell Exchange products on the Exchange website, though consumers will not be referred to a specific producer or company.

Navigators in Maryland will be limited in what they can tell consumers about products offered outside the Exchange. Maryland has determined that only Navigators will be allowed to enroll consumers in public affordability programs, and any agent or broker who encounters a consumer eligible for a public affordability program will be required to refer that consumer to a Navigator.

Agent Appointments and Selling on the Exchange
States may need to reconcile their producer licensing laws and rules with any Exchange Navigator certification or licensing requirements.

States will need to consider captive agent status under their licensing laws. In addition, states may need to address state and carrier appointment requirements and review the ability of all agents and brokers to enroll consumers in all QHPs within an Exchange.

States will need to evaluate what is best for their market and determine what requirements, if any, will need to be met to allow agents and brokers to sell on the Exchange.

Agent Training
States will need to decide what kind of training will be required of agents and brokers before allowing them to sell plans on the Exchange and to what extent training will need to be incorporated into the continuing education requirements for agents to remain eligible to sell on the Exchange. For example, agents and brokers may need to be trained on:

- Eligibility and tax subsidy calculation.
- Changes in eligibility (transition risk).[7]
- Basic Medicaid and CHIP eligibility, and issues for mixed eligibility status families.
- Scope of what Navigators are allowed to do.
- Sensitivity to cultural differences and norms of minority populations.
- How to report exemptions from individual mandate.
- Eligibility issues for consumers with employer-based coverage.
- How to use the Exchange website.
- Tax subsidies available for small businesses.

Training for agents in Kansas will be similar to the training required of Navigators, but with the option to test out of training that covers basic insurance concepts. Kansas is also planning to add Exchange-specific training to agent- and broker-required CE hours in order to stay eligible to sell on the Exchange.

Conflict of Interest Standards
States should consider what conflict of interest standards will apply to agents and brokers. States could gather information on the enrollment patterns of consumers who utilize an agent or broker versus those who do not to ensure that consumers are not being steered toward plans that offer agents and brokers the highest commission rate. States might also consider what recourse consumers would have if they are adversely affected by an agent or broker who violates this conflict of interest standard. HHS will provide a conflict of interest standard template for Navigators, and states may be able to adapt this language to suit agents and brokers as well.

[7] See Footnote 6.

Commission Structure for Agents and Brokers
States will need to consider how commission structures may change for agents and brokers who sell QHPs on the Exchange. Maryland and Utah have determined that traditional commission structures may remain in place, and Utah is planning to require agents and brokers to disclose their commissions to consumers.

Web-based Brokers in the Exchange
States may need to determine if Web-based brokers require different regulations from traditional agents and brokers and, if so, what those differences would be, including conflict of interest standards. Since Web-based brokers may use a website other than the Exchange portal, states should strive to ensure that all websites selling QHPs are built in a way that will not confuse consumers, perhaps including a disclaimer that the Web-based broker website is not the official Exchange website. States should ensure that subsidy availability and regulations are clearly available on these websites.

Considerations for SBEs, FFEs, and PFFEs
In the general guidance issued May 16, 2012, CCIIO stated that HHS expects that licensed agents and brokers will continue to assist consumers in accessing health insurance in states with an FFE or PFFE. The agency indicates it will work with agents and brokers to promote enrollment through the Exchange. To the extent permitted by a state, an FFE will permit agents and brokers to enroll individuals in a QHP "through an Exchange" if the agent or broker ensures that an individual completes the eligibility verification and enrollment application using the Exchange website or another Exchange-approved website. HHS will provide licensed agents and brokers with a portal to the FFE website if applicable standards are met. HHS intends to work with Web-based brokers that meet all applicable requirements.

In addition, HHS indicated that agents and brokers will be a primary channel that small businesses can use to access coverage through an FFE-SHOP Exchange. HHS also anticipates that agents and brokers will continue to be a primary point of contact for a variety of administrative, billing and claims-related issues.

In an SBE, the role of agents and brokers will be determined by the state. However, state standards and requirements cannot conflict with the federal regulations and standards, including the requirement that a Navigator's role is to facilitate enrollment.

Marketing

Background
The ACA requires the Secretary of HHS to establish criteria for the certification of QHPs that require that plans, at a minimum, meet marketing requirements, and not employ marketing practices or benefit designs that discourage enrollment by people with significant health needs. The federal law and regulations require QHPs to follow state marketing laws.

Considerations and Options for State Officials
In this paper, marketing is considered to be the way that insurers and/or producers try to get consumers to buy a particular plan. Marketing should be considered separately from general consumer outreach intended to educate consumers about insurance or the Exchange in general.

Currently states, in general, do not have specific marketing rules for traditional health insurance plans, beyond state unfair trade practices laws. States do reserve the right to review advertising materials at any time, but typically do not pre-approve advertising for traditional health insurance plans. Some states, including Florida, do make a distinction between invitations to inquire and invitations to contract. States may want to re-evaluate the current laws that govern insurance marketing to decide if additional regulation is necessary for plans sold inside and outside the Exchange.

Currently Utah does not have any additional regulation for marketing plans through their Exchange. However, they have found the need to specify that producers may not create an online website that looks like the official Exchange website, and must explicitly state that their website is not affiliated with the official Exchange portal.

Considerations for SBEs, FFEs, and PFFEs
States with an SBE will have the ability to control advertising inside and outside of the Exchange. Plans will continue to have to follow the Health Insurance Portability and Affordability Act (HIPAA) fair market rules and other marketing requirements. DOIs may want to put guidelines in place to ensure that products and rates are not constructed or marketed in such a way as to discourage people away from the Exchange.

In an FFE, HHS will maintain control of marketing plans inside the Exchange. States will retain control of plans marketed outside the Exchange. HHS may wish to have a Memorandum of Understanding (MOU) or contract with the state to share information to do this.

In a PFFE, states may be willing to take on some plan management functions, including marketing. If a state opts for a plan management PFFE, it will retain marketing oversight like an SBE. If a state selects only a consumer assistance PFFE, HHS will have authority over the marketing of Exchange plans.

Summary of Benefits and Coverage

Background
The ACA requires all group health plans and individual insurers to provide, under certain circumstances, a uniform Summary of Benefits and Coverage (SBC) disclosure to consumers for private health insurance plans. For the group market, the disclosures must be provided for plan years beginning after September 23, 2012. Insurers must provide the disclosures for the individual market as of September 23, 2012, regardless of plan year. The uniform template requires insurers to include a description of the coverage, including:

- Cost-sharing for each category of benefits identified by HHS.
- Exceptions, reductions and limitations on coverage.
- The cost-sharing provisions of the coverage, including the deductible, coinsurance and copayment obligations.
- The renewability and continuation of coverage.
- Coverage examples that illustrate the costs for common benefit scenarios defined by HHS.
- A statement that the Summary of Benefits is only a summary.
- A contact number to call with questions and a website where a copy of the full policy for the plan can be obtained.
- A website where consumers can access the standard glossary of insurance and medical terms provided for in the final SBC rule.

In 2013, the SBC standard template will be updated to require insurers to include a statement about whether the plan provides minimum essential coverage and meets the affordability requirements for Exchanges. HHS will also provide up to four additional coverage examples in 2013, and insurers will need to include these additional examples in all SBCs beginning Jan. 1, 2014.

Considerations and Options for State Officials

Purpose
The purpose of the SBC is to provide a uniform basis for comparing coverage options and to help consumers understand the benefits and costs under their coverage. States may not alter the SBC forms, but may require insurers to provide additional information to consumers.

If states find that additional disclosures are necessary, they may consider exploring one of the following:

- Continue to require complete disclosure documents to be distributed with duplicative information.
- Require the inclusion of an addendum with the SBC that contains additional non-duplicative information required by state law.

States will also need to include a required disclosure pursuant to Section 2709 of the PHSA (previously codified at Section 2713 and was part of the HIPAA disclosure requirements) that requires issuers to disclose the possibility that rates can go up. State DOIs may also wish to establish mechanisms to monitor the accuracy of the SBC disclosures submitted by insurers.

Conclusion

As noted in this white paper, the Exchange final rules and regulations provide states with some flexibility concerning Navigators, agents and brokers, and marketing within the Exchange. However, states are fairly limited in flexibility concerning the SBC. Many of the decisions that states will have to make concerning the areas discussed in this paper will depend on whether the state establishes an SBE, an FFE or a PFFE. States should use this paper to begin discussions with stakeholders and state agencies to best determine how Navigators and agents and brokers will be transitioned into the

Exchange system, and to decide how best to regulate marketing and SBC requirements in their current insurance regulatory environment.

W:\National Meetings\2012\Summer\Cmte\B\Marketing Consumer Info White Paper Adpted by B Committee 6-27-12 Final.docx

Draft: 6/27/12
As adopted by the Health Insurance and Managed Care (B) Committee, 6/27/12

NAIC Form Review White Paper

Introduction

Under the federal Patient Protection and Affordable Care Act (ACA)[1], an American Health Benefit Exchange will be established in each state, either by the state or the federal government, in time to operate beginning January 1, 2014.[2] Some of the states where there is a federally facilitated Exchange (FFE) may opt to handle plan management functions for the Exchange, including certification of qualified health plans (QHPs), by entering into a Partnership agreement. Regardless of the type of Exchange operating in a particular state, state insurance regulators should be aware of important changes that impact the requirements of form review, whether coverage is offered inside or outside of an Exchange. This paper discusses those requirements, while focusing in large part on considerations for state departments of insurance (DOIs) that plan to handle or participate in QHP certification for either a state-based Exchange (SBE) or an FFE.

Plans offered in the Exchanges must be QHPs that meet certain federal requirements laid out in the ACA and subsequent regulations,[3] as well as any additional QHP certification requirements that might be imposed by the state. Additionally, QHP form documents must meet the applicable requirements that a state might adopt on insurance forms. Because review of a QHP for certification is akin to the form review process already performed by the various DOIs[4], if they are granted authority to do so in conjunction with a SBE, or as part of a Partnership Exchange agreement, the DOIs may also determine, as part of, or concurrently to form review, if plans may be certified as QHPs, and are thereby eligible to be sold in the Exchanges.

The form review process for QHPs will be the same for individual coverage and small employer coverage offered in an SBE. While there might be some differences in applicable requirements, some requirements apply consistently across these markets. For example, all non-grandfathered plans in the individual and small group markets (inside and outside of an Exchange) will be required to be guaranteed issue.[5] They also will be required to include the essential health benefits (EHBs) and will be required to comply with the actuarial value (AV) and cost-sharing standards in the ACA.[6]

DOIs responsible for, or assisting with, QHP certification will also need to verify that each issuer selling on the Exchange is offering at least one gold QHP and one silver QHP.[7] The issuer must also offer a child-only plan at the same level of coverage as any QHP.[8] Due to the fact that only non-grandfathered plans may be sold in the Exchanges, grandfathered plans will not be reviewed for certification requirements, nor will non-grandfathered plans not intended for sale on Exchanges.

Provisions Unique to QHPs

The Exchange regulations promulgated by HHS apply special provisions to QHPs sold on the Exchanges. These provisions include, but are not limited to, requirements for the following: offering plans to deliver federally financed cost-sharing reductions for low-income individuals[9], enrollment periods[10], termination of enrollment[11], grace periods[12], minimum offering of gold, silver and child-only plans[13], network adequacy[14], service areas[15], quality accreditation of plans[16] and the segregation

[1] Pub. L. 111-148 (ACA), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010).
[2] ACA §1304(b)(1).
[3] ACA §1301 and 45 CFR §156.200–295.
[4] Some state insurance regulators may go by different names, or responsibility may be divided among more than one entity. The term "DOI" as used in this paper refers to all types of these arrangements.
[5] PHSA §2702.
[6] ACA §1302(a).
[7] ACA §1301(a)(1)(C)(ii).
[8] PHSA §2707(c).
[9] ACA §1402.
[10] 45 CFR §156.265.
[11] 45 CFR §156.280.
[12] 45 CFR §156.270(g).
[13] 45 CFR §156.200.

© 2012 National Association of Insurance Commissioners

of funds for coverage of elective abortion services[17]. State insurance regulators' review of QHP policy documents will need to account for these special requirements, which may differ from existing state standards. The states may wish to consider applying many of the QHP-specific standards in federal law (such as open enrollment periods and minimum offering standards) to issuers both inside and outside the Exchange market, as a means of making market rules consistent and minimizing the risk of adverse selection.

Multi-State Plans

The ACA required the U.S. Office of Personnel Management (OPM) to enter into an agreement with at least two issuers to offer multi-state plans on the Exchanges of every state in the individual and small group markets.[18] Though multi-state plans are deemed to be QHPs and the Exchanges must allow them to be offered, nothing in the law preempts state insurance regulators from ensuring that these plans, which may only be sold by licensed issuers, meet all applicable state laws. The form review process for multi-state plans will, therefore, not be appreciably different from the form review process for any other plan sold in the individual or small group market, except that communication with OPM will be necessary. Additional information regarding the requirements for multi-state plans will be available when OPM releases regulations for this program.

CO-OPs

The ACA creates a program to help create new, private non-profit health issuers, called Consumer Operated and Oriented Plans (CO-OPs). [19] CO-OPs will be able to offer health plans through the Exchanges. An Exchange must recognize a health plan offered by a CO-OP if the plan is deemed certified by the U.S. Centers for Medicare & Medicaid Services (CMS) or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO-OP QHPs as set forth in the ACA and, except for a narrow exception, all state-specific standards established by an Exchange for QHPs operating in that Exchange. [20] The form review process will not differ from the form review process for any other QHP. It should be noted that CO-OPs must be licensed as issuers in each state in which they operate and are subject to state laws and regulations that apply to all similarly situated issuers.

Dental Coverage

In addition to QHPs, the ACA permits stand-alone dental plans to be sold on Exchanges.[21] While dental-only coverage is considered an excepted benefit under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is not subject to most of the insurance reforms in the ACA, the federal Exchange regulations do apply cost-sharing limits and prohibitions on annual and lifetime limits to pediatric dental coverage offered through the Exchanges and apply the same certification standards to qualified dental plans (QDPs) as apply to QHPs, except for those that cannot be met because QDPs offer only pediatric dental benefits.[22] Due to the fact that QHPs may omit coverage for pediatric dental benefits if dental-only coverage is available on the Exchanges, QDPs[23] will likely provide a portion of the EHBs, so the states may want to consider which provisions, beyond the federal requirements, should be applied to them, as a matter of state law. In the absence of federal guidance on which federal requirements would apply, some provisions that the states may want to consider will include guaranteed issue, guaranteed renewability, rating rules and the prohibition on rescissions, among others. Other

---

[14] 45 CFR §156.235.
[15] 45 CFR §155.1055.
[16] 45 CFR §156.275.
[17] 45 CFR §156.280.
[18] ACA §1334.
[19] ACA §1322.
[20] 45 CFR §156.520(e) of the HHS final rule on CO-OPs says health plans offered by a loan recipient may be deemed certified as a CO-OP qualified health plan to participate in the Exchanges for two years and may be recertified every two years for up to 10 years following the life of any loan awarded to the loan recipient if it meets all state-specific standards established by an Exchange for qualified health plans operating in that Exchange, except for those state-specific standards that operate to exclude loan recipients due to being new issuers or based on other characteristics that are inherent in the design of a CO-OP.
[21] ACA §1311(d)(2)(b).
[22] 45 CFR §155.1065.
[23] While the term "qualified dental plan" does not appear in the ACA, the NAIC's *American Health Benefit Exchange Model Act* (#929) uses this term to refer to stand-alone dental products sold on Exchanges.

provisions may be difficult to apply to QDPs. There is considerable uncertainty about how the presence of QDPs on Exchanges will affect the calculation of AV for QHPs that do not offer pediatric dental benefits and about how AV requirements will apply to QDPs. According to representatives of dental plans, metal tiers could be difficult to apply because a silver plan, with a 70% AV, would include cost-sharing well in excess of what is commonly sold on the market today and would not be desirable to consumers. However, dental plans will have to change in many cases to adjust to new requirements, in particular because those offering pediatric dental coverage must ensure they do not have annual or lifetime limits on the dollar value of such coverage, which is an EHB. Additionally, while the pediatric dental portion of the EHB may be provided through a QDP, the ACA and related guidance indicate that the AV may be calculated not for individual dental plans but based on EHB coverage as a whole. The summary of benefits and coverage (SBC) was not developed with dental plans in mind and may not be appropriate for QDPs. To date, the U.S. Department of Health and Human Services (HHS) has not proposed an alternative SBC document for QDPs.

Grandfathered Plans

Plans in effect on the date of enactment of the ACA (March 23, 2010) may be considered grandfathered plans, and are, therefore, exempt from most of the law's requirements, if significant changes have not been made to the plan.[24] The major provisions of the ACA that apply to the form review of all grandfathered health plans include the elimination of lifetime dollar limits on EHBs, the prohibition of rescissions except in the case of fraud or intentional misrepresentation of material fact, and the extension of dependent coverage for children until age 26.[25]

Grandfathered health plans in the small and large group markets must also comply with limitations on annual dollar limits on EHBs. As of January 1, 2014, grandfathered group plans also must eliminate annual dollar limits on EHBs and comply with the prohibition on preexisting condition exclusions (the prohibition on such exclusions for children under age 19 went into effect September 23, 2010).[26]

Changes to the Form Review Process

While the ACA makes sweeping changes to the substantive requirements that the form review process is designed to verify compliance with, the process itself will remain the same in many respects. For most provisions of the ACA, form reviewers will be verifying that the policy documents either contain required elements, such as extended dependent coverage for adult children up to age 26,[27] or do not contain provisions that violate prohibitions or restrictions in the law, such as prohibitions on preexisting condition exclusions[28] and limitations on cost-sharing.[29] State insurance regulators are already familiar with this type of review, even if the substantive requirements will be new.

The appendix at the end of this paper contains summaries of some of the major new requirements, prohibitions and restrictions that form reviewers may be looking for in policy documents.

Other reforms in the ACA, however, will require important changes to the way that issuers file policy forms and the states review them. Most significantly, while forms are currently filed and evaluated at the product level, several provisions of the ACA will require analysis at the plan level.

A *product* is a package of benefits that an issuer offers that is reported to state regulators in an insurance filing[30]. A single product filing may include many different plans, each of which is a discrete pairing of a package of benefits and a particular cost-sharing option (not including premium rates or premium quotes).[31] It should be noted that a product, as defined in the federal EHB guidance, does not include a cost-sharing structure.

[24] Conditions under which a plan will lose its grandfathered status are specified in federal regulations, at 45 CFR §147.140.
[25] 45 CFR §147.140(d).
[26] 45 CFR §147.140(e).
[27] PHSA §2714.
[28] PHSA §2704.
[29] ACA §1302(c).
[30] 45 CFR 159.110.
[31] *Ibid.*

Product filings typically include:

- Contracts (also referred to as "evidence of coverage" or "policy").
- Certificates (also referred to as "member handbook").
- Summary of benefits (also referred to as "explanation of benefits" or "schedule of benefits").
- Riders or endorsements that alter the provisions of a contract.

In addition to the use of riders or endorsements to alter provisions of a contract, the language of one or more product filings may include bracketed material where individual plans differ from one another. Such filings are often accompanied by statements of variability presenting form reviewers with more information about these differences. For most provisions of the ACA, this approach will continue to work well, allowing regulators to review common policy provisions in an efficient manner. Other provisions, particularly those dealing with the cost-sharing[32] and actuarial value of plans,[33] must be reviewed on a plan-by-plan basis. For this reason, issuers will most likely need to submit the necessary information for review of these provisions on a plan-by-plan basis, indicating which product filings these plans are based on. The states should evaluate if and how their form and related rate review processes should be amended to accommodate a plan-level review in addition to a form-, product- or market-level review.

For those plans that are intended as QHPs, additional requirements will apply, mainly related to procedures for enrollment and disenrollment through the Exchange, although the states may also impose their own QHP certification requirements. State insurance regulators may need to coordinate the form review process for compliance with these requirements with the Exchange, which is addressed in more detail in the "Interactions with Exchanges and other Entities" section of this paper. Also, those states with use-and-file dispositions may need to consider how to adjust that process to address QHP certification, because each plan must undergo regulatory review to ensure it meets all state and federal requirements before it can be sold as a QHP on the Exchange.

Because of the changes that will be occurring in the form filing and review processes, and because of the increased volume of filings leading up to 2014, the states may want to consider issuing bulletins and guidance on changes to the form filing and review process in order to make issuers aware of the new requirements and to ensure a timely and uniform review process. Some of the states require that form filings be accompanied by rate filings. For purposes of ACA-related form review, the states may consider decoupling form review from rate review, which would allow form review to proceed with the related rates filed subsequently. This could assist with workflow while also ensuring that rates accurately reflect the product design in the approved forms.

A number of ACA provisions will require review procedures that are well outside of those currently employed by state insurance regulators in the form review process, which merits a separate discussion.

Essential Health Benefits (EHBs)

Plan compliance with EHB requirements will most likely be determined in much the same way that the states currently enforce mandated benefit laws. For QHP products to be offered on an Exchange, the states initially may want to consider streamlined workflow processes, as suggested elsewhere in this paper, to ensure appropriate review, but also timely approval, for initial Exchange offerings.

The major difference will be that issuers will, unless a state prohibits it, be allowed to make actuarially equivalent substitutions of benefits within each of the 10 required service categories.[34] From the preliminary information currently available, it is likely that products offering benefits that vary from a state's benchmark package will need to be accompanied by a demonstration of equivalent value in each category using actuarial methodology following accepted standards of practice. This demonstration may include a description of the methodology used by the issuer to make the equivalence determination, as well as data used to support the determination. Evaluation of these filings will likely require substantial actuarial resources, depending on how complex and subjective the process is. It should be noted that nothing in the federal statute or guidance would appear to prevent a state from limiting or prohibiting

[32] ACA §1302(c).
[33] ACA §1302(d).
[34] U.S. Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), "Frequently Asked Questions on Essential Health Benefits Bulletin," Feb. 17, 2012, p. 3.

these substitutions. Those states with limited resources in form and actuarial review may wish to consider how such limits or prohibitions may facilitate the state's review of insurance forms and plans for use after 2014.

Note: Additional guidance from HHS will be needed regarding whether the states can limit or prohibit benefit substitutions and how to evaluate benefit substitutions, as the current guidance is incomplete and preliminary in nature.

Actuarial Value and Cost-Sharing Reductions

While additional guidance and a completed AV calculator[35] will be needed before specific regulatory processes can be developed, the states will likely require form filings for each plan to include a disclosure of how benefits were defined and entered into the AV calculator. Additionally, although information issued by HHS indicates that the states will verify AV using the calculator for each plan inside and outside of the Exchange, the states may wish to consider requiring filings to include a printout of the inputs and results from the AV calculator (if the calculator allows this functionality) in order to facilitate the submission and review/approval process, provided future federal guidance permits such. This will allow the states to use the calculator to verify the plan's AV or to review the submitted results, and may dispense with the need for actuarial staff to review AV calculations for plans without features, such as tiered provider networks with expected utilization spread across tiers and some value-based insurance designs that cannot be easily captured in a calculator. In these cases, issuers may also need to provide their methodology for augmenting the results of the AV calculator. Evaluation of this supplemental information will require additional actuarial resources that are not today used in the form review process. To the extent that the calculator can be designed with an application programming interface (API) or other interface that allows programmatic access to the calculator by the NAIC's System for Electronic Rate and Form Filing (SERFF), the state regulatory workflow could be streamlined by automating this verification process. Additionally, the states may wish to consider the use of issuer attestations and certifications in certain instances (and if permitted by federal standards) in order to reduce the volume of plans for which AV must be independently confirmed by the state.

Note: Additional federal guidance and a completed AV calculator are needed before specific regulatory processes can be developed.

Discriminatory Benefit Design

The ACA prohibits discriminatory benefit designs that would discourage enrollment by individuals with significant health care needs.[36] The bulletin issued by HHS in December 2011 indicates that this prohibition will also be incorporated into EHB regulations to satisfy the requirement that EHBs not discriminate against individuals because of their age, disability or expected length of life.[37]

Note: HHS has indicated that it is considering developing an electronic tool that it will use in an FFE to determine QHP compliance with this standard. It is unclear yet whether a state in a Partnership Exchange would be required to use the federal tool or whether it would be able to use its own procedures. This tool may also be made available for use by SBEs, although the states wishing to use their own procedures and tools for enforcing these prohibitions would be free to do so.

Meaningful Difference

HHS has indicated that as part of QHP certification process related to "being in the best interest of the public," that "meaningful difference" between QHPs on the FFE will be performed in order to ensure that QHPs within a single metal level and issuer have some meaningful difference. A state with an SBE may wish to perform a similar analysis in order to help address risk avoidance and to ease consumers' ability to compare plan options.

[35] CCIIO, "Actuarial Value and Cost-Sharing Reductions Bulletin," Feb. 24, 2012, p. 6.
[36] ACA §1311(c)(1)(A).
[37] ACA §1302(b)(4)(B).

© 2012 National Association of Insurance Commissioners

"Consumer Best Interest"

The ACA provides that, in addition to other certification requirements, an Exchange must determine if a QHP is in the "best interest" of qualified individuals and qualified employers.[38] A state operating an Exchange has significant discretion in determining the criteria that will be considered in making this determination. State insurance regulators performing QHP certification may wish to coordinate with their Exchange as to which entity should perform this part of the QHP certification process. Issues related to state insurance regulators' authority and possible conflicts of interest may hinder state insurance regulators' ability to perform this part of certification, especially if it includes processes such as competitive bidding for Exchange participation. Such a process may be more appropriately performed by another entity.

Resource Considerations

Implementation of the ACA in 2014 is likely to require that additional resources in the DOI be devoted to the form review process for QHPs in the Exchange and for health plans outside the Exchange. The state may require additional actuarial resources (such as actuaries, actuarial students or administrative staff) in order to accommodate the review of new and revised plan designs, the accuracy of actuarially equivalent substitutions of EHBs, the assessment of the actuarial value, the implications and effects of cost-sharing reductions and discriminatory benefit design analysis.

In addition to new actuarial resources, the insurance department and other state agencies will need adequate professional and administrative staffing to review new and revised forms, as well as to ensure compliance with new and existing state and federal laws. In particular, the period leading up to the October 2013 initial open enrollment period will likely be quite busy as issuers prepare QHP filings to be sold on the Exchange. In addition to the increased number of filings, the ACA's new requirements may cause some confusion, extending the amount of time needed for review. As filers and reviewers become accustomed to the new requirements over time, the process will likely become more efficient. In the interim, the states may want to implement tools to streamline the process by updating their current product review standards through statutory or regulatory amendments, online state-specific standardized checklists, or other online filer tools to assist the health care industry with the submission of plans to the states for review. Additional training for industry filers and state form review and actuarial staff will be paramount in order to ensure a good knowledge base for the most efficient and consistent review of products and plans.

Interactions with Exchanges and Other Entities

It is important to consider how the DOI will interact with the Exchange in order for an issuer to have plans available for purchase. These interactions should be carefully designed, keeping in mind the amount of time involved for a DOI to complete its reviews of policy forms and rates, as well as a review to determine if a plan should be certified as a QHP. Bypassing any redundant workflows will be necessary to ensure the accuracy of plan information displayed on an Exchange. Electronic processes for communication between DOIs and an Exchange also will be imperative to ensure timely and accurate QHP approval processes.

In all Exchange options as described below, a state retains its regulatory authority for plan review for compliance with all state laws. An entity that performs plan form review and QHP certification will most likely be able to significantly reduce the timeline and resources necessary for a QHP to be offered on an Exchange. When an entity other than a DOI performs QHP certification, the DOI will still review the plan for compliance with all state and federal insurance laws. Another entity, the federal government or the Exchange (whether an SBE or a Partnership Exchange), also will have to review the plan for compliance with QHP certification requirements. Issues to be resolved and decisions made will then need to be communicated and reconciled among all entities. Communication between the DOI and the Exchange may be facilitated through SERFF in order to leverage existing technology that is already in use today. HHS has made a commitment to working with the NAIC so that SERFF can be leveraged by SBE and Partnership states to perform certain plan management functions, including QHP certification, benefit and rate data collection, and reporting associated with QHP submissions. HHS also has committed to working with the NAIC to ensure that, in the FFE, issuers will not be overly burdened by duplicative

[38] ACA §1311(e)(1)(B).

data entry. The states may continue to utilize existing technology to perform regulatory review of forms and rates to confirm that benefit and rate information intended for display within the FFE is consistent with that which was approved by the state.

State-Based Exchange

An SBE will offer the greatest amount of flexibility for the states, which will need to determine which entity will certify plans as QHPs. The DOI is familiar with similar processes and is best suited for an effective and efficient review for QHP certification; however, a state may alternatively vest QHP certification responsibilities with the Exchange or some other entity, particularly if it pursues a selective contracting Exchange model. If some or all of the QHP certification is to be undertaken by the Exchange or another entity, DOIs may consider recommending their proven, effective and efficient processes as guidance to assist with timely approval of QHPs to be offered on the Exchange. Processes for loading QHPs onto an Exchange once they have been properly filed, reviewed and approved by a DOI and have received QHP certification should be streamlined. Again, incorporating SERFF into the Exchange's plan management infrastructure will help facilitate this process.

Partnership Exchange

A state that enters into a Partnership Exchange will have the option to retain plan management responsibility, which includes QHP certification, or to delegate plan management in its entirety to the federal government. In a Partnership Exchange where the state maintains plan management, the interaction between the state and the FFE would be similar to the interaction between the state and an SBE. Once the certification process is complete, the state would need to communicate that fact to HHS via SERFF or some other method.

Federally Facilitated Exchange

The federal plan management process is not yet fully defined. With an FFE, the state will retain existing form and rate review responsibilities for compliance with state laws, although plans intended for sale on the Exchange will likely undergo an additional round of review by HHS for QHP certification purposes.

Multi-State Plans and OPM

With multi-state plans, the states will review them for compliance with all state laws, while the U.S. Office of Personnel Management (OPM) will likely review them for compliance with the terms of its contractual requirements with multi-state plans.

Note: How interactions, such as communication and reconciliation between a state and OPM, will be accomplished is unknown until OPM releases regulations governing multi-state plans.

Use of SERFF

Over the past 10 years, the states have worked to improve the process for issuers to submit their rate and form filings to DOIs. The NAIC has assisted in this process through speed-to-market initiatives and the submission of electronic rate and form filings via SERFF. SERFF can play a role in Exchange administration for regulators who need to implement new requirements, conserve resources and integrate regulation inside and outside of Exchanges.

The states can continue to use SERFF for form review as they establish their ACA-related requirements for health insurance forms. SERFF can be an avenue for each state to configure and publish its new substantive and procedural requirements. For example, with regard to benefit design, when a state has decided on its EHBs, the state can maintain a list of its EHBs in SERFF to function as a compliance checklist for issuers and regulators, for informational purposes. As an example with regard to consumer protection and transparency, SERFF is one of the places where a state can inform issuers how that state will treat the federally required summary of benefits and coverage (SBC): as a form subject to review, as supporting documentation or as an informational item. A state can also use SERFF to instruct issuers on whether forms must be redlined to show ACA-related changes from previously approved versions, whether supplemental benefits or non-discrimination provisions should be flagged for state reviewers and how other ACA requirements apply in that state. The states using SERFF will need to review federal ACA requirements and related final rules in relation to their state-specific requirements, update those respective standards accordingly and repost them within SERFF.

While not yet available, enhancements to SERFF that are currently under way will enable the states to use SERFF not only for form and rate review but also to review QHP applications, certify QHPs to participate in Exchanges and carry out related oversight functions, such as renewing, monitoring, recertifying and decertifying QHPs. It is envisioned that an issuer that wants to base a QHP on an insurance product it already offers in a particular state will have the ability to "build" a QHP in SERFF using forms and rates that the state has already accepted, depending on the state's existing requirements.

This QHP-building capability is one way to bridge the gap between products and plans. This capability also will minimize the duplication of submission efforts for issuers, as well as the duplication of form review and enforcement efforts for regulators. However, issuers and regulators should expect that the initial rounds of QHP applications may require new and revised forms and rates, with efficiency increasing as the number of QHPs increases. Finally, if QHP forms and related information reside in SERFF along with non-QHP forms and information, regulators will have consistent, simultaneous access to health insurance products on and off the Exchange. This will facilitate any parallel and crosswalked reviews required by ACA.

© 2012 National Association of Insurance Commissioners

APPENDIX: 2014 ACA Rules and Regulations that Will Impact Form Filings

The following summarizes federal law and regulations relating to market reforms found in the ACA that are effective January 1, 2014. As noted, some market reforms are specific requirements related to QHPs only. The states may wish to analyze existing state protections against the federal standards in light of the preemption provisions of the ACA.

Benefit Design Requirements

Essential Health Benefits (EHB)

The ACA requires that all non-grandfathered individual and small group plans, inside and outside the Exchange, provide coverage for the EHBs outlined in §1302(b) of the ACA. This section provides that the EHBs include items and services within the following 10 benefit categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

In December 2011, HHS issued a bulletin summarizing its intended regulatory approach. The bulletin outlined a process for the states to select a benchmark plan from the following list whose benefits will constitute the EHBs for the individual and small group markets for the state for calendar years 2014 and 2015:

- The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options by enrollment.
- The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

HHS has also advised that, under this approach, a state may select only one of the benchmark options as the applicable EHB benchmark plan across its individual and small group markets, both inside and outside of the Exchange. If the selected benchmark package does not include services from any one of the required categories, the state would be required to supplement the package, as outlined in the bulletin or in future guidance or rules, with the benefits in that category from another one of the benchmark plans or from another source. HHS also defined the largest plan by enrollment in the largest small group product as the default benchmark should a state not make an election.[39]

Proposed HHS guidance has indicated that plans will be permitted to make actuarially equivalent substitutions within each of the 10 categories specified. At this point, whether a state can limit or prohibit such substitutions is not clear. Nonetheless, companies requesting actuarially equivalent substitutions will be expected to provide supporting documentation and detailed demonstrations that the form meets all required EHB categories, as well as include additional demonstrations if actuarially equivalent substitutions are made within any of the categories.

The states may accept a certification of compliance from issuers requesting actuarially equivalent substitutions and/or request review by an actuary. Where applicable, the states may continue to require statements of variability and/or copies of previously approved forms with "tracked' changes.

[39] For more details on HHS' specification of the default EHB benchmark plan, please see CMS, CCIIO, "Essential Health Benefits Bulletin," Dec. 16, 2011, p. 11. Additional details are expected in forthcoming EHB regulations.

Dental Plan Benefits

A plan may not be excluded from the Exchange for failure to provide pediatric dental benefits if a QDP offering the pediatric dental EHB is available on the Exchange.

Benefit Limits

Currently, annual limits on the dollar value of EHBs are restricted and lifetime limits on the dollar value of EHBs are prohibited. In 2014, issuers also will be prohibited from imposing annual limits on the dollar value of EHBs. This limitation does not apply to any individual or group plan for specific covered benefits that are not EHBs to the extent that such limits are otherwise permitted under applicable federal or state law.

Mental Health Parity and Addiction Equity Act (MHPAEA)

Section 1311(j) of the ACA states: "Section 2726 of the Public Health Service Act (PHSA) shall apply to QHPs in the same manner and to the same extent as such section applies to health insurance issuers and group health plans." In turn, Section 2726 of the PHSA applies to a "group health plan or a health insurance issuer offering group or individual health insurance coverage."[40] Therefore, the requirements of the MHPAEA must be applied to all plans of health insurance coverage whether issued inside and outside of the Exchange, to an individual or through an employer group.

The MHPAEA indicates that plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations upon mental health and substance abuse treatment services that are more restrictive than the predominant requirements and limitations that apply to substantially all medical and surgical services. Financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximums. Although the MHPAEA regulation excludes aggregate lifetime and annual dollar limits from the meaning of financial requirements, the ACA requirements for annual and lifetime dollar limits includes mental health and substance abuse disorders as part of the EHBs.

Additionally, mental health and substance abuse services may not be subject to separate cost-sharing requirements, and if a plan provides for out of network coverage of medical and surgical services, it must also provide out-of- network coverage for mental health and substance abuse treatment.

Cost-Sharing Limitations

Section 1302(c) of the ACA and Section 2707 of the PHSA, as added by the ACA, address the restrictions on cost-sharing that apply to non-grandfathered health plans. The law limits cost-sharing under a health plan to the maximum cost-sharing allowed in 2014 for high-deductible health plans that qualify for use with a health savings account (currently, $5,950 for an individual/$11,900 for a family). In subsequent years, the limitation on cost-sharing is indexed to the rate of average premium growth. Additionally, deductibles for plans in the small group market are limited to $2,000 for an individual/$4,000 for a family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.

Note: Additional information regarding cost-sharing limitations should be provided as further guidance is released.

Prohibition on Discriminatory Benefit Design

HIPAA protections already in effect for the small employer market include these same health status-related factors with the exception of "any other health status-related factor deemed appropriate by the Secretary." In addition, the benchmark plan that will be in place in 2014 will be reviewed and approved by HHS; therefore, the benchmark plan will include eligibility provisions that comply with this requirement. When issuers make substitutions in the benchmark, the states will need to conduct an in-depth form review to ensure that benefit design substitutions are not discriminatory. In the absence of HHS-established guidelines governing benefit design prohibitions that have the effect of discouraging the enrollment of individuals with significant health needs in a particular plan, some of the states may choose to require company certification of

[40] PHSA §2726.

compliance in this area. A related provision prohibits the use of health status-related factors by issuers. For more information on that provision, see the section on discrimination based on health status-related factors below.

Note: The states will look to HHS for additional guidance or rules regarding the prohibition of plans that employ discriminatory plan design.

Prohibition on Preexisting Condition Exclusions

Since September 23, 2010, issuers have been prohibited from excluding coverage for preexisting conditions for children younger than age 19. This prohibition applies to all health benefit plans and health insurance policies except for grandfathered individual market policies.

For plan years beginning January 1, 2014, the prohibition on preexisting condition exclusions will extend to people of any age, but will still not apply to grandfathered individual market policies. This prohibition will apply to all other health benefit plans and health insurance policies sold inside and outside of the Exchange.[41]

It is not expected that issuers will need to submit additional supplemental information. However, the regulating state will need to perform an appropriate review of the forms to ensure the presence of required provisions and the absence of prohibited language.

Network Adequacy/Service Areas

Section 156.230 of the final Exchange regulations require that a QHP include within its provider network a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals. This section defines "essential community providers" as those health care providers defined in Section 340B(a)(4) of the PHSA.

At a minimum, QHP plans should ensure a sufficient choice of providers in a manner consistent with applicable network standards of Section 2702 (c) of the PHSA, provide information to enrollees and prospective in-network and out-of-network providers, and include those defined essential community providers as referenced previously. Furthermore, the states with tribal organizations may wish to explore designating Indian Health Service providers as essential community providers.

Note: Additional federal guidance may be forthcoming relating to adequacy of essential community providers.
Considerations include the need to address how QHPs respond to areas with recognized shortages of health providers (especially rural and remote areas); provider participation; reimbursement levels; requirements for health issuers and participating providers; filing requirements and state administration; network and provider disclosure to insureds; and enforcement.

Reviewers of QHP-related forms that include in-network and out-of network provisions should be mindful of descriptions of service areas, and consult current statutes governing managed health care arrangements along with the ACA directives.

For more information, please refer to a separate NAIC white paper titled, *Plan Management: Network Adequacy White Paper*, which discusses this issue in greater depth.

Abortion Services and Separation of Funds

The ACA requires QHPs to segregate funds in a separate allocation account to pay for coverage of certain elective abortion services that cannot be paid for with federal funds. A QHP issuer satisfies this requirement if it issues an itemized bill that separates the costs of abortion coverage from the costs of all other coverage, collects the required separate payments through a single transfer of funds in response to the itemized bill, and maintains "allocation accounts" in line with current industry practice. A QHP issuer must collect separate payments *only* from individuals receiving premium assistance credit; therefore, the segregation requirements apply only to these individuals. QHPs must also submit a plan to the state insurance commissioner that details its process and methodology for complying with these requirements.

[41] 45 CFR 155.1065.

Reviewers of forms with the provision for abortion coverage should be mindful of such statutory and regulatory requirements and any relevant state laws.

Individuals in Clinical Trials

Effective January 1, 2014, the ACA requires that if a "qualified individual" is in an "approved clinical trial," the plan cannot deny coverage for related services. Plans are not required to cover treatments that fall outside of the designated class of approved clinical trials, and plans may not deny coverage because a member is participating in an approved clinical trial conducted outside of the state in which the member lives.

A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate or the individual provides medical and scientific information establishing that their participation is appropriate.

An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

In connection with expenses, "routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include: 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data-collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan's network area unless out-of network benefits are otherwise provided under the plan.

If a participating provider is participating in an approved clinical trial, the plan may require the individual to participate in the trial through that participating provider if the provider will accept the individual as a participant in the trial.

Many of the states may already mandate coverage for clinical trials relating to cancer and other diseases or conditions. The ACA provision extends to life-threatening conditions. State coverage mandates should be examined to ensure that they are consistent with these federal requirements.

Consumer Protection and Transparency Requirements

Guaranteed Availability

Effective in 2014, Section 2702 of the PHSA requires each QHP issuer to accept every qualifying employer and individual that applies for coverage and who works or resides in its state. However, issuers may restrict enrollment to open and special enrollment periods and enrollment periods for qualifying events.

Currently effective for plan years starting six months after enactment of the ACA, plans must already comply with the requirement of providing coverage to enrollees up to age 19.

Regulators should review QHP forms to ensure that prohibited provisions are not included.

Guaranteed Renewability

Section 2703 of the PHSA, as amended by the ACA, guarantees the renewability of insurance coverage. An issuer that offers health insurance coverage in the individual or group market must renew or continue in-force coverage at the option of the plan sponsor or individual. An issuer may only non-renew or cancel coverage in the event of nonpayment of premiums, fraud, violation of participation or contribution rates, market exit, movement outside the service area or cessation of association membership.

State insurance regulators should review issuers' forms to ensure continued compliance.

Enrollment

QHPs within the Exchange must provide an initial open enrollment period, an annual open enrollment period and a special enrollment period for qualifying events. Such dates must be clearly defined. Enrollments as a result of birth, adoption or placement for adoption must be effective on the date of birth, adoption or placement for adoption. Additionally, beginning in 2014, issuers in the Exchange must provide a written notification of annual open enrollment to each enrollee.

Forms will need to be revised, or an endorsement/amendment form(s) will need to be attached to current forms. Regulators will need to review such forms for compliance with these required provisions and notification(s). Additionally, application/enrollment forms and possibly marketing materials may also require review to determine compliance with the updated enrollment requirements.

Note: The states will need to consider additional, anticipated federal guidance on open enrollment periods outside of an Exchange.

Termination of Coverage

Section 155.430 of the final Exchange regulations sets rules establishing when individual's coverage in a QHP may be terminated, when an enrollee may terminate his or her coverage, the appropriate effective date of termination and proper notification of termination requirements.

State insurance regulators will need to review QHP-related forms and any endorsements or amendments for compliance with these provisions.

Grace Periods

Section 156.270 of the final Exchange regulations requires a provision within the termination coverage section that directs QHP issuers to provide notice to all enrollees who are delinquent on premium payments. Individuals receiving an advanced premium tax credit and lose coverage due to non-payment of premium must be provided a three-month grace period. The QHP must cover all allowable claims for the first month of the three-month grace period and may pend subsequent claims in the second and third months of the grace period. During the grace period, a QHP issuer will continue to collect subsidy payments on the delinquent enrollee's behalf and return such payments of the premium tax credit for the second and third months of the grace period if the enrollee exhausts the grace period.

State insurance regulators will need to review QHP-related forms, along with any endorsements or amendments, to ensure compliance with QHP grace period and proper notification requirements, as well as necessary disclosure regarding retention of premium tax credits.

State insurance regulators also must ensure that the grace period is applied uniformly to all QHP enrollees in similar circumstances and that the QHP maintains proper records of the termination of coverage.

Waiting Periods

Section 2708 of the PHSA sets rules prohibiting group health plans and coverage from imposing excessive waiting periods. A waiting period begins on the date the employee becomes a qualifying employee and must not exceed 90 days.

QHP forms must be revised to include an updated definition of a waiting period pursuant to Section 2704(b)(4) of the PHSA to state the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

Note: This definition does not distinguish between full-time and part-time employees.

State insurance regulators must review forms for prohibited excessive waiting period provisions (also known as probationary periods) that may appear within application or enrollment forms.

State insurance regulators also must review forms, including application/enrollment forms, for prohibited excessive waiting period provisions (also known as probationary periods).

Prohibition on Utilization of Health-status Related Factors

The ACA requires that, for plan years beginning January 1, 2014, non-grandfathered plans may not include in eligibility provisions or continued eligibility provisions, rules for eligibility based on any "health status-related factor." A "health status-related factor" means any of the following: health status, medical condition (physical or mental), claims experience, receipt of health care, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or any other health status-related factor deemed appropriate by HHS.

Non-Discrimination Against Participants and their Beneficiaries Based on Race, Ethnicity, Nationality, Gender, Age, Disability, Sexual Orientation, Genetic Information and Religion

Under Section 1557 of the ACA and existing civil rights laws, no enrollee shall, on the basis of race, color, national origin, sex, age or disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, under any health program or activity, any part of which is receiving federal financing assistance, including credits, subsidies or contracts of insurance.

Some of the states may require a review of forms to ensure that prohibited provisions are not present. Some of the states may only require the issuer to submit written certification providing acknowledgement and assurance that the issuer does not discriminate based on race, ethnicity, language, nationality, gender, age, disability, sexual orientation or domestic violence.

In any case, because Section 1557 of the ACA and existing civil rights laws apply broadly, regulators must review application and enrollment forms for questions that may include any prohibited elements and the potential underwriting or eligibility determinations based on such responses. Issuers of QHPs are covered under Section 1557 of the ACA and other federal civil rights laws because they will receive insurance premium payments through federal premium credits, which is a form of federal financial assistance. In addition, Exchanges must also comply with Section 1557's ban on discrimination as entities established under Title I of the ACA. Exchanges are, therefore, barred from allowing insurance companies that discriminate to participate in Exchanges, because to do so would be to provide assistance to discriminatory policies themselves in violation of Section 1557 of the ACA and other federal civil rights laws. Additional requirements in the ACA require that regulators be assured that SBC documents are provided in linguistically correct language. Additionally, actuarial memorandums and rate manuals may need to be analyzed for such non-discrimination underwriting practices.

Prohibition on Discrimination Against Providers Acting within Scope of Own Licensure or Certification

Plans may not discriminate against providers acting within their scope of practice. However, this law does not require that a plan contract with any willing provider and does not prohibit tiered networks. QHPs must ensure a sufficient choice of providers in a manner consistent with network adequacy provisions.

This is an insurance plan/provider contract issue and it is not clear where this provision would be applicable within a QHP insurance coverage plan, other than assuring that medical staff and facilities are sufficient enough for compliance with the provisions of preventive health benefits as it applies to women's health services and screenings for infants, children and adolescents.

Additional guidance from HHS is needed.

Prohibition on Discrimination Against Individuals Receiving Subsidies and Cooperating with Investigations

This section prohibits issuer and health benefit plan discrimination against individuals because they receive a credit or subsidy, or because they provided information to investigators or cooperated in the investigation of a violation of the Fair Labor Standards Act, or because they objected to any activity they believed to be in violation of the Fair Labor Standards Act.

© 2012 National Association of Insurance Commissioners

Summary of Benefits and Coverage (SBC)

A group or individual plan must provide, without charge, a written uniform summary of benefits and coverage (SBC) document for each benefit package, to individuals and beneficiaries or plan sponsors upon receipt of an application, if there is a change in the SBC, or within seven days upon request. Additional time period scenarios are also specifically defined.

An SBC is to be provided to participants and beneficiaries who enroll or re-enroll in group health coverage beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. In the individual market, these requirements are applicable to health insurance issuers beginning September 23, 2012.
There are 12 content elements required to be within the SBC, including uniform standard definitions of medical and health coverage terms; a description of the coverage including the cost-sharing requirements (such as deductibles, coinsurance and copayments); and information regarding any exceptions, reductions or limitations under the coverage; illustrative coverage examples; network provider information; contact information; and a clear disclosure that the SBC is only a summary.

Specific rules also regard the manner in which the SBC is to be provided, the appearance and format of the SBC, and that it is to be delivered in a culturally and linguistically appropriate manner.

Some of the states have determined that the SBC is a form of advertising, outline of coverage or marketing material and is, therefore, required to be submitted to the DOI for review and approval. Other states have determined that the SBC is not a part of the contract and, as such, there is no regulatory authority for review. The states also may request that the SBC be submitted (perhaps as a variable template) for informational purposes, thereby not taking review and approval action.

Any of the states that review of the SBC document may wish to confirm that the benefits of the SBC reflect the covered EHBs, cost-sharing and AV (metal level) that the final approved rates and forms permit. The SBC can only be completed after the rate and form filings have been approved.

The SBC document may need to be modified for QDPs, although HHS has not yet provided such a document.

Actuarial Requirements

A number of ACA provisions will likely require the states to devote actuarial resources to determine whether health insurance plans are in compliance with the law. Actuarially equivalent substitutions of EHBs, compliance with actuarial value requirements and the provision of reduced cost-sharing to individuals with household incomes up to 250% of the federal poverty level (FPL) are all likely to require some level of actuarial analysis in the form review process.

Actuarially Equivalent Substitutions of EHBs

Of these three provisions, the most intensive actuarial work will most likely come from actuarially equivalent substitutions of EHBs. Section 1302(b) of the ACA requires all health insurance plans sold through Exchanges to include EHBs, including benefits in each of 10 categories of services, as defined by HHS. Section 2707(a) of the PHSA, extends this requirement to all plans in the individual and small group markets. In a bulletin issued December 16, 2011, HHS signaled that it was considering permitting issuers with "some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories." The bulletin suggested that these substitutions could potentially occur within and across the 10 categories, although a subsequent FAQ document seems to limit them to those within a category. All substitutions must be actuarially equivalent; using the same measures defined in the Children's Health Insurance Program (CHIP),[42] and must comply with prohibitions on discriminatory benefit designs. Because the benefits of the EHB benchmark as adopted by a state and approved by HHS, if required, should be non-discriminatory, the states may wish to focus their limited actuarial resources for discriminatory benefit design analysis upon plans that have utilized actuarial substitutions.

[42] 42 CFR §457.431.

Actuarial Value

Section 1302(d) of the ACA requires non-grandfathered individual and small group health insurance plans, except for catastrophic plans, to fall within one of four "metal tiers" defined by the AV[43] of the benefits offered by the plan, relative to the full cost of the EHBs:

- Platinum: 90% AV
- Gold: 80% AV
- Silver: 70% AV
- Bronze: 60% AV

Section 2707(a) of the PHSA extends this requirement to all plans in the individual and small group markets. Plans would be allowed a margin of +/- 2% of the required AV for each metal tier. At a minimum, all issuers selling coverage through the Exchange must make available at least one plan in the silver level and one plan in the gold level.

Section 1302(e) of the ACA defines a catastrophic plan as a permissible benefit design offered to certain qualified individuals. Catastrophic plans do not have to meet a specific AV, but must comply with the maximum out-of-pocket limits.

On February 24, 2012, HHS issued a bulletin describing their intent to develop an actuarial value calculator that will be publicly available and based on a single set of nationwide data reflecting the price of care and utilization patterns of non-elderly individuals in the individual and small group health insurance markets. The states would be divided into three tiers, reflecting geographic variations in the cost and use of health care services, in order to more accurately calculate the AV of a plan sold in a specific market. Alternatively, the states would be allowed to substitute their own data sets in order to gain further accuracy. Issuers would enter major cost-sharing features of each health insurance plan to be sold in the calculator, which would return the expected actuarial value of the plan.

Some of the states have considered using standard benefit designs on the Exchange, but the federal law does not require it. Each state will have the option to develop specific benefit designs or benefit design parameters for each of the metal coverage levels, which could greatly increase consumers' ability to understand their coverage options and compare plans on the basis of price and quality. Alternatively, the states could allow issuers broad leeway to design their products as long as they meet all applicable federal and state standards. EHB benchmark plans will not reflect cost-sharing or metal tiers. Some of the states will require plans that are offered inside the Exchange to be offered outside of the Exchange.

Consumer representatives have urged regulators to consider the potentially discriminatory effects of complex and unusual cost-sharing interactions. Representatives of health issuers, however, caution that overly broad caution could limit health plan innovation or the use of quality-driven networks and tiers. Consumer representatives also suggested that portions of the form filing demonstrating actuarial value should be subject to independent actuarial review and available to the public. Issuer representatives disagreed, citing a need to maintain the confidentiality of proprietary information and trade secrets.

Cost-sharing Reductions for Individuals below 250% of Federal Poverty Level (FPL)

Section 1402 of the ACA outlines requirements for QHPs to provide reduced cost-sharing for individuals purchasing coverage through the Exchange and have a household income below 250% of FPL. The actuarial value bulletin published by HHS in February 2012 also provides guidance for the provision of reduced cost-sharing. Each silver-level plan submitted to the Exchange must be accompanied by three variants providing AVs of 73%, 87% and 94%. These AVs would be verified in the same way that AVs for the metal tiers will be verified. In addition, state insurance regulators must verify that the reduced cost-sharing was achieved in accordance with federal requirements. According to the bulletin, cost-sharing must first be reduced by lowering the out-of-pocket limit to levels specified in annual guidance that will be provided by HHS, and then by applying adjustments to other cost-sharing factors. Nothing in the law or federal regulations would prevent a state from being more specific about how issuers offering silver plan variants must reach the higher AVs associated with the cost-sharing reductions. (Such state specifications would have to be consistent with the federal standards described above.) Some of the states may wish to consider such specifications, for example, as a way to: 1) ensure that low-income individuals can access plans with up-front cost-sharing charges that are as low as possible; 2) ease comparability of different coverage options for

[43] "Actuarial value" is a measure of the percentage of expected health care costs a health plan will cover and can be considered a general summary measure of health plan generosity.

consumers; and 3) simplify regulators' work in ensuring plans provide the required actuarial values. Like AVs for metal tier levels, the states also will need to ensure that the design of reduced cost-sharing variants does not violate prohibitions on discriminatory benefit design.

Additionally, Section 1402 of the ACA provides that QHPs covering an American Indian/Alaskan Native whose family income is less than 300% of the FPL shall not be subject to any cost-sharing under the plan. This provision is not specifically addressed in the AV bulletin, so additional guidance from HHS would be expected to address how the plans should be structured to comply with AV requirements.

W:\National Meetings\2012\Summer\Cmte\B\Form Review White Paper Adpted by B Committee 6-27-12 Final.docx

© 2012 National Association of Insurance Commissioners

Draft: 6/27/12
As adopted by the Health Insurance and Managed Care (B) Committee, 6/27/12

Rate Review White Paper

The purpose of this white paper is to assist state policymakers with the implementation of the Affordable Care Act (ACA) provisions related to health insurance rating, rate filing and rate review. The focus of the paper is the rate review requirements related to the certification of qualified health plans (QHPs) in the Exchanges, but many of the ACA provisions impacting rate review apply to all plans in the individual and small group markets.

I. Introduction

The federal Patient Protection and Affordable Care Act (ACA)[1] includes several provisions that will affect health insurance rating and rate review. These provisions include requirements for the review and disclosure of rate increases above certain defined thresholds, rating and underwriting requirements and limitations, programs to mitigate adverse selection and pricing risk, and additional requirements placed on plans offered through Exchanges. Although some of these provisions have already been implemented, those with a significant impact on rating will be effective for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by state insurance regulators, as applicable, in advance of January 1, 2014, and, in the case of qualified health plans (QHPs) offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013.

Issuers and state insurance regulators will need to create a process for developing, submitting and reviewing rates that allow for potential differences between grandfathered and non-grandfathered plans, plans inside and outside of the Exchange, plans by market if the states have varying levels of review authority and effective rate review designations, and rate increases, where applicable, at or above defined thresholds (currently 10%) vs. those under the defined thresholds.

Additionally, rate review processes and requirements should be consistently applied for multi-state plans and Consumer Operated and Oriented Plans (CO-OPs) to maintain a level playing field. Rating and plan accounting will also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with medical loss ratio (MLR) requirements, and any new federal or state taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new adjusted community rating requirements and underwriting limitations, pooling risks across products within a market (or in some cases across markets), and changes in the small group market.

The ACA also creates roles related to rate review for the federal government and new Exchange entities. Exchange governance and functional responsibilities will vary across the states and may include various combinations of state insurance regulators, Exchange entities and the federal government. The federal government will specifically play a role in rate review in cases where a state either does not have an "effective rate review program" or does not establish a certified state-based Exchange (SBE) or plan management Partnership Exchange. The states might consider how to effectively and efficiently work with these various entities to ensure non-duplication, maintain consistency within the market, and mitigate issuer burden and consumer confusion.

II. Individual and Small Group Market Rate Review in the States before the ACA

State oversight of health insurance rates has, historically, varied substantially. While many of the states review proposed increases to determine if they are reasonable before they are used in the marketplace, other states lack the legal authority or resources to review rates prior to their implementation. Some of the states had no authority whatsoever to deny or reduce proposed rate increases.

[1] Pub. L. 111-148 (ACA), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010).

© 2012 National Association of Insurance Commissioners

A. Types of Rate Regulation

There are four main types of rate regulation in place in the individual and small group markets today:

1. ***Actuarial Justification:*** In markets with actuarially justified rating requirements, issuers must demonstrate a correlation between case characteristics and increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums within which plans may generally vary rates without providing justification. These are used by most of the states. Plans that vary rates in excess of these safe harbors may be required to submit data justifying their use of the characteristics in question.

2. ***Rating Bands:*** Particularly in the small group market, many of the states have implemented rating bands that limit the variation in premiums attributable to health status and other characteristics. Rating bands are either expressed as a ratio of the highest rating factor to the lowest (e.g., 1.5:1) or as the allowable variation above and below an index rate (e.g., +/- 25%). Rating bands may also take the form of composite rating bands that place limits on the combined effects of multiple case characteristics (e.g., a composite rating band that allows 4:1 variation based on health status, age, gender, industry and group size combined).

3. ***Adjusted Community Rating:*** Adjusted (or modified) community rating laws prohibit the use of health status or claims experience in setting premiums. Other case characteristics, such as age and geography, may be used to vary premiums, although limits may be placed upon these factors, as well.

4. ***Community Rating:*** "Pure" community rating laws prohibit the use of any case characteristics besides geography to vary premiums.

B. Commonly Used Risk Classifications

Following is a list of some of the more commonly allowed risk classifications. Use of these classifications varies greatly from state to state.

1. ***Health Status and Claims Experience:*** The most direct way for issuers to base premiums on expected costs for an individual or group is to use health status information collected during the underwriting process or claims experience for policies being renewed. Most of the states that allow health status to be used for rating purposes in the small group market limit it using rating bands that vary from +/-10% to +/-60%. Premium increases due to changes in a business' health status may also be limited to 15% per year in many of the states.

2. ***Age:*** Because an individual's health status deteriorates as he or she grows older, leading to increased claims, age has become one of the most commonly employed case characteristics. Under the NAIC safe harbor guidelines, overall variation of 5:1 or less is reasonable in the small group market based on the expected claim costs of 22-year-olds and 62-year-olds.

3. ***Gender:*** During childbearing years, women can be expected to incur medical costs that are more than 45% higher than men, excluding the costs of normal maternity coverage. The difference in expected claims narrows with increasing age and, by their mid-50s, men surpass women. At age 62, men can be expected to have costs that are at least 17% higher than women.

4. ***Group Size:*** Issuers often charge higher rates to smaller companies for two main reasons: 1) it is more expensive to issue and service a policy for a small business than for a larger one; and 2) small employers purchasing coverage are more likely to have greater knowledge of their employees' potential future needs for health care services, creating a greater risk of adverse selection for the issuer. This risk is higher in a guaranteed-issue environment where denial of coverage based on underwriting criteria is prohibited, and businesses with one to four employees may be charged as much as 20% more than for those with 10–24 employees.

5. ***Industry and Occupation:*** Working conditions and the type and lifestyles of workers may lead to higher claim costs in some industries than in others. The NAIC has adopted a safe harbor of 15% for premium

© 2012 National Association of Insurance Commissioners

variation due to industry in the small group market. Occupation is also often used as a factor in the individual market.

6. ***Geographic Location:*** The cost of delivering care varies dramatically from one area to another, and issuers often vary their rates by county or by ZIP-code using the employer's business address in the small group market, or the applicant's home address in the individual market. Safe harbors for geography have been set for each state, depending on the variation in medical costs within the state, and range from no variation in the District of Columbia to 1.9:1 in Florida. Not all of the states allow use of the safe harbor.

7. ***Duration of Coverage:*** In medically underwritten, guaranteed-renewable markets, an issuer has the best picture of the health of enrollees on the date that they submit their application. Over time, enrollees' health may deteriorate from what it was at the time of application, leading to higher claims costs. To offset this, issuers in the individual market will often charge higher premiums to individuals who have been enrolled in the same plan for several years. This practice can encourage healthy enrollees who can pass medical underwriting to reapply in order to get the lower, new enrollee rate, exacerbating the very phenomenon it is attempting to fix.

8. ***Wellness:*** In recent years, several of the states have allowed issuers in the individual market to provide premium discounts or other incentives to individuals participating in wellness programs in order to encourage them to adopt healthier lifestyles. In practice, this has been a difficult policy to implement without allowing carriers a back-door way to use health status in setting premiums, and, in at least one state where it is allowed, no carriers are using it. State flexibility and further study of the best way to use wellness in setting premiums may be warranted.

C. Pooling of Risk

In applying rating factors, issuers will group policyholders into classes and blocks of business.

1. Class of Business: Issuers will maintain different "classes of business" that reflect administrative differences in how policies within them were sold or acquired by the company. For instance, a company may maintain one class of business composed of policies sold by its agents in the regular market, a second class of business may contain policies sold through a purchasing pool, while a third may be made up of policies that were acquired from another issuer. Most of the states limit the number of classes that an issuer may maintain and the variation of premiums between classes. Most of the states with community rating or adjusted community rating disallow the maintenance of separate classes of business. The 1993 NAIC *Small Employer Health Insurance Availability Model Act*,[2] which is the basis of most of the states' small group rate regulation, limits issuers to nine classes of business and limits the index rate for the highest priced class of business to 120% of the index rate for the lowest priced class of business.

2. Block of Business: Issuers will also group business by the form of the policy, creating a block of business. In the individual market, issuers will also create "rating blocks" based on initial health status classification. For instance, an issuer may group all-new business that is charged a 25% health adjustment into a single block and then apply experience adjustments to the entire block, rather than re-underwriting each renewed policy every year. When issuers stop actively selling a block of business, the result is a closed block, which can experience rate spirals as those who can pass medical underwriting purchase other coverage, leaving a pool of risk that becomes progressively sicker. In the small group market, limitations on the use of rating factors apply across all blocks of business.

D. Rate Review Processes

Many of the states use "prospective" regulation of rates, while others use "retrospective" regulation. Prospective regulation includes prior review and/or approval of rates, while retrospective regulation includes "file and use," where the rates go into effect, but the regulator can take action if the rates are later determined to be unreasonable

[2] The 1993 *Small Employer Health Insurance Availability Model Act* was replaced by a 1995 version. The 1995 version provides for adjusted community rating in determining premium in place of classes of business.

under a standard such as one of the above. Retrospective regulation often relies on consumer complaints to indicate a problem with a company's rates.

The NAIC has several documents to provide guidance to the states in rate review, including the *Health Policy Rate and Form Filing Model [Act] [Regulation]* (#165), the *Guidelines for Filing of Rates for Individual Health Insurance Forms* (#134) and the *Guidance Manual in the Evaluation of Ratings Manuals and Filings Concerning Small Employer and Individual Health Insurance*.

Most of the states with rate review laws require that the company provide a qualified actuary's opinion that the rates are reasonable and comply with state law, as described in Model #134. This allows the states to rely on the Code of Professional Conduct and the Actuarial Standards of Practice that actuaries must follow. In addition, the states often look at the whole financial picture of a company when reviewing rate filings.

Most of the states have different types of prospective or retrospective rate regulation for different comprehensive medical markets, such as individual, small employer, association group, employer-paid, blanket coverage, mini-medical coverage and state/local employee plans.

E. Filing of Rates

Forty-nine states, the District of Columbia and Puerto Rico use the NAIC's System for Electronic Rate and Form Filing (SERFF) for the filing of rates. While rating rules and policy requirements can differ greatly from state to state, SERFF helps companies by walking them through a checklist of state-specific and federal requirements and then submitting their requests to the states.

III. Rate Increase Disclosure and Review Requirements Under ACA

A. Background

The ACA reorganizes, amends, and adds to the provisions of Part A of title XXVII of the Public Health Service Act (PHSA) relating to group health plans and health insurance issuers in the group and individual markets. Section 1003 of the ACA adds a new Section 2794 of the PHSA (42 USCS §300gg–94). In particular, this section:

1. Directs the Secretary of the Department of Health and Human Services (Secretary), in conjunction with the States, to establish a process for the annual review, beginning with the 2010 plan year, of ''unreasonable increases in premiums for health insurance coverage";'

2. Requires health insurance issuers to submit to the Secretary and the relevant State justification for an unreasonable premium increase prior to the implementation of the increase. Requires health insurance issuers to prominently post the submitted justification on their website;

3. Requires the Secretary to carry out a program to award grants to the States during the 5-year period beginning with fiscal year 2010 to assist such States in reviewing and approving premium increases for health insurance coverage, and to establish centers to collect medical reimbursement information;

4. For those States that are awarded grants, requires the State insurance commissioner to provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State and to make recommendations, as appropriate, to the State Exchange about continued participation in the Exchange by an issuer based on a pattern or practice of excessive or unjustified premium increases;

5. Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States, must continue to monitor premium increases of health insurance coverage offered through the Exchange and outside the Exchange; and

6. In determining whether to offer QHPs in the large group market through an Exchange after 2016, the States are required to take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange.

© 2012 National Association of Insurance Commissioners

On December 23, 2010, the U.S. Department of Health and Human Services (HHS) published in the *Federal Register* a Notice of Proposed Rulemaking (NPRM) to implement Section 2794 of the PHSA.[3] In announcing the proposed rulemaking, the Secretary addressed a letter to insurance commissioners stating:

> "This proposed regulation recognizes and builds upon the traditional role the states have played in regulating insurance rates and complements existing State-based rate review processes. All proposed rate increases at or above 10 percent would be subject to review, and issuers in the individual and small group markets would be required to provide a justification to both the states and HHS to comply with Section 2794's requirement that such information be publicly disclosed prior to the implementation of the increase. States with effective rate review programs would review such proposed increases to determine whether they are in accordance with state law. In the small number of states that do not have the legal authority or resources to review rates, HHS would review proposed rate increases of 10 percent or more to determine whether they are reasonable, based on actuarial and other analyses that are currently used by many states to assess rate increases."

On May 23, 2011, HHS published in the *Federal Register* a final rule requesting comments on amending the definitions of ''individual market'' and ''small group market'' in 45 CFR §154.102 to include coverage sold to individuals and small groups through associations in all cases.[4]

On September 6, 2011, after consideration of the comments, HHS published in the *Federal Register* amendments to the May 23, 2011, final rule to provide that individual and small employer policies sold through associations will be included in the rate review process, even if a state otherwise excludes such coverage from its definitions of individual and small group coverage.[5]

B. Application of Section 1003 to Issuers, CO-OPs and Multi-State Plans

1. Issuers

Section 1003 of the ACA applies in the individual and small group markets. It does not apply to grandfathered health insurance coverage, nor does it apply to self-funded plans. This section will apply to QHPs offered in the Exchange beginning in 2014.

2. CO-OPs

Section 1322(a) of the ACA directs the Secretary to establish the CO-OP program to foster the creation of member-governed qualified nonprofit health insurance issuers to offer CO-OP QHPs in the individual and small group markets in the states in which they are licensed. The CO-OP program offers low-interest loans to eligible private, nonprofit groups to help set up and maintain health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly and high-quality health insurance options.

Starting January 1, 2014, CO-OPs will be able to offer health plans through the Exchanges. In addition to offering health plans through an Exchange, CO-OPs may also offer health plans outside of an Exchange. An Exchange must recognize a health plan offered by a CO-OP if it is deemed certified by the U.S. Centers for Medicare & Medicaid Services (CMS) or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO-OP QHPs set forth in the ACA and, except for a few narrow exceptions, all state-specific standards established by an Exchange for QHPs operating in that Exchange. Thus, it would appear that Section 1003 will be applicable to CO-OPs offering plans inside and outside of the Exchange.

[3] *www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf.*

[4] *www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf.*
[5] *www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf.*

3. Multi-State Plans (OPM Plans)

The ACA authorizes the U.S. Office of Personnel Management (OPM) to enter into an agreement with issuers to offer multi-state plans in the individual and small group markets through an Exchange. OPM must contract with at least one nonprofit carrier and the plans offered as a multi-state plan are to be considered QHPs and the Exchange must allow them to be offered. However, nothing in the ACA exempts these multi-state plans from applicable state laws and/or regulations. OPM is in the process of promulgating regulations relating to these plans.

IV. ACA Rules and Regulations that Will Impact How Issuers Price Health Plans and How the States Perform Rate Review

The ACA includes several provisions that will affect health plan rating and rate review. Although some of these provisions have already been implemented (and are not explicitly covered below), those with a significant impact on rating will be implemented for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by state insurance regulators, as applicable, in advance of January 1, 2014, and in the case of QHPs offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013.

Note: Non-grandfathered plans outside of the Exchange will also be affected by the ACA market reforms, and health insurance offered in the outside market may be issuing renewal notices as early as July 1, 2013, for plans effective after January 1, 2014. Therefore, rates will need to be approved months in advance of the October 1, 2013, date for Exchange enrollment.

Issuers and state insurance regulators will need to create a process for the timely development, submission and review of rates that allows for potential differences between grandfathered and non-grandfathered plans; plans inside and outside of the Exchange; and plans by market if a state has varying levels of review authority and effective rate review designations. Delays in implementing rate increases could result in an inadequate premium being charged which could result in higher subsequent rate increases. Additionally, rate review processes and requirements should be consistently applied for multi-state plans and CO-OPs to maintain a level playing field. Rating and plan accounting will also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with MLR requirements, and any new federal or state taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new rating requirements and underwriting limitations, pooling risks across products within a market (or, in some cases, across markets), new benefit requirements and changes in the small group market.

It is clear that the significant number of unknowns that will require issuers to estimate, as well as the interplay of the new elements, present a challenge to issuers and state insurance regulators.

Considerations for each of these issues are outlined below.

A. Underwriting Limitations

Issuers will be significantly limited in their ability to deny coverage or charge high premiums to individuals and groups with higher than average health risks. Underwriting provisions in ACA include:

- Guaranteed availability of coverage (non-grandfathered only): Issuers must accept all individual and employer applicants, limited to open enrollment periods in the individual Exchange.
- Elimination of medical underwriting for non-grandfathered plans in the individual and group markets.
- Prohibition of pre-existing condition exclusions.

The impact of these changes on rates and premiums in most markets is expected to be significant. In addition, these provisions could lead to adverse selection if not sufficiently addressed by other provisions in the ACA or required by the states.

© 2012 National Association of Insurance Commissioners

B. Other Provisions Resulting in Demographic Changes

The ACA includes other provisions that are expected to have an impact on the population covered by health plans. The following provisions are expected to bring new entrants into the health insurance market:

1. ***Establishment of Exchanges:*** Exchanges will provide a mechanism for individuals and small groups to perform more standardized comparisons of available health plan options.

2. ***Individual Mandate:*** Individuals will be required to have health insurance or will pay a penalty, unless they are exempted for religious, affordability or other allowable reasons.

3. ***Premium Subsidies and Cost-Sharing Reductions:*** For coverage purchased through the Exchange, federal subsidies will be available to individuals and families with household incomes up to 400% of the federal poverty level unless they have affordable minimum essential coverage available to them. Individuals and families with household incomes up to 250% of the federal poverty level will also be eligible for cost-sharing reductions.

4. ***Medicaid Expansion:*** The significant increase in the number of people eligible for Medicaid under the ACA will impact the demographics of the individual market.

The above provisions, coupled with the underwriting limitations and rating requirements, are expected to encourage previously uninsured individuals into the health insurance market. The relative health risk and expected cost of this population is a significant unknown. Issuers will need to work with regulators to develop reasonable assumptions related to the expected cost of these new enrollees.

C. Rating Requirements

The ACA also limits rating variations for non-grandfathered plans in the individual and small group markets, to the following:

1. ***Geographic Rating Area:*** The states are charged with defining standard geographic rating areas, subject to approval by the Secretary. The states will need to consider how narrowly to define geographic rating areas to balance affordability and access considerations for individuals in potentially high-cost areas. The selection of geographic rating areas may also have an impact on risk adjustment in the state.

2. ***Age:*** Age factors will be limited to a ratio of 3:1 for adults; permissible age bands will be defined by the Secretary in consultation with the NAIC.

3. ***Benefit Coverage:*** Guidance with regards to flexibility related to benefit coverage factors has not been provided at the time of this writing. It is unclear, for example, whether benefit coverage factors could account for selection or utilization differences resulting either from group demographics or benefit design.

4. ***Family Structure:*** Guidance with regard to flexibility related to family structure factors has not been provided at the time of this writing.

5. ***Tobacco Use:*** Rating for tobacco use is limited to a ratio of 1.5:1. Note that HHS is still considering how tobacco use will be accounted for in the risk-adjustment model they are developing. Use of tobacco rating factors may also have an impact on the affordability of health insurance. In addition, the most recent Internal Revenue Service (IRS) regulation on premium subsidies indicates that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.[6]

Note: The rating limitations above apply to large group insured, non-grandfathered plans beginning in 2017 if the state allows large group coverage to be offered through the Exchange.

[6] *www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf*.

© 2012 National Association of Insurance Commissioners

Under the ACA, a state may further restrict use of rating factors, as long as the state law does not "prevent the application" of the federal law. For example, given that under the IRS regulation tobacco use penalties would not be reflected in the federal subsidy, and that such penalties are difficult to enforce, a state could prohibit rating based on tobacco use.

D. Risk Pools

The ACA also requires issuers to consider all enrollees in non-grandfathered plans within a given market (individual or small group) as part of a single risk pool. Grandfathered plans can be priced in their own risk pool. The states also have the option of merging the individual and small group markets into a single risk pool.

The states will need to consider how rates should be filed for effective dates starting in 2014. Because there will be a single risk pool in each of the individual and small group markets, the states may want to consider how the filing process may differ from historical methods, including evaluating whether all filings will need to be made on a plan basis in the future, or whether issuers may provide a single filing for non-grandfathered rates to reduce duplication.

Additionally, in those states that define small group as groups with 50 or fewer employees, the small group market will be expanded to include groups of up to 100 employees beginning in 2016.

E. Benefit Changes

Issuers of non-grandfathered plans will also need to price for several required benefit changes, including:

1. Essential health benefits (EHBs) applicable for years 2014 and 2015 may be defined at the state level by sometime in the third quarter of 2012, or will be defined by the federal government if the state does not act. Annual dollar limits will not be permitted on EHBs.

2. Annual maximum out-of-pocket cost sharing for plan years beginning in 2014 will be limited to those in effect for health savings accounts in that year.

3. Deductibles in small group plans will be limited.

4. Non-grandfathered plans in the individual and small group markets (both inside and outside of the Exchange) will need to meet actuarial value requirements such that each plan fits into a metal level of coverage (bronze, silver, gold or platinum), except for the catastrophic plans offered to certain enrollees.

Note that the states may need to engage their actuaries as part of the form review process, to validate actuarial equivalence for benefit substitutions as defined in EHB guidance, along with verification of a plan's metal level.

F. Risk Mitigation Programs (Three Rs: Reinsurance, Risk Adjustment and Risk Corridors)

In order to mitigate selection and pricing risk for issuers, the ACA includes implementation of three risk-mitigation programs. First is a temporary reinsurance program that reimburses non-grandfathered individual plans, both inside and outside of the Exchange, for a portion of the cost of high-cost enrollees. The aggregate amount of reinsurance payments will be fixed at a state level at decreasing amounts over three years (2014 through 2016). Second is a permanent risk-adjustment program that will transfer funds from non-grandfathered individual and small group plans with a lower-than-average risk population to such plans with a higher-than-average risk population. The risk-adjustment program will be budget-neutral within each market (individual and small group) at the state level. Third is the federal risk corridor program.

The risk adjustment program is designed to equalize risks across plans within each applicable market. As a result, theoretically, all issuers should price their non-grandfathered individual and small group plans, assuming they get an average risk population. In practice, however, risk adjustment is not perfect and does not account for all selection differences across plans. In addition, given other ACA changes, there is significant uncertainty related to what an "average risk population" will be, especially in the individual market. Once the market stabilizes and

© 2012 National Association of Insurance Commissioners

relative health risks across issuers are better known, plans should be able to price their plans based on anticipated risk adjustment payments and charges.

In the meantime, issuers will need to work with regulators to develop reasonable assumptions related to the impact of anticipated population changes in 2014. This pricing risk, based on high levels of uncertainty in the individual market, is intended to be addressed by ACA's third risk mitigation program: risk corridors. In this program, issuers participating in the individual and small group markets will be limited in their level of gains and losses for their QHPs in calendar years 2014–2016. Specifically, HHS will reimburse QHPs 50% of the difference between allowable costs and a target amount for differences between 103% and 108%, and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs in excess of 108% of the target amount. Conversely, HHS will charge 50% of the difference between allowable costs and a target amount for differences between 92% and 97% and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs less than 92% of the target amount. Risk corridors will be applied after reinsurance and risk adjustment. Issuers and regulators should consider the impact of risk corridors in determining reasonable levels of margin to include in rates for 2014–2016, as well as rate adequacy given the program subsidizes losses. Issuers and regulators will also need to consider the interaction of the risk mitigation programs with the calculation of MLR rebates.

G. MLR Requirements

The ACA requires issuers to provide rebates to consumers if certain minimum MLRs are not met. Those ratios are, generally, 80% for the individual and small group markets and 85% for the large group market. A state may choose a higher level, and several of the states have applied for and received adjustments that lower the ratio in the initial years (this applies to the individual market only). This requirement became effective calendar year 2011, with rebates paid by August of subsequent years.

Although the MLR requirement in ACA is a retroactive standard, some issuers may want to address the requirement prospectively in their rating to mitigate the risk of having to pay rebates.

Note: The MLR is calculated on a statewide aggregate level by segment, whereas rates are often at the plan level (and will be at the plan level of QHPs). Thus, some care should be taken when incorporating the MLR requirement into the rate review process and standards.

H. New Federal Taxes and Fees

Under the ACA, health issuers will be required to pay new annual issuer taxes and fees beginning in 2014. Health insurance issuer excise taxes, calculated based on an issuer's market share and using the previous calendar year premium as a proxy, are prescribed in the ACA[7] as follows:

Year	Amount (Billions)
2014	$8
2015	$11.3
2016	$11.3
2017	$13.9
2018	$14.3
After 2018	Increased by premium growth

In addition, the non-deductible nature of the excise tax will require issuers to build in more than the actual fee amount into their premiums.

[7] ACA §1406.

Other new fees or assessments that will likely be charged to health insurance issuers include: Exchange user fees; the reinsurance program assessment benefitting the individual market (totaling $25 billion from 2014–2016); the Patient-Centered Outcomes Research Institute (PCORI) fee; and, in 2018, the excise taxes on high value health insurance that will apply in some cases.

I. Rating Inside and Outside of the Exchange

Issuers offering QHPs in the Exchange must offer the "same premium rate" for plans offered inside and outside of the Exchange and whether they are sold directly or through an agent. It is unclear what steps regulators will need to take to validate that this requirement is being met. The states may want to consider establishing a process that requires issuers to submit plan filings in the same manner both inside and outside of the Exchange.

The ACA includes additional rate review requirements for QHPs offered through the Exchanges. Exchanges are required to consider the following as part of QHP certification:

- A justification for a rate increase prior to the implementation of the increase.
- Recommendations provided to the Exchange by the state as required under the premium review grant program.
- Any excess of rate growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

The states with premium review grants are required to make recommendations to Exchanges regarding whether particular health issuers should be permitted to offer plans on the Exchange. This recommendation is based on a "pattern or practice of excessive or unjustified premium increases" and information regarding premium growth rates inside and outside of the Exchange. Those states that have not received a premium review grant can, of course, make the same recommendation to the SBE or the federally facilitated Exchange (FFE).

It is unclear at the time of this writing whether there will be a specific format for Exchange rate increase justifications, and whether those justifications need to be at a QHP level of detail, or some higher level (e.g., product or market). Concern exists over the granularity and credibility of the data should the justifications be required at the QHP level. Exchanges and state insurance regulators will also need to consider the measures to determine excess of rate growth outside of the Exchange.

It is also important to note that issuers wishing to participate in Exchanges will need to submit plan-level data as part of the QHP certification process. Some of the states may choose to review rates at the plan level outside of the Exchange, as well, to ensure consistent processes across the markets. In addition, plans outside of the Exchange will also need to meet the actuarial value (AV) requirements. If the states review actuarial values consistently inside and outside of the Exchange, plan-level data may need to be collected for the non-Exchange plans, as well as the Exchange plans.

J. Small Group Considerations

The ACA has a specific definition of small group that might not be consistent with current state-specific definitions. For example, the ACA counts employees using an average of the total number of employees on business days during the preceding calendar year, whereas some of the states may count only full-time employees, or use some other counting method. Additionally, the ACA does not treat sole proprietors with no employees (other than a spouse) as small groups, which differs from their treatment in some of the states.

The ACA definition applies to participation in the Small Business Health Options Program (SHOP) and calculation of the MLR. The states might consider aligning their definition of small group with that of ACA to avoid any confusion in the market.

Another consideration in the small group market is the ability to set group-level rates in an employee choice model provided through the SHOP Exchange. It is unclear how group rates would be determined in an environment where employees of a given employer can select multiple plans from multiple issuers.

K. Rating of Grandfathered Plans

The ACA provides for the grandfathering of health insurance plans in which an individual was enrolled or was offered to a group on March 23, 2010.[8] While some provisions of the ACA do apply to grandfathered plans (e.g., MLR requirements, elimination of lifetime limits), the rating and benefit requirements, as well as many of the underwriting provisions above, do not apply. The ACA also prohibits the states from requiring that grandfathered plans be pooled with non-grandfathered plans for rating purposes. Grandfathered plans are also not subject to the premium review disclosure requirements.

The states will need to consider how to review rates for grandfathered plans. Grandfathered plans are not open to new groups or individuals. Because different coverage and rating rules apply to grandfathered plans, the states may want to consider requiring separate filings for grandfathered vs. non-grandfathered plans.

L. Multi-State Plans and CO-OPs

The ACA directs the director of OPM to enter into contracts with health issuers (at least one must be a nonprofit) to offer at least two multi-state QHPs through each Exchange in each state.[9] It does not appear that multi-state plans will go through the same certification process required by other plans offered through the Exchange. However, nothing in the ACA exempts multi-state plans from applicable state laws and/or regulations.

The ACA also establishes CO-OPs to "foster the creation of qualified nonprofit health insurance issuers to offer QHPs in the individual and small group markets in the states in which the issuers are licensed to offer such plans."[10] In the states where CO-OPs are established, they are required to be offered on the Exchanges and comply with all Exchange rules and other applicable state laws and/or regulations.

The ACA requires a level playing field across health issuers, including multi-state and CO-OPs. Specifically, the ACA states that "health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law… if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334, is not subject to such law."[11]

There is nothing in the ACA that would preempt state laws and regulations for CO-OPs or multi-state plans. OPM has not yet published proposed regulations for the multi-state plans, but the NAIC has stated in a letter to OPM that multi-state plans will be required to comply with all applicable state laws and/or regulations.

M. Stand-Alone Dental Plans

The ACA specifically states that stand-alone dental plans may be sold through the Exchanges. These plans must offer pediatric dental services, which are included as a required EHB in the ACA. The states will need to decide how rates for these plans will be reviewed and what rating rules will apply to them.

N. Wellness Program Discounts

In Section 2705 of the PHSA, premium discounts for participation in wellness programs are allowed if they meet the criteria set forth in the PHSA. How these discount programs interact with rating factors and their impact on the cost of coverage based on health should be considered by the states.

In addition, the most recent IRS regulation on premium subsidies states that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.

[8] ACA §1251.
[9] ACA §1334.
[10] ACA §1322.
[11] ACA §1324.

© 2012 National Association of Insurance Commissioners

V. Individual and Small Group Market Rate Review under the ACA

A. State Rate Review

1. Reporting of Certain Rate Increases

Prior to establishment of an Exchange, all issuers must submit rate increases in excess of the rate review threshold established in each state (currently set at 10% in every state) to the federal Health Information Oversight System (HIOS). This requirement applies to all non-grandfathered products. The states with effective rate review programs will review the rates and determine whether rates are considered unreasonable. This determination and associated justification must be reported in HIOS. The states that are determined to not have an effective rate review program will have those rate increases reviewed by HHS, although HHS has no authority to deny a rate increase.

Beginning in 2014, all QHPs in the Exchange will be required to report any rate increase to HIOS. Plans outside of the Exchange will only be required to report increases that exceed the threshold established in each state.

Under a state-based system, it is assumed that the reasonable or unreasonable determination will be consistent with the state's own approval process. For example, if a state approves a filing, it will also find the rates to be "not unreasonable."

The states receiving rate review grants have additional reporting requirements through HIOS. These include quarterly reports of the activity associated with the rate review grants, periodic conversations with CMS staff, and quantitative reports showing patterns of rate increases. SERFF has provided an interface with HIOS to allow the states using SERFF to seamlessly report the rate activity in their quarterly HIOS reports.

2. Geographic Regions and Age Bands

The states must report to HHS the proposed rating areas established for the individual and small group markets under Section 2701 of the PHSA. If a state does not establish the rating areas, or HHS deems the rating areas inadequate, HHS will determine the rating areas for the state.

Section 2701 of the PHSA allows individual and small group market issuers to rate based on age provided that the age rates do not vary by greater than a 3:1 for adults. Age bands are required and the selected age bands must be approved by HHS after consultation with the NAIC. The NAIC Health Actuarial (B) Task Force has been working to develop guidance to HHS regarding the establishment of age bands.

As these provisions apply to products sold both inside and outside of the Exchange, the states, along with the NAIC, should endeavor to establish the rating areas and age rating bands by the end of 2012 to provide adequate time for issuers to establish and submit rates for approval, both under state rating laws and as part of the QHP submission process. Time is critical; some issuers will need to submit rate filings as early as October 2012 in order to obtain approval by July 2013 for a January 1, 2014, effective date.

3. Consumer Disclosure

As required under 45 CFR §154.301 of the rate increase disclosure and review final rules,[12] the states with effective rate review systems must post to its website Parts I and II of the Preliminary Justifications and provide a means for comments to be submitted on any proposed rate increases that exceed the state rate review threshold. The U.S. Center for Consumer Information and Insurance Oversight (CCIIO) has encouraged the states to provide links to the consumer disclosure forms on *www.Healthcare.gov*, rather than posting the Preliminary Justifications on their websites to ease the burdens on the states to update the files on their own websites.

[12] *www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf*.

This process could be used to notify the Exchange of rate increases exceeding the state threshold. In addition, the website could be used to post rate increases for all QHPs to allow the Exchange to access all rate changes as part of their requirement to review patterns of rate increases. The states should consider all options to communicate rate increases to the Exchange, especially those that leverage current processes and minimize duplicative effort.

4. General Rate Review Items

The states will be motivated to maintain their "effective rate review Program" status, as it will be a sign to consumers that the state has a transparent premium oversight process, and it will avoid the additional regulatory burden on health insurance issuers of having to undergo both a state and federal rate review process.

The American Academy of Actuaries (AAA) has stated that effective premium oversight should be based on the following actuarial principles: health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges; premium oversight should be done in conjunction with issuer solvency oversight; premium oversight requires strong actuarial representation; appropriate risk-based capital (RBC) levels must be in place; premiums should be self-supporting and not subsidized by other lines of business; the premium-review process should be transparent and equitable for all issuers; the premium-review process should allow for adequate premiums that appropriately reflect past experience; and the premium review process needs to be coordinate between state and federal regulatory entities.[13]

There are 13 areas of necessary review that are defined in the "effective rate review program."[14] One thing to keep in mind is that, even if a state already reviews these items for reasonableness, they will now be required to examine the validity of the historical data underlying the assumptions used in rate development and are expected to review the emerging actual experience in relation to the expected of each carrier as part of the rate review process.[15] For many of the states, this will result in a more in-depth actuarial review than they have performed previously.

a) The Impact of Medical Trend, Cost and Utilization, and Cost-Sharing Changes by Major Service Categories

Because trend, cost and utilization, and cost-sharing will usually have the most material impact on proposed rates, this will be where the majority of the time is spent in the rate review process.

The states will need to perform trend analysis broken down by the required major service categories, and by unit cost vs. utilization pursuant to 45 CFR §154.301(a)(3). The medical trend will be analyzed at a more aggregate level, such as class of business. Issuers need to submit the data used to develop the trend assumptions, prior projections of trend assumptions, and the actual trend realized in recent periods. In short, pricing actuaries are expected to report how well previous actuarial assumptions have compared to actual experience, and the basis for their current actuarial assumptions. This new requirement might be something to which state insurance regulators are not accustomed.

If there have been cost-sharing changes, issuers will need to show how the experience used for rate development has been adjusted and disclose the impact of the change. These disclosures could come in the form of changes in plan actuarial values or plan benefit factors.

[13] American Academy of Actuaries Premium Review Work Group comment letter to HHS regarding Section 2794 of the PHSA (May 14, 2010).
[14] 45 CFR §154.301(a)(4).
[15] 45 CFR §154.301(a)(3).

b) The Impact of Benefit Changes

Along with the impact on rates, issuers will need to show that they have adjusted the experience used in rate development. State insurance regulators will need to be able to check that the effect of benefit changes has not been double-counted (once in the trend and again in the factors).

c) The Impact of Changes in Enrollee Risk Profile

Issuers will be required to submit sufficient information to demonstrate that historical experience has been adjusted to reflect the anticipated enrollee risk profile.

d) The Impact of Any Overestimate or Underestimate of Medical Trend for Prior-Year Periods Related to the Rate Increase

Disclosing the impact of any overestimate or underestimate of medical trend for prior-year periods related to the rate increase may help delineate what part of the rate increase request may be attributable to a prior misestimate. It should be noted that trend is calculated at an aggregated level and should not differ by plan (with the exception of deductible leveraging). By breaking this out, this will help state insurance regulators better judge the reasonability of the filed rates.

e) The Impact of Changes in Reserve Needs

Reviewing the impact of changes in reserve needs will consist of a review of the completion factors used in reserve development. Regulators might want to evaluate the historical adequacy of the claim reserve by having issuers disclose how a prior period's claim reserve compares with the actual claims paid. State insurance regulators also might want to monitor the change in completion factors, as this can skew trend estimations.

f) The Impact of Changes in Costs Related to Programs that Improve Health Care Quality and Other Health System Improvement Costs

Requesting that costs related to programs that improve health care quality and other health system improvement costs be categorized in accordance with the federal MLR guidelines will allow the states to monitor the overall MLR level as defined by HHS. However, because some of the states have MLR targets that are independent of the federal guideline MLR requirement, these states might choose to use their own reporting categorizations and definitions.

g) The Impact of Changes in Applicable Federal Taxes, Licensing or Regulatory Fees

Issuers should submit actual taxes, licensing or regulatory fees for a period corresponding to the base period used for claims experience, as well as those anticipated during the projected period. If historical taxes, licensing and fee ratios vary materially from those used in pricing, an explanation should be given.

h) MLR

Many of the states have established minimum MLRs on a prospective basis, often calculated as the present value of benefits divided by the present value of premiums. The federal government, through the ACA, has established a retrospective standard for minimum MLRs (see Section IV(g) of this white paper). The states should continue to enforce the state-specific standards.

Some of the states have chosen to incorporate the federal minimum MLR requirements in their rate review process, thereby applying the federal standard on a prospective basis. It should be noted that a retrospective credibility adjustment should not be applied to a prospective loss ratio.

The states that do not require issuers to price to the retrospective federal MLR may wish to have issuers indicate their intention to comply with the federal minimum MLR rebate requirements. The states may

also wish to request that carriers provide an estimate of the federal MLR as further demonstration of anticipated compliance and to ensure that the range of potential rebates is reasonable.

i) The Health Insurance Issuer's Capital and Surplus

Capital and surplus levels are already included in financial statements filed with the state; therefore, some of the states do not require issuers to include this in their rate filings.

j) Allowed Case Characteristics and Community Rating

The allowable case characteristics that are permitted in rate filings have varied historically state-by-state. Starting in 2014, all of the states will adopt modified community rating with the following set of allowable case characteristics:

- Geographic rating areas.
- Age.
- Family size/composition.
- Tobacco use.

The states will need to verify that the variation in rates created by each case characteristic complies with federally mandated ratios.

k) Risk Adjustment

As a result of guaranteed issue and community rating requirements, there will be increased adverse selection and issuers will have a decreased ability to vary premiums to appropriately reflect the specific risks they are insuring. In response to this, a risk-adjustment mechanism will be implemented in 2014.

A risk adjustment mechanism will need to be calibrated so that it can financially compensate (or charge) issuers when the risk of their block of business is greater (or less) than the average risk in the market in a state. As a result, issuers will need to price their business based on the average risk pool of the state market, rather than the average risk pool of their own block of business. It is not clear what tools or information will be given to issuers in order for them to be able to do this.

Further complicating the matter, any risk adjustment algorithm, no matter how good, will not perfectly compensate issuers for the risk of their member populations. As a result, issuers might add a degree of conservatism to their rates until they understand how the risk adjustment mechanism will affect their financial results.

State insurance regulators will need to be aware that rate filings will include an adjustment for the issuers' expected risk population compared to the expected average market risk, plus potential shortcomings of the risk adjustment program.

It should be noted that the risk adjustment program, as envisioned by HHS, will be based on *relative,* not *absolute*, risk, so it will be nearly impossible for any issuer to assess its relative risk in the first year of operation of the risk adjustment program, and possibly longer given the time frames for filing rates, time frames for risk adjustment settlement and data audit adjustments.

l) Temporary Risk Mitigation Programs

Starting in 2014 and lasting for three years, a reinsurance and risk corridor program will be in place to help stabilize the market.

© 2012 National Association of Insurance Commissioners

i. Reinsurance

The reinsurance program will collect "premiums" from all market participants in the small group, large group, self-insured and individual markets, while the "claims" will be reimbursed only in the individual market. The effect in each market is not neutral, even if the total premium across all markets equals total claims. Also, if reinsurance premiums collected are less than claims covered, then the reinsurance pool would not be able to pay all reinsured claims. Because of this risk, it is possible that issuers in the individual market will add an extra margin to their pricing to cover the uncertainty related to payment of claims.

ii. Risk Corridor

The risk corridor likely would not affect pricing or rate review of filings, at least initially.

m) Small Group: List Bill vs. Composite Rating

As this relates to the manner of billing rather than rating or pricing one might reasonably expect that it would not affect the rate review.

5. Coordination of Regulatory Efforts with Exchange

a) Coordination of Frequency of Review

In an effort to minimize the regulatory burden on issuers and to promote efficient Exchange management, the plan management functions should generally be performed by the state insurance department to the extent they have familiarity with and authority to perform the rate review function under plan management. Many of the states require annual filings for rates and, for those states that do so, they should consider coordinating the QHP rate review with the issuer's annual rate filing. To the extent issuers submit rate filings less than annually, the Exchange, in coordination with the state insurance department, should request premium renewal information from the issuer for purposes of evaluating patterns of rate increases.

b) QHPs

As required under 45 CFR §155.1020, an Exchange must receive justification for rate increase for a QHP prior to implementation. It is expected that Exchanges will leverage existing regulatory mechanisms to meet the rate review requirements under plan management.

c) Recommendations Provided to the Exchange by the State in Accordance with Section 2794(b)(1)(B) of the PHSA

Section 2794(b)(1)(B) of the PHSA requires the state insurance commissioner to make recommendations, as appropriate, to the Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases. This provision explicitly involves the state insurance commissioner; therefore, the states should consider developing a process to review issuers' history of rate increases in order to make recommendations to the Exchange. It is appropriate for state insurance regulators to perform this analysis and report to the Exchange on an annual basis unless the Exchange requests an interim review due to a recent pattern of rate increases.

6. Other Considerations

a) SERFF

The NAIC, at the request of its members, has established a project to build out the required plan management functions through SERFF, proposed key functions to support rate review, including: navigation between rate/form filings and plans; managing plans within SERFF; communication and

© 2012 National Association of Insurance Commissioners

correction of issues by issuers; and state certification of plans according to state-specific needs. A key component for rate review is the navigation function, which will permit SERFF users to leverage plan filings to existing or new forms and rates filed and approved with the state to satisfy the related components of the QHP review and certification process. The remaining components provide the states and issuers with the necessary interface to manage and communicate issues, similar to the current SERFF functionality for rate and form filings.

The SERFF implementation team expects the release of the QHP plan management module to occur in December 2012, with the functionality for renewal and decertification to follow in the second and third quarters of 2013. The plan management functions in SERFF are support an exchange regardless of whether it is an SBE, Partnership Exchange or FFE.

b) New vs. Existing Plans

The QHP certification process will be applied to all plans seeking QHP status on the Exchange effective January 1, 2014. This will include both the review of any rate increase, as well as the evaluation of patterns of rate increases as required under Section 2794 of the PHSA. Once the Exchange has been established, new plans would be expected to follow the same process applied to plans seeking QHP status on January 1, 2014. Existing plans will have the same requirements, but the states can leverage prior evaluations of rate increase patterns to minimize the regulatory effort.

c) Grandfathered Plans

Because grandfathered plans cannot be offered on an Exchange, it is expected the regulatory burden for grandfathered plans to be significantly less than non-grandfathered plans; for example, grandfathered plans are not subject to the federal rate review process. However, the states should understand the size and composition of insureds remaining in grandfathered plans to understand the potential adverse selection effects on Exchange business. Also, the states may apply the same rate review requirements on grandfathered plans.

Due to the numerous triggers resulting in the loss of grandfathered status, it is expected that the number of grandfathered plans will diminish significantly over time.

d) Catastrophic Plans

Section 1302(e) of the ACA allows issuers to offer catastrophic-type plans to individuals under the age of 30 that meet certain affordability or hardship standards. The plans will cover EHBs but will include deductibles equal to the amounts specified as out-of-pocket limits for health savings account (HSA)-qualified high deductible health plans (HDHPs).

Because catastrophic plans are considered QHPs, the rate review requirements under QHP certification will apply equally to catastrophic and metal-level plans.

e) Funding/Resources

Federal rate review grant funds have been made available to the states for the purpose of upgrading rate review processes to meet the minimum federal standards for an effective rate review process. However, the continued availability of these funds is not guaranteed and, in fact, unlikely. As the states consider enhancing rate review standards and processes the need for additional resources, and the sources of funds to cover those costs, need to be taken into consideration.

B. Federal Rate Review

1. Authority

Section 2794 of the PHSA requires the Secretary, in conjunction with the states, to establish a process for the annual review of unreasonable rate increases in premiums for health insurance coverage. The ACA requires

health insurance issuers to submit to the Secretary and the relevant state insurance departments, a justification for a premium increase over the threshold amount prior to the implementation of the increase.

On May 19, 2011, CMS published in the *Federal Register* the final regulation on Rate Increase Disclosure and Review Requirements.[16] Pursuant to the regulation, CMS must determine if a state has effective rate review authority over health insurance. In 45 CFR §154.301, the criteria for determining whether a state has an effective rate review program includes: receipt of data and documentation sufficient to make the justification determinations required by federal law; timely and effective review of the reasonableness of assumptions; and effective review of the impact of changes to medical trend, utilization, cost-sharing, benefits, risk profiles, reserve needs, MLR and other information relating to administrative costs. In addition, the state's reasonableness determination must be made under a standard set forth in state law or regulation, and the state must provide public access to Preliminary Justifications.

If CMS determines that a state does not have an "effective rate review program," CMS will perform the review of rate increases equal to or greater than 10% or any other "state-specific threshold" identified in later years. In 2011, CMS identified seven states that had ineffective rate review authority or no rate review authority, in whole or in part, over rates in the individual and small employer group non-grandfathered major medical health insurance market. CMS conducts the review of rate increases over 10% pursuant to 45 CFR §154 in those states.

When reviewing rate increases for an "ineffective" state, if CMS finds that a particular rate increase is "unjustified," "excessive" or "unfairly discriminatory," it will make a public announcement of that finding, post it on the CMS website and require the health insurance issuer to post that finding on its website, as well. CMS does not have the authority to "disapprove" a rate increase or prohibit an issuer from using the rate that it found to be unjustified.[17]

An issuer may choose to reduce its rate increase below the 10% and avoid the publicity. If the issuer lowers its rate increase, but not below the threshold, it must submit a new Preliminary Justification and CMS will review it again. If a health issuer implements a rate increase determined by CMS to be "unreasonable," the issuer must submit a "Final Justification" to CMS that responds to the unreasonable rate increase determination and the health insurance issuer must post the finding on its website. The information in the final justification must be consistent with the information filed in the Preliminary Justification.[18]

2. Federal Reporting Requirements

Beginning September 1, 2011, all non-grandfathered small employer group and individual market health insurance rate increases that are 10% or more (state-specific thresholds may change in subsequent years), must be reported to the Secretary and the state insurance department, if that department has an effective rate review program. CMS will defer to the state's determination of reasonableness in states that CMS has determined to have an effective rate review program.[19] In the states that do not have effective rate review, all rate increase information required to be reviewed under the regulation is filed with the Secretary through HIOS. CMS has actuaries on staff and under contract who review those rate increases. CMS will share information and discuss its review with the "ineffective" states, if the state insurance commissioner requests that information.

Health insurance issuers must submit to the Secretary a "Preliminary Justification" for each product affected by the increase on a form prescribed by the Secretary that contains the following information: the rate increase summary (Part I), a written justification of the rate increase (Part II) and rate filing documentation (Part III). An "ineffective" state can require that Parts I and II also be filed with its insurance department. However, Part III is sent to CMS only. A single, combined Preliminary Justification can be sent for multiple

[16] *www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf*.
[17] 45 CFR §154.205; 45 CFR §154.225.
[18] 45 CFR §154.230.
[19] 45 CFR §154.210.

products, if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same for all those products.[20]

3. Consumer Disclosure

CMS posts Parts I and II of all Preliminary Justifications on its website. The state insurance department must also post this information on their website.

The Preliminary Justification contains a rate increase summary (Part I) and the written description justifying the rate increase (Part II). The rate increase summary must include: historical and projected claims experience; trend projections related to utilization; any assumptions related to benefit changes; allocation of premium increase to claims and non-claims cost; per enrollee per month allocation of current and projected premiums; and a three-year history of rate increases for the product. The written description justifying the rate increase must include a simple and brief narrative describing the data assumptions used, including an explanation of the most significant factors causing the rate increase and a brief description of the overall experience of the policy, historical and projected. Part III of the Preliminary Justification contains documentation supporting the rate increase. Part III information will be posted only to the extent that it does not contain trade secrets or is otherwise confidential. CMS enables the public to comment on the Preliminary Justifications.[21]

CMS posts its determination and a brief explanation of its findings on its website. State insurance departments may also post the information. The health insurance issuer is legally required to prominently post on its website the information relating to CMS's determination of "unreasonable," if the issuer chooses to implement a rate increase determined to be unreasonable by the state or CMS. The issuer must also include its "Final Justification" for implementing the increase despite the unreasonable determination. The health insurance issuer must keep this information on its website for at least three years.[22]

4. Coordination with and Role of the States

CMS will coordinate its review with state insurance departments that have been determined to be "ineffective," if that state has some authority to review or investigate health insurance rates and is interested in being involved with the federal effort to implement and enforce the "Health Insurance Issuer Rate Increases: Disclosure and Review Requirements" regulations. State insurance department involvement may benefit consumers and assist with public disclosure.

VI. Exchange QHP Review

A. State Based Exchange

1. Authority

The ACA authorizes each state to establish an Exchange by no later than January 1, 2014, for the purpose of facilitating the purchase of QHPs.[23] The Exchange is only authorized to offer health plans that are certified as QHPs.[24]

[20] 45 CFR §154.215.
[21] 45 CFR §154.215.
[22] 45 CFR §154.230.
[23] ACA §1311(b); 42 USC §18031(b).
[24] 45 CFR §155.1000.

© 2012 National Association of Insurance Commissioners

2. Rate Review

a) QHP Certification

The ACA requires the Secretary to promulgate regulations to "establish criteria for the certification of QHPs."[25] It also authorizes an Exchange to certify health plans as QHPs if they meet certain requirements, including those specifically established by the Secretary through regulation.[26] A health plan may be certified as a QHP if the health insurance issuer demonstrates compliance with the minimum certification requirements stated in the regulations.[27]

Health plans seeking certification as QHPs must: 1) "submit a justification [to the Exchange] for any premium increase prior to implementation of the increase" and prominently post the justification on their websites;[28] and 2) agree to charge the same premium rate for each QHP it offers, regardless of whether the plan is offered through an Exchange or in the outside market.[29] Exchanges are specifically required to take the justification information submitted by health plans, along with information and recommendations provided by a state related to patterns of excessive or unjustified rate increases, into consideration when determining whether a particular health insurance issuer's plan(s) should be offered through the Exchange.[30] The Exchange is also required to consider information reported by a state regarding "any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange."[31]

b) Degree of Overlap or Independence with State Insurance Department

As noted in a) above, Exchanges are specifically required to take information and recommendations provided by a state's insurance department when determining whether a health plan should be available on the Exchange. HHS encourages Exchanges to minimize the potential burden on QHP issuers by leveraging the existing state rate review processes, including adopting the format currently being used by health issuers for the submission of rate justifications to the states,[32] but does not specifically prohibit Exchanges from conducting additional review of rate increases.[33] However, it is noted that an Exchange's consideration of rate increases is limited to determining whether a QHP should be offered on the Exchange.[34] It is also important to note that the requirement for a QHP to post a rate increase justification on its website is required regardless of whether the increase is considered an "unreasonable increase" and subject to review by a state.[35]

c) Comparison of Rates and Growth of Rates Inside and Outside of the Exchange

As noted above, an Exchange is also required to consider information regarding excess premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange when considering

[25] ACA §1311(c), 42 USC §18031(c).
[26] ACA §1311(e), 42 USC §18031(e).
[27] 45 CFR §155.1000.
[28] ACA §1311(e); 42 USC §18031(e); 45 CFR §155.1020.
[29] ACA §1301(a); 42 USC §18021(a).
[30] ACA §2794(b); 42 USC §300gg-94(b); 45 CFR §155.1020.
[31] ACA §1311(e); 42 USC §18031(e); 45 CFR §155.1020.
[32] ACA §2794(a); 42 USC §300gg–94(a).
[33] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,407 (March 27, 2012).
[34] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).
[35] 45 CFR §156.210; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).

© 2012 National Association of Insurance Commissioners

the rate increase justifications submitted by QHPs. HHS notes that information about rates and rate increases for similar health plans being sold outside of the Exchange may be helpful in this process.[36]

d) SERFF[37]

In the fall of 2011, NAIC staff began discussions with HHS officials regarding the potential use of the existing SERFF system as a tool for the states to use when performing rate review functions associated with the certification of QHPs. The NAIC created a SERFF Plan Management Technical Study Group to define the business requirements for the SERFF Plan Management project, with a focus on the capabilities that will be needed in early 2013 when issuers begin to submit their plans for QHP certification. These critical capabilities include: 1) creation and submission of plans by issuers; 2) review functions for approval and certification the by the states and Exchanges; and 3) the ability to share plan data among Exchange-related software applications. Work to implement these functions will continue throughout 2012 and will be available to the states for use in 2013.

While the SERFF development team has been working on modifications to support Plan Management functionality related to Exchanges, SERFF will separate the code for the Plan Management portion of SERFF to greatly reduce the possibility of impacts to non-Plan Management SERFF customers. Users will access SERFF using the same user ID and password they have today, with the intent of presenting a "look and feel" that is consistent with the current SERFF user interface as the additional QHP-specific screens are developed. As with other aspects of SERFF, only the users who need to see and work with the additional Plan Management features will see the associated options in SERFF.

3. Coordination with State Insurance Departments

a) Effective Rate Review States vs. States Without Effective Rate Review Status

Although the regulations issued by HHS to date do not provide clear guidance regarding the role of states that do not have an "effective rate review program" as it relates to Exchanges, these states may still have an obligation to assist Exchanges in meeting their QHP rate justification requirements. HHS has stated that CMS will determine whether rate increases subject to review under Section 2794 of the PHSA are "unreasonable" unless a state has an effective rate review program.[38] However, Section 2794 of the PHSA also requires the states that have been awarded premium review grants to make recommendations to Exchanges regarding whether particular health insurance issuers should be permitted to offer plans on the Exchange based on a "pattern or practice of excessive or unjustified premium increases" and information regarding premium growth rates inside and outside of the Exchange. Exchanges are required to take such recommendations into consideration.[39]

b) Coordination of Frequency of Review

Health insurance issuers offering QHPs in an Exchange must: 1) submit information on rates at least annually in a manner and form specified by HHS; 2) set rates for an entire benefit year or SHOP plan year; and 3) submit justification for any rate increase prior to the implementation of the increase.[40]

During the comment period for the Exchange regulation some commenters expressed concerns about the requirement to set rates for an entire benefit or plan year because of the possible need to establish new rates, quarterly or annually, to accommodate federal or state regulatory changes. HHS declined to make an exception to the "entire year" rule, because it determined that such regulatory changes are

[36] 45 CFR §155.1020; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).
[37] NAIC HIX Bulletin, Issue 4, April 30, 2012.
[38] 45 CFR §154.210
[39] ACA §2794(b), 42 USC §300gg–94(b); ACA §1311(e), 42 USC §18031(e).
[40] 45 CFR §155.1020; 45 CFR §156.210

© 2012 National Association of Insurance Commissioners

generally known to issuers well in advance and it believes the number of changes that would take effect in the middle of a benefit or plan year would be limited.[41]

c) Recommendations Provided to the Exchange by the State in Accordance with Section 2794(b)(1)(B) of the PHSA

See comments in a) above.

4. Federal Reporting Requirements

a) HIOS

As addressed in other sections of this white paper, the ACA requires the states that receive premium review grants to provide quarterly reports to HHS, through HIOS, regarding the number of rate filings received and reviewed, number requesting an increase, and number approved, denied or deferred.[42] The states must also provide specific information about each filing, including the identity of each insurance company submitting a filing and the type and amount of the requested rate change. In addition, the states that have an effective rate review program are also required to provide CMS with a final determination of whether a requested rate increase is unreasonable, which must include a brief description of its analysis of the rate filing and how it arrived at its determination.[43]

b) Other Reporting Requirements

In addition to the general rate review requirements, as stated above, the states have specific reporting obligations related to Exchanges, including information related to "patterns or practices of excessive or unjustified premium increases" and information about the growth rate of premiums both inside and outside of the Exchange.[44]

5. Consumer Disclosure

As stated above in section V.B.3., all QHP issuers are required to submit to the Exchange a justification for all rate increases prior to their implementation and to prominently post these justifications on their websites.[45]

6. Funding

Exchange establishment grant funds are available for states through 2015. These funds may be used to cover costs of establishing an SBE, including upgrading systems and processes for rate review. However, funding for the ongoing operation of the Exchange is a responsibility of the states. State insurance departments that will be performing additional functions for the Exchange will need to ensure that additional costs are covered.

[41] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).
[42] ACA §2794(b), 42 USC §300gg–94(b).
[43] 45 CFR §154.210.
[44] ACA §2794(b); 42 USC §300gg–94(b).
[45] ACA §2794(b); 42 USC §300gg–94(b); 45 CFR §156.210

© 2012 National Association of Insurance Commissioners

B. Partnership Exchange[46]

1. State Partnership with Federally Facilitated Exchange

In guidance issued in May 2012, HHS provided some insight into how a federal/state partnership might work.[47] In such an arrangement, HHS would retain full authority and responsibility for the Exchange as an FFE, but the states could choose to fulfill the plan management and/or consumer assistance functions of the Exchange.

In the May 2012 guidance, the various functions are broken down as follows:

Plan Management	**Consumer Assistance**
QHP Certification, Recertification and Decertification	Support, Administer and Oversee Navigators
QHP certification review: • Licensure in Good Standing • Service Area • Network Adequacy • Essential Community Providers • Marketing Oversight • Accreditation • Essential Health Benefits • Actuarial Value • Discriminatory Benefit Design • Benefits of Meaningful Difference • Rates (New and Increases)	Provide In-person Assistance to Consumers: • Filing an Application • Receiving an Eligibility Determination • Renewing Coverage • Comparing and Selecting a Coverage Option • Enrolling in a QHP
QHP Issuer Account Management	
QHP Oversight and Monitoring, Including Marketing	
Collect Data	
Verify Accreditation Status and Collect Data for Exchange	
Collect and Display Quality Data	
Coordinate with HHS on Quality Rating and Enrollee Survey	

A state choosing to partner with the FFE must agree to fulfill all of the functions under plan management and/or consumer assistance in order to be a partner. The states are eligible to receive federal Exchange establishment grant funds, as a partner, to pay for additional expenses to prepare for fulfilling the Partnership functions. It is still unclear how operational costs will be covered, or how the roles and responsibilities of the federal and state partners will be finalized, though likely through a memorandum of understanding (MOU).

The enhanced SERFF Plan Management functionality that will be available to states with SBEs will also be available for use by the states that choose to perform plan management as a part of a Partnership Exchange.

Further details on what will be expected of state partners are currently not available. Those states interested in partnering with the FFE should begin discussions with their regional contact to ensure the state's processes will meet the needs of the federal Exchange.

The states must submit an application by November 16, 2012, expressing their intent to partners with the federal government and outlining their plan for fulfilling the functions by October 1, 2013.

[46] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18325-18,326 (March 27, 2012).
[47] *http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf*.

© 2012 National Association of Insurance Commissioners

2. Funding

The states may receive funds from Exchange establishment grants for the cost of updating systems and processes to perform the plan management functions and/or consumer assistance functions required as part of the partnership agreement. These funds are available through 2015. The grant funds may also be used by states to transition from a Partnership Exchange to an SBE.

However, how ongoing operation costs will be covered is yet unclear. Will the state be responsible for raising the funds to cover operational costs? Will the states be reimbursed by the FFE? Additional guidance and discussion is needed on this issue.

C. Federally Facilitated Exchange

1. Authority

If a state fails or elects not to establish an SBE, HHS is authorized to establish and operate an Exchange within the state.[48] HHS has stated that Section 1321 of the ACA "does not contemplate divided authority over an Exchange" and HHS "retain[s] ultimate responsibility and authority over operations and all inherently governmental functions" of an FFE.[49]

In guidance published in May 2012, HHS indicated that, under an FFE, all QHP certification functions, including the review and approval of QHP premium rates, would be performed by HHS. However, the states would also retain all existing statutory authority related to the review and/or approval of premium rates consistent with the procedures described in other sections of this white paper, including those rates used by issuers for QHPs sold through the FFE operating within the state. HHS has acknowledged that certification of a QHP rate filing by the Exchange would be contingent upon a state's approval of the submitted rate, if appropriate. In addition, as noted above, the states that receive premium review grants would presumably continue to fulfill their obligations to provide the Exchange with information about rate practices and trends both within and outside of the Exchange.

2. SERFF

The enhanced SERFF Plan Management functionality that will be available to the states with SBEs and Partnership exchanges will also be available for use by states that utilize the full FFE model in order to enable the states to affirm plans are approved for use within a state, where the state has the regulatory authority to approve or disapprove.

[48] ACA §1321(c); 42 USC §18041(c); 45 CFR §155.105.
[49] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,326 (March 27, 2012).

© 2012 National Association of Insurance Commissioners

Draft: 8/20/12

Exchanges (B) Subgroup
Atlanta, GA
August 10, 2012

The Exchanges (B) Subgroup of the Health Insurance and Managed Care (B) Committee met in Atlanta, GA, Aug. 10, 2012. The following Subgroup members participated: Monica J. Lindeen, Chair (MT); Sandy Praeger, Vice Chair (KS); Linda Brunette (AK); Michelle Robleto (FL); Robert Wake (ME); Mike Rothman and Manny Munson-Regala (MN); Ted Hamby (NC); Martin Swanson and Holly Blanchard (NE); Mike Wilkey (NH); John G. Franchini (NM); Susan Dobbins (OK); Randy Moses (SD); Neal T. Gooch and Tanji Northrup (UT); Leslie Krier (WA); J.P. Wieske (WI); and Michael D. Riley and Jeremiah Samples (WV). Also participating were: Jim Riesberg (CO); and Herb Olson (RI).

1. Adoption of June 26 Meeting Minutes

Mr. Moses motioned, and Commissioner Gooch seconded, to adopt the June 26 meeting minutes (Attachment Two-A). The motion passed unanimously.

2. Discussion of State Perspectives on Exchange Implementation

a. West Virginia

Mr. Samples said West Virginia has not decided whether it will move forward with a state-based Exchange (SBE). To assist in making the decision, he said, West Virginia has conducted a lot of analyses and studies. He said one of the analyses West Virginia has conducted involves estimating the "take-up" rate to determine the number of potential enrollees in the individual and the Small Business Health Options Program (SHOP) Exchange. Mr. Samples noted the limitations and assumptions of the analysis. He said West Virginia has also conducted an analysis concerning the possible expense of operating an SBE. Mr. Samples said West Virginia reviewed state Exchange establishment grant rewards as one indicator of the possible cost. He said West Virginia used three budget approaches: high cost, low cost and moderate cost, which were then applied to each enrollment scenario.

Mr. Wieske asked Mr. Samples if he believed there would still be a robust outside market given West Virginia's projection of a SHOP take-up rate of 22.5% for 2016. Mr. Samples said he believed there would still be a robust outside market, particularly in the employer market, based on the information West Virginia obtained from Maryland. He noted that the projections did not take into account any assumptions related to employee dumping. Mr. Samples also said that West Virginia has not made any decision related to Medicaid expansion since the U.S. Supreme Court issued its opinion June 28 on that issue.

b. Rhode Island

Mr. Olson discussed Rhode Island's activities as to Exchange implementation. He said Rhode Island has been moving full-tilt toward establishing an SBE. The state has figured out what it needs to ensure its SBE is operational, but is nervous about getting all of the necessary work done on time. He said the focus has been on regulatory alignment, given the number of state and federal agencies involved in carrying out the work necessary to make the exchange operational. Mr. Olson said it was necessary to care about this in order to prevent duplicative regulation. He said conscious efforts have to be made to collaborate and develop an integrated approach in order for Rhode Island not to lose its state-based regulatory goals, such as rate review and affordability standards. He detailed Rhode Island's regulatory alignment principles: 1) wherever possible, a single regulating entity or agency for each plan management function; 2) wherever possible, plan management standards will apply market wide; and 3) issuer and health plan review processes will build on existing regulatory structures in a simple, non-duplicative manner.

Mr. Wieske asked Mr. Olson what Rhode Island was spending most of its time on related to getting its SBE operational. He also asked what problems they have encountered. Mr. Olson said he would not characterize it as a problem, but the sheer amount of work to be done is daunting. In addition, having to do this work without having clear federal guidance in some areas made it more challenging. He said most of the time spent so far related to the SBE has been building an integrated

© 2012 National Association of Insurance Commissioners

eligibility and enrollment system in order to meet one goal of the SBE as being seamless to the consumer, whether they are Medicaid-eligible or obtaining coverage through the private insurance market.

Commissioner Lindeen asked what state agency was taking the lead for Rhode Island's SBE. Mr. Olson said the governor's office was taking the lead pursuant to an Executive Order establishing the SBE. He noted that the Executive Order establishing the SBE was authorized by an underlying state statute.

c. Nebraska

Mr. Swanson said Nebraska, like West Virginia, has been planning and designing a possible SBE, but has not made a decision on whether it will operate a SBE. He said that if Nebraska decides to move forward with an SBE, it would be housed within the state insurance department. He also noted that Medicaid expansion is the one issue that Nebraska will have to examine and gauge its impact before making a decision. He said Nebraska has asked the federal Center for Consumer Information and Insurance Oversight (CCIIO) what impact the U.S. Supreme Court ruling on Medicaid expansion will have on exchanges. Mr. Swanson said information on its Exchange activities is posted on the state insurance department's website. He said Nebraska is currently in the process of determining its essential health benefits (EHBs). He said that, like West Virginia, Nebraska is awaiting more federal guidance to assist it in making a determination on whether to move forward.

d. General Discussion of State Exchange Implementation

North Dakota State Rep. George Keiser said states have taken three approaches regarding Exchange implementation: SBEs, federally facilitated Partnership Exchanges (FFPE) and federally facilitated Exchanges (FFE). He outlined scenarios related to the possible repeal of the Affordable Care Act (ACA), depending on the outcome of the presidential election in November. State Rep. Keiser said if Republicans win the presidential election, then repealing the ACA most likely would not be finished by Jan. 1, 2014, which is the date the ACA's Exchange provisions and market reforms are effective. He noted, however, that the Budget Reconciliation process could be used to de-fund the ACA Exchange funding. State Rep. Keiser asked if there had been any discussions on what happens if funding is taken away and states have already committed to operating an SBE.

Commissioner Lindeen said the Subgroup has not had those sorts of discussions. She said that, because the ACA is currently the law, the states continue to review their options in this environment. Mr. Wieske said he believed that the scenarios outlined are a bit more complicated. Mr. Olson said he believed the impact of any of these ACA repeal or de-funding scenarios will most likely be dependent on the specific facts and situation.

Commissioner Rothman said Minnesota has chosen to move forward with an SBE. He said Minnesota is focused on the Jan. 1, 2013, date when the Secretary of the U.S. Department of Health and Human Services (HHS) is to certify that a state pursuing an SBE option will be ready for open enrollment beginning in October 2013, with full implementation Jan. 1, 2014.

State Rep. Keiser asked whether states have looked at the funding of an SBE versus the current uncompensated care costs being incurred by the uninsured. Commissioner Praeger said she agreed that utilization will rise with exchanges, but she believed the health care delivery system was up to the task of making sure everyone gets the health care services they need in a timely manner.

Commissioner Lindeen asked for comments from interested parties. Timothy Jost (Washington and Lee University) said that, according to a RAND corporation study, with stop loss attachment points of $20,000, 33% of small-business owners would move to self-insure once the ACA is fully implemented. He asked if any of the states have looked at the SHOP Exchange becoming a high-risk pool because all of the healthy, low-risk small employer groups will self-insure, leaving the unhealthy, high-risk small employer groups in the exchange. Mr. Olson said Rhode Island has looked at this possibility, but found it hard to predict what will happen. He also said adjusting the attachment points for medical inflation in the NAIC *Stop Loss Insurance Model Act* (#92) is a key in making the SHOP Exchange work as intended.

3. Update on CCIIO Health Insurance Exchange Activities

Timothy Hill (CCIIO) said CCIIO considers the U.S. Supreme Court decision upholding the individual mandate as the end. CCIIO is moving forward with its implementation activities required by the ACA and is not considering any potential impact related to the outcome of the presidential election in November. Mr. Hill discussed CCIIO's activities related to Exchange implementation. He noted that CCIIO has issued level 1 and 2 Exchange establishment grants to 34 states. He noted also that

CCIIO issued in June a federal opportunity announcement (FOA) providing states with 10 additional opportunities to apply for funding to establish an SBE or FFPE, or to prepare state systems for an FFE. Mr. Hill said CCIIO issued an Exchange Blueprint for the states to use to demonstrate how their Exchange will work to offer a wide range of competitively priced private health insurance options. He noted that the Blueprint also sets forth the application process for states seeking to enter into an FFPE. If a state chooses to operate its own SBE or an FFPE, HHS will review and potentially approve or conditionally approve the Exchange no later than Jan. 1, 2013, so it can begin offering coverage on Jan. 1, 2014. Mr. Hill said CCIIO has heard from 13 states of their plans to operate an SBE. He noted that CCIIO has heard from a number of states of their intent not to operate an SBE. He also explained that CCIIO has been providing technical assistance to Exchange stakeholders on various aspects of Exchange implementation through the convening of user groups and holding webinars.

Mr. Hill said he believes the federal Centers for Medicare and Medicaid Services (CMS) is on track to have FFEs ready for open enrollment in October 2013. He said CCIIO is working with the states that will have FFE to make it work, particularly as to plan management functions. He said the data hub is moving forward. Some testing has already been done. He said CMS has created a government oversight group to help to ensure that it will be a seamless process for the states.

Mr. Wieske asked how CCIIO will handle situations where a state has said that it will not operate an SBE or FFPE and then the state changes its mind and decides to pursue one. Mr. Hill said CCIIO will work with the state. He noted, however, that if a state has not started any sort of implementation activities as of Nov. 16, which is the date the states are to submit a Declaration Letter to CCIIO as to which Exchange model they intend to operate, the state most likely could not operate an SBE in 2014.

Mr. Samples thanked CCIIO for the technical assistance it has provided to the states, particularly as related to plan management. He asked whether CCIIO has developed any cost estimates for operating an FFE. Mr. Hill said CCIIO has not made any specific cost estimates, but suggested that Mr. Samples review HHS' 2013 budget request to obtain a rough estimate. He noted, however, that these figures are only from a budget perspective. Mr. Hill said the biggest costs to an FFE will be the personnel involved in making eligibility determinations and involved in the consumer assistance functions. He said the necessary information technology (IT) improvements and requirements are costly in terms of complexity, but not in terms of dollars.

Mr. Samples asked Mr. Hill if CCIIO had any additional information related to the consumer assistance component of the FFPE. Mr. Hill said CCIIO is in the process of developing more specifics. He noted that the ACA specifically prohibits using Exchange grant money to fund the Navigator program. However, the states could use other personnel to provide consumer assistance, which could be funded using Exchange grant money. Commissioner Praeger asked whether CCIIO envisioned the states having these "assistors" in each county in a state. Mr. Hill said he did not believe there was such a specific policy. Commissioner Praeger asked whether CCIIO was envisioning permitting the use of "assistors" as being more flexible than the Navigator program. Mr. Hill said he believed that was the case.

Commissioner Riesberg asked how HHS is dealing with the situation where states do not have the necessary statutory or regulatory authority to enforce the ACA. Mr. Hill said HHS will enforce the ACA's requirements in those states, but will work with the state on the various enforcement issues. Mr. Swanson asked if there had been any change in HHS' decision that under an FFE, the state would have no input into the entities chosen to participate in the Navigator program. Mr. Hill said that, because federal grant money is involved, the states could not decide what entities would be Navigators. However, he said a state could be involved in the selection process.

4. Update on SERFF Activities Related to Health Insurance Exchange Plan Management

Julie Fritz (NAIC) said SERFF held its fifth Health Insurance Exchange Plan Management Forum Aug. 9. She said 47 states participated with more than 250 people attending. She said this Forum was conducted a bit differently than previous Forums, as it was oriented to provide an opportunity for information-sharing among the various stakeholders and obtaining feedback. Ms. Fritz emphasized that the NAIC was participating as a facilitator only as to what data elements will be required related to the plan management functions. She said the NAIC will not be deciding the data elements. If a state is operating an SBE, it would choose; for an FFE and FFPE, CCIIO will be deciding. Ms. Fritz said SERFF is looking for uniformity and consistency for the states and issuers who already use SERFF. She said SERFF is willing to work with the states to make sure that what they need to carry out plan management functions under an SBE or FFPE will be available on SERFF. However, she needs to hear from the states. Ms. Fritz said SERFF will continue to hold Forums. The next Forum will be held in

conjunction with the NAIC's Fall National Meeting. Its focus will be on implementation. Commissioner Praeger asked about the use of SERFF for states that will default to an FFE. Ms. Fritz said CCIIO has said that it is willing to integrate with SERFF in an FFE. If that occurs, then the impact for issuers and the states will be less if the state eventually moves to an FFPE or SBE in the future.

5. Any Other Matters

Brian Webb (NAIC) said NAIC staff is working on a set of decision points related to various Exchange implementation scenarios for states to consider whether the state chooses to operate an SBE, participate in an FFPE or default to an FFE. He said that, after this project is completed, he anticipates NAIC staff holding a series of conference calls or webinars to discuss. Mr. Webb also said that possible next projects or activities the Subgroup may want to consider would be to develop best practices papers outlining education and outreach issues for issuers, agents and brokers, and state departments of insurance.

Having no further business, the Exchanges (B) Subgroup adjourned.

W:\National Meetings\2012\Summer\Cmte\B\ExchangesSG\08-ExchangesSG.docx

© 2012 National Association of Insurance Commissioners

Draft 7/6/12

Exchanges (B) Subgroup
Washington, DC
June 26, 2012

The Exchanges (B) Subgroup of the Health Insurance and Managed Care (B) Committee met in Washington, DC, June 26, 2012. The following Subgroup members participated: Monica J. Lindeen, Chair (MT); Sandy Praeger, Vice Chair (KS); Michelle Robleto (FL); Yvonne Clearwater and Colleen Burns (IL); Jill Mitchell and Andrea Kruchinski (KY); Megan Mason (MD); Tom Record, Glenn Griswold and Bob Wake (ME); Tina Armstrong, Patrick Hultman and Stephanie Krieg (MN); Jean Holliday, Ted Hamby and Ernest Nickerson (NC); Martin Swanson and Holly Blanchard (NE); Alex Feldvebel (NH); Susan Dobbins (OK); Randy Moses and Jill Kruger (SD); Paul Anderton, Nancy Askerlund and Tanji Northrup (UT); Beth Berendt (WA); J.P. Wieske, Richard Wicka, Jennifer Stegall, Stephanie Cook, Susan Ezalarab, Gina Frank, Laura Brown and Diane Dambach (WI); and Jeremiah Samples, Mark Hooker and Kathy Beck (WV). Also participating were: Peg Brown (CO); Tom Donovan (ID); Dustin Swanson and Greta Hockwalt (IN); Linda Sheppard, Cindy Hermes and Lacey Kennett (KS); Kevin Dyke (MI); Emma Fontenot and Alecia Johnson (LA); Molly White (MO); Christina Goe and Rosann Grandy (MT); Eileen Hayes and Abby Nash (NY); Tricia Hill (OH); Franca D'Agostino (PA); Christopher F. Koller (RI); Julie Mix McPeak and Chlora Lindley-Myers (TN); Karl Baker and Hector Garza (TX); and Jacqueline K. Cunningham and Althelia Battles (VA).

1. Opening Remarks

Commissioner Lindeen said that, at the Spring National Meeting, the Subgroup approved developing white papers that the states could use as a resource if they were establishing a State-Based Exchange (SBE) or planning to assume responsibility for Exchange plan management functions under a Partnership Exchange. She said that, immediately following that meeting, five Exchange plan management teams were established to develop these white papers: Accreditation and Quality Team, Form Review Team, Marketing and Consumer Information Team, Network Adequacy Team and Rate Review Team. Each of the teams began meeting on a weekly basis in mid-April in order to complete the white papers by mid-June in order for them to be considered for adoption by the Subgroup in late June. Commissioner Lindeen said the main purpose of this meeting is for the Subgroup to consider adoption of these white papers.

Brian Webb (NAIC) said the teams drafted the white papers on an expedited basis because of the Nov. 16 deadline set by the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) for each state to submit a Declaration Letter on whether the state intends to operate an SBE, enter into a Partnership federally facilitated Exchange (PFFE) or have the U.S. Department of Health and Human Services (HHS) operate a federally facilitated Exchange (FFE). He said that, given this deadline, it was important that the white papers be adopted by the NAIC membership at the Summer National Meeting in order to assist the states in making this decision. To be adopted at the Summer National Meeting, the teams had to complete the white papers by mid-June and then forward them to the Subgroup and the Health Insurance and Managed Care (B) Committee for adoption by the end of June. Mr. Webb said that, following adoption by the Health Insurance and Managed Care (B) Committee, if changes are needed to any of the white papers because of additional federal regulations or guidance, the Committee could hold a conference call to adopt those changes prior to the Summer National Meeting.

2. Discussion and Adoption of Exchange Plan Management White Papers

a. Network Adequacy Team

Mr. Moses, as Team co-lead with Ms. Berendt, presented the report of the Network Adequacy Team. He said the Team began drafting the white paper in April. The Team held open conference calls May 10, 17 and 31, and adopted the white paper during an open conference call June 7. He said that, during each of the calls, the Team considered and discussed comments received from interested parties on each white paper draft. Mr. Moses said that, in drafting the white paper, the Team kept in mind throughout the process that the purpose of the white paper was to provide a framework for the states to consider when developing or, in some cases, reviewing its existing network adequacy standards to meet the federal Patient Protection and Affordable Care Act (ACA) network adequacy requirements as further outlined in the Exchange final rules.

He said the white paper is divided into five sections: Introduction, Background, Network Adequacy Regulatory Standards, Minimum Network Adequacy Processes and Conclusion. It also includes three appendices, one of which includes the ACA

© 2012 National Association of Insurance Commissioners

provisions related to network adequacy and another includes sections of the final Exchange regulations related to network adequacy. The last appendix is a comparison of the final Exchange regulations related to network adequacy and the NAIC's *Managed Care Plan Network Adequacy Model Act* (#74)

Mr. Moses said that, after the white paper was adopted, the Team received two suggested changes from NAIC staff. The first is to correct a reference in the white paper to GeoAccess. GeoAccess is now called OptumInsight. The second change suggests that the white paper include information related to the Exchange plan management activities of the System for Electronic Rate and Form Filings (SERFF) and the potential for the states to leverage its work as it relates to evaluating network adequacy for qualified health plan (QHP) certification. Mr. Moses motioned, and Ms. Northrup seconded, to adopt the *Exchange Plan Management Function: Network Adequacy* white paper with these revisions.

Joan Gardner (BlueCross and BlueShield Association—BCBSA) expressed appreciation for the work of the Team and its consideration of BCBSA's comments. However, she stressed that it was important when implementing the ACA that there is the right balance and suggested that white paper draft did not appropriately strike that balance between what is required under the ACA as to network adequacy and what is required in Model #74. Ms. Gardner said the BCBSA suggested in its comments that the white paper draw a distinction between what is required under the ACA and what is not. She said the Model #74, in many respects, goes beyond the ACA requirements. She said the ACA network adequacy requirements seek to ensure that QHPs have adequate provider networks to ensure consumers have access to providers. Ms. Gardner expressed concern particularly with those aspects of the white paper concerning continuity of care and access to providers outside the network. She said BCBSA's comments offered specific suggestions for revising the white paper for more consistency with the ACA requirements.

Ms. Berendt said she appreciated Ms. Gardner's comments. She noted, however, that in discussing the ACA's network adequacy requirements with representatives of CCIIO, Model #74 was referred to as the floor for meeting those requirements. Ms. Berendt said the Team considered BCBSA's comments. It accepted some, but not others. She said that, with respect to the two issues—continuity of care and access to out-of-network providers—raised by Ms. Gardner, she believes the white paper struck the appropriate balance. Ms. Berendt noted that, in determining network adequacy, there are vast differences between rural areas and suburban areas. She said making such determinations was more of an art than science.

The motion to adopt the *Exchange Plan Management Function: Network Adequacy* white paper, as revised based on the Network Adequacy Team's suggested revisions, passed unanimously (Attachment Two-A1).

b. Accreditation and Quality Team

Ms. White, as Team co-lead with Ms. Lindley-Myers, presented the report of the Accreditation and Quality Team. She said the Team began its work in April with several education sessions and webinars with the National Committee for Quality Assurance (NCQA) and URAC. She said the Team held weekly conference calls. During the conference calls, the Team discussed comments received on the white paper drafts from the accrediting entities, the health industry, consumer groups and state insurance regulators. Ms. White said the Team adopted the white paper during a conference call June 15. She noted that, for the most part, the drafting of white paper was a collaborative process except with respect to options for accreditation for dental plans.

Ms. White discussed the specific provisions in the white paper. She said the goal of the white paper was to provide core information to state insurance regulators and to raise issues that the states might want to consider. Ms. White said the white paper does not provide answers to these issues, because these issues must be decided by each state based on future federal guidance and/or state-specific needs and goals. She said other issues raised during the drafting process were beyond the white paper's scope.

Ms. White said that, based on the comments received after the white paper was adopted, the Team is suggesting a few revisions to the white paper. Those revisions include: 1) adding to the appendix additional relevant sections of the ACA and excerpts from CCIIO guidance on FFEs and the proposed HHS rules on recognition of accrediting entities; 2) adding a note that all references in the white paper to the proposed rules may change in the final rules; 3) simplifying the language in the white paper on data-sharing regarding the need for Exchanges to protect confidential and proprietary data; 4) correcting the timeline for accreditation for consistency with CCIIO guidance on FFEs and Partnership Exchanges; 5) clarifying that HHS intends that only federally recognized accreditors may be used for QHP certification purposes; 6) clarifying that HHS intends to establish when accreditation can fulfill additional federal quality reporting requirements; and 7) clarifying that Health Insurance Oversight System (HIOS) is available for FFEs and Partnership Exchanges for purposes of accreditation data-

sharing. Ms. Berendt motioned, and Mr. Moses seconded, to adopt the *Exchanges Plan Management Function: Accreditation and Quality* white paper, as revised.

Mr. Samples asked about a provision in the white paper concerning the possibility of providing monetary assistance to non-accredited issuers to become accredited. He said this provision references Consumer Operated and Oriented Plans (CO-OPs), but not multi-state plans. Mr. Samples suggested that multi-state plans were similar to CO-OPs and, as such, should be referenced. Ms. White said the Team would be open to adding such a reference. She explained, however, that because the federal Office of Personnel Management (OPM) has not issued regulations on multi-state plans, accreditation requirements for multi-state plans are unknown.

Candy Gallaher (America's Health Insurance Plans—AHIP) raised concerns with the language in the white paper concerning the time frame for non-accredited issuers to obtain accreditation. Ms. White said clarifying this language was part of the revisions the Team is suggesting that the Subgroup adopt for inclusion in the white paper. David Korsh (BCBSA) expressed concern with language in the white paper suggesting that some of the states might want to choose one accreditation organization, as a number of the states have done for their Medicaid programs. He said that, as expressed in the comments submitted by BCBSA, Exchanges are not a program in the same way Medicaid is a program. Additionally, requiring the use of one accreditation body could result in substantial additional expense to issuers should their accrediting body not be selected by the state, forcing them to re-accredit at additional cost. Ms. White said the white paper does not instruct a state to select one accrediting body. It merely raises the option for the states to consider. Commissioner Praeger said she could understand BCBSA's concerns, but, as Ms. White notes, the white paper includes this language as an option that the states can consider. The motion to adopt the *Exchanges Plan Management Function: Accreditation and Quality* white paper, as revised based on the Accreditation and Quality Team's suggested revisions, passed unanimously (Attachment Two-A2).

c. Form Review Team

Ms. Holliday, as Team co-lead with Ms. Battle, presented the report of the Form Review Team. She said the Team began work in April on its charge to develop a white paper that discusses the changes to the form review process in response to provisions of the ACA that are effective in 2014. She said the Team held six open conference calls and five regulator-to-regulator conference calls. The Team solicited and considered comments from interested parties on each draft of the white paper. Ms. Holliday said the Team adopted the white paper during a conference call held June 8 and then exposed the white paper for public comment.

Ms. Holliday said the white paper that was adopted by the Team summarizes the changes to the form review process that are anticipated to occur in 2014. The white paper also identifies resource implications for state insurance regulators as a result of these anticipated changes. Ms. Holliday said the most significant change will be the need to consider some elements of form filings at a plan level, instead of the product-level review that is typical today. She explained that compliance with the ACA's actuarial value (AV) requirements for the bronze, silver, gold and platinum "metal" levels, in particular, will require this type of review. Ms. Holliday also noted that verification of the actuarial equivalence of essential health benefit (EHB) substitutions also could be a resource-intensive process for state insurance regulators. She said the white paper suggests that the states might want to consider how they will evaluate these substitutions and the resources that are available for that purpose.

Ms. Holliday said three sets of comments were received on the white paper draft adopted by the Team. She said comments from the NAIC consumer representatives suggested relatively modest changes to the white paper, which the Team suggests the Subgroup include in the white paper. Most were generally wording changes to clarify meaning or to ensure the paper matches federal law or regulations. Ms. Holliday said the Indiana Department of Insurance recommended in its comments that the white paper explain the meaning or usage of the terms "grandfathered" and "non-grandfathered," and how those terms apply to Exchanges as related to QHP requirements. She said that, in its comments, the Michigan Office of Financial and Insurance Regulation expressed disagreement with the white paper's conclusion that the states have the flexibility to prohibit or restrict actuarially equivalent substitutions of EHBs. Ms. Holliday said the Team chose not to accept the Indiana or Michigan's comments. She explained that the Team felt there was no need for clarification of the meaning or usage of "grandfathered" and "non-grandfathered." With respect to Michigan's comments, Ms. Holliday said the Team believed that, based on the information available to date, the states must permit actuarially equivalent substitutions of EHBs. As noted in the white paper, additional guidance from HHS will be needed before reaching a definitive conclusion on this issue. Ms. Goe suggested an additional clarification concerning the authority of state departments of insurance (DOIs) to perform QHP certification. She suggested that this language specifically provide that DOIs can be granted such authority either through a Partnership Exchange or an SBE. Ms. Holliday agreed to her suggested revision.

© 2012 National Association of Insurance Commissioners

Commissioner Hamm motioned, and Mr. Moses seconded, to adopt the *Form Review White Paper*, as revised, based on the Form Review Team's suggested revisions (Attachment Two-A3). The motion passed unanimously.

d. Marketing and Consumer Information Team

Ms. Dobbins, as Team co-lead with Ms. Hermes, presented the report of the Marketing and Consumer Information Team. She said that, from the outset, the Team sought to clearly delineate the white paper's scope and what it would and would not cover. Ms. Dobbins said the white paper explores the issues and options for the states related to the implementation of certain provisions of the ACA and regulations issued to date regarding the management of marketing, the summary of benefits and coverage (SBC) required to accompany each policy beginning in September 2012, as well as how agents, brokers and Navigators will be regulated and managed in regard to the ACA. She said the white paper does not address issues concerning consumer outreach in general, nor does it address the many facets of issues surrounding agents, brokers and Navigators that do not directly involve how DOIs will manage these individuals. Those issues might be addressed at a later date when more information has been released by HHS. Brian Webb (NAIC) noted that, unlike the other white papers, this white paper is not limited to Exchange plan management because it discusses Navigators, which the CCIIO has included in the consumer assistance Partnership option.

Ms. Dobbins said the Team held a number of conference calls. The Team solicited and considered comments from interested parties on each white paper draft. Ms. Dobbins said the Team adopted the white paper during a conference call June 15 and released the white paper for additional public comment. She said she and Ms. Hermes reviewed the comments received and agreed to accept some of them. Many of the comments that were not accepted went to issues that were beyond the white paper's scope. Ms. Dobbins motioned, and Ms. Berendt seconded, to adopt the *Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage*, as revised.

Wes Bissett (Independent Insurance Agents and Brokers of America, Inc.—IIABA) said the IIABA still has concerns with certain provisions in the white paper. He explained some of IIABA's major concerns, which included the language in the Considerations and Options for State Officials: Licensing and Certification provision. Mr. Bissett said this language should be revised to include language defining what a licensing scheme would look like, as the final Exchange regulations said the states could require Navigators to be licensed. He also suggested revisions to the language in the Recourse for Consumers provision suggesting that the states consider requiring Navigator entities to purchase errors and omissions (E&O) insurance or furnish a surety bond or other evidence of financial responsibility. Mr. Bissett also suggested that language be included alerting the states that they may restrict Navigator activities, such as prohibiting a Navigator from recommending one QHP plan over another. He also suggested that the white paper include a new section alerting the states of their option to require that Navigators undergo criminal and regulatory background screening.

Mr. Bissett expressed general concern with language in the white paper derived from the final Exchange regulation's preamble. He said the preamble has no force of law. Specifically, he noted the language in the white paper stating that the states cannot require Navigators to be licensed agents or brokers. Elaine Saly (Families USA) disagreed with Mr. Bissett's comments regarding the Exchange final regulation's preamble. Claire McAndrew (Families USA) said it was important for the states to not impose on Navigators activities that are not part of their role as envisioned by the ACA. She said the states should be encouraged to treat Navigators like state Senior Health Insurance Information Programs (SHIIPs).

Ms. Gallaher suggested revisions to the footnote related to specialty health plans in the white paper concerning what should be included in Navigator training. She also suggested language be included in the marketing section of the white paper suggesting that the states consider the value of supporting electronic submission of consumer materials. Also, for the marketing section, Ms. Gallaher suggested that language be added suggesting that the states might want to consider setting uniform open enrollment periods for both inside and outside of the Exchange as means to ensure that marketing information can be provided at the appropriate time for consumers to make necessary decisions for coverage. Ms. Lueck expressed support for uniform open enrollment period for both inside and outside of the Exchange. With respect to comments regarding Navigators, she said she believes there would be plenty of work for all, including agents and brokers, given the anticipated influx of consumers. Ms. Lueck said she believes Navigators have a role in helping consumers navigate through the QHP selection and enrollment process.

The motion to adopt the *Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage*, as revised based on the Marketing and Consumer Information Team's suggested revisions, passed unanimously (Attachment Two-A4).

© 2012 National Association of Insurance Commissioners

e. Rate Review Team

Ms. Sheppard, as Team Co-Lead with Mr. Anderton, presented the report of the Rate Review Team. She said the Team began its work in April. The Team held five regulator-to-regulator calls to develop an outline for the white paper and then prepare an initial draft for consideration. The Team draft was exposed for public comment after the May 16 regulator-to-regulator call. Ms. Sheppard said comments were received from regulators, industry representatives, consumer groups and other interested parties. She said the Team discussed the comments and recommendations during open conference calls May 30 and June 6. Ms. Sheppard said the Team adopted the white paper June 11 and forwarded it to the Subgroup for its consideration.

Ms. Sheppard said the Team developed the white paper to assist state policymakers with the implementation of the ACA's provisions related to health insurance rating, rate filing and rate review. She said the white paper's focus is on the rate-review requirements related to Exchange QHP certification. Ms. Sheppard noted, however, that many of the ACA provisions impacting rate review apply to all plans in the individual and small group markets. She said that, from the beginning of its work, the Team agreed that the purpose of the white paper was not to tell the states how they should fulfill their rate review responsibilities. Instead, the white paper lays out the provisions in the ACA and the changes in the regulatory environment that will impact rates and the rate review process.

Ms. Sheppard described the white paper's provisions. She noted that, although it was an issue that the states will have to address, the white paper did not include a discussion of timelines when the states will be ready to begin to review QHP submissions in order for an Exchange to begin enrollment in October 2013. Ms. Sheppard said that, after the white paper was forwarded to the Subgroup for its consideration, comments were received on the white paper from state regulators, BCBSA and other interested parties. Mr. Anderton said the Team reviewed the comments and would recommend that the Subgroup accept the suggested revisions related to medical loss ratio (MLR) and reinsurance provisions. He also suggested that the Subgroup accept suggested revisions from the Rhode Island Office of the Health Insurance Commissioner related to the characterization of costs related to programs that improve health care quality. Mr. Anderton motioned, and Mr. Swanson seconded, to adopt the *Rate Review White Paper*, as revised based on the Rate Review Team's suggested revisions (Attachment Two-A5). The motion passed unanimously.

3. Discussion of Next Steps

Mr. Webb discussed options that the Subgroup might want to consider as next steps following the adoption of the white papers. He said one option could be for the Subgroup to develop best practices papers that would highlight some of procedures or processes of some of the states related to some Exchange plan management activities. Mr. Webb suggested such a paper would probably be most relevant for rate and form review. He also suggested that the Subgroup might also want to consider developing consumer information outreach strategies that the states might want to use related to Exchange implementation. Mr. Webb also mentioned the possibility of the Subgroup developing Navigator training standards.

Commissioner Lindeen suggested that the Subgroup consider these options and be prepared to discuss its possible next steps at the Summer National Meeting.

Having no further business, the Exchanges (B) Subgroup adjourned.

W:\National Meetings\2012\Summer\Cmte\B\ExchangesSG\6-26-12-ExchangesSG.docx

© 2012 National Association of Insurance Commissioners

DRAFT: 6-26-12
As adopted by Exchanges (B) Subgroup, 6/26/12

Plan Management Function: Network Adequacy White Paper

I. Introduction

The federal Patient Protection and Affordable Care Act (the "Affordable Care Act," or ACA) provides for the establishment of American Health Benefit Exchanges ("Exchanges") to facilitate the purchase of health insurance by qualified individuals and qualified employers.[1] Under the Affordable Care Act, for States electing to establish an Exchange, the Exchange must be established and meet certain minimum requirements by Jan. 1, 2014.[2] In States that do not establish a qualifying Exchange, the ACA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an Exchange, known as a federally facilitated Exchange (FFE), for the residents of that State.[3]

In the proposed rules on "Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" published in the *Federal Register*, July 15, 2011, HHS announced the State Partnership model. Under this model, both HHS and the States will operate functions of the Exchange. HHS, however, will remain responsible and accountable to ensure the Exchange meets all of the standards and requirements under the ACA. As stated by HHS, the State Partnership model is intended to give the States another option to tailor their Exchange to accommodate local needs and market conditions. In addition, the State Partnership model is a way that the States can transition to fully operating their own state-based Exchange (SBE).

On Sept. 19, 2011, at a State Exchange Grantee meeting, HHS' Center for Consumer Information and Insurance Oversight (CCIIO) provided additional information to the States on Exchange Partnerships.[4] As provided at this meeting, States entering into a Partnership must agree under the terms of their grants to ensure State insurance department, Medicaid and Children's Health Insurance Program (CHIP) cooperation to coordinate business processes, systems, data/information and enforcement. Also, as part of a Partnership agreement, a State may choose to operate plan management functions and/or some consumer services, such as consumer assistance programs, using Exchange grant funding to establish functionality, thereby maintaining existing relationships and allowing for easier transitions to SBEs in future years.

Specifically, under the proposed Partnership, CCIIO stated that a State may choose to operate the following Exchange functions:

- Option 1 –Plan management functions, such as collection and analysis of plan information and plan monitoring and oversight;
- Option 2 –Selected consumer assistance functions, such as Navigator management and in-person application and other assistance; or
- Option 3 –Both selected consumer assistance and plan management functions.

Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options.

These plan management and consumer assistance functions can be further defined as including: 1) licensure and solvency; 2) network adequacy; 3) rate and form review; 4) benefit design standards; 5) marketing and consumer information, which includes reviewing marketing materials and overseeing navigators; 6) accreditation; and 7) quality ratings, quality improvement strategies and enrollee satisfaction surveys.
On May 16, 2012, CCIIO issued additional guidance "General Guidance on Federally-facilitated Exchanges."[5] The guidance outlined HHS' approach to implementing a FFE in any State where a SBE is not operating. It also described more specifically HHS' approach on how the States can partner with HHS to implement select functions in an FFE. Consistent with the information provided at the State Exchange Grantee meeting, in September, 2011, the guidance provides that the

[1] Pub. L. 111-148 (ACA), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010)
[2] ACA Sec. 1311(b)
[3] ACA Sec. 1321 (c)
[4] http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf

[5] http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf

© 2012 National Association of Insurance Commissioners

States will have the option to enter into a Partnership with an FFE under which the State Partner may assume primary responsibility for the plan management function, in-person consumer assistance functions, including oversight and management of Exchange Navigators, or both. The guidance requires those States that decide to assume primary responsibility for plan management that the State Partner will conduct all plan management activities. In addition, the State Partner will collect and transmit necessary data to HHS in a specific format and manage certified QHPs. The guidance also details responsibilities for the States that enter into a Partnership to assume primary responsibility for in-person consumer assistance functions.

The purpose of this white paper is to provide a framework for the States to consider for ensuring compliance with the network adequacy requirements (both statutory and regulatory) for both inside an Exchange for qualified health plans (QHPs), whether a state is implementing a SBE, a FFE or a State Partnership federally facilitated Exchange (PFFE) and outside an Exchange for managed care plans.

Section II. Background

The Affordable Care Act requires the Secretary of HHS to establish, by regulation, criteria for the certification of health plans as QHPs.[6] The regulations must include certain specified criteria that a plan must satisfy in order to be certified as a QHP and, as such, eligible to be offered on an Exchange. Among the criteria listed is criteria related to plan network adequacy requirements. Specifically, as related to network adequacy, the ACA requires the certification criteria to:

1) Ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act (PHSA)), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers; and

2) Include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the PHSA and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure (*See* Appendix A for the full text of Section 1311(c)(1)(B) and (C) of the ACA).[7]

The Secretary of HHS published in the *Federal Register*, March 27, 2012, the final rules "Exchange Establishment Standards and Other Related Standards under the Affordable Care Act."[8] The final rules set out the minimum requirements for network adequacy that a plan must meet to be certified as a QHP. Subpart C – Qualified Health Plan Minimum Certification Standards, section 156.230 Network Adequacy standards, states that a QHP issuer must ensure that the provider network of each of its QHPs meets these standards:

1) Include essential community providers in accordance with § 156.235;

2) Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and

3) Is consistent with the network adequacy provisions of section 2702(c) of the PHSA.

In addition, the final rules require a QHP issuer to make its provider directory for a QHP available to the Exchange for publication online and to potential enrollees upon request. The provider directory must identify providers that are not accepting new patients (*See* Appendix B for the full text of 45 CFR §156.230).

Section 156.235 of the final rules sets out the requirements related to the inclusion of essential community providers in a QHP provider network (*See* Appendix B for the full text of 45 CFR §156.235). As defined in §156.235(c), essential community providers are providers that serve predominately low-income, medical underserved individuals, including providers that meet specified criteria. This section includes an alternative standard for meeting this requirement for QHP

[6] Section 1311(c)(1) of the ACA
[7] Section 1311(c)(1)(B) and (C) of the ACA
[8] http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

issuers that provide a majority of its covered professional services through physicians employed by the issuer or through a single contracted medical group.

In developing the language for the final rules, HHS reviewed many comments concerning the network adequacy standard initially included in the proposed 45 CFR §155.1050. As noted in the preamble to the final rules, many commenters supported the flexibility provided to the States in the proposed rules, noting that such flexibility could facilitate the alignment of markets inside and outside of an Exchange. Other commenters suggested that HHS establish a national, uniform network adequacy standard. Among the standards suggested that HHS adopt as a national standard and include in the final rules was the NAIC *Managed Care Plan Network Adequacy Model Act* (#74) (NAIC Model). Again, as noted in the preamble, in balancing the competing policy goals and considerations that come into play with examinations of network adequacy (that QHPs must provide sufficient access to providers; that Exchanges should have discretion in how to ensure sufficient access; that a minimum standard in this regulation would provide consistent consumer protections nationwide; that network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions; and that a standard in regulation could misalign standards inside and outside of the Exchange), HHS modified the language in 45 CFR §155.1050, as reflected in 45 CFR §156.230(a)(2) in the final rules, to better align with the language used in the NAIC Model.

Specifically, the final rules establish a minimum standard for QHP issuers as to QHP network adequacy requirements while also providing sufficient discretion to Exchanges to structure network adequacy standards that are consistent with standards applied to plans outside an Exchange and are relevant to local conditions. HHS notes in the preamble that placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current State practice.

While the Affordable Care Act and the final rules prescribe that mental health providers be incorporated into networks for plans inside the Exchange, it must be recognized that mental health is covered under many circumstances outside the Exchange such as federal mental health parity, State specific mental health mandates and plans that choose to cover mental health. Therefore, mental health providers should be a component of networks inside and outside the Exchange.

To the extent that a State already has network adequacy standards, it would make sense for the State to extend those requirements to QHPs to minimize adverse selection against the Exchange. However, in some cases, the ACA's network adequacy standards may go beyond a State's existing requirements, particularly as related to its requirement that essential community providers be included in the QHP's provider network. Whether a State has existing network adequacy standards or not, each State will need to consider whether to apply the same standards for QHP certification to the outside market, the potential for adverse selection against the Exchange if they choose not to require the same standards and the cost to issuers in the outside market to comply if they choose to require the same standards.

For a comparison of the language in the final rules and the NAIC Model, please see Appendix C.

III. Network Adequacy Regulatory Standards.

The final rules provide the States with considerable flexibility in fashioning network adequacy standards for QHPs that wish to participate in an Exchange. One of the ways that the States can put into place network adequacy standards that, with the following exceptions, would be sufficient to meet the final rules would be the adoption of the NAIC Model. While some States have adopted the NAIC model in a manner such that it only applies to HMOs, the NAIC model and the final rules are designed so that these standards apply to all network plans including PPOs and any plan that either requires enrollees to use, or creates incentives, including financial incentives, for enrollees to use the plan's participating provider network.

Areas in which the NAIC Model can be enhanced to ensure compliance with §156.230 include: 1) inclusion of essential community providers, as defined in §156.235(c), in networks; and 2) inclusion of mental health and substance abuse providers in networks.

Regardless of whether a State has adopted the NAIC Model, general regulatory authority should be applied to assure that the network is adequate to deliver the services promised under the benefit contract. Further, if financial incentives are provided for the use of certain preferred providers, a sufficient number of the preferred providers must be made available in a given

service area. In addition, some carriers[9] may be required under State law to deliver prepaid health services through contracts with participating providers. An insufficient number of providers in any given service area may prevent the carrier from selling or renewing benefit plans in that area.

National Accreditation entities such as the National Committee for Quality Assurance (NCQA)[10] and URAC[11] have established provider network criteria that measure network adequacy and provide guidance for reviewing networks. States may also refer to standards established by the federal government for Medicaid managed care or Medicare programs. States could consider relying on a QHP plan's accreditation for network adequacy as a complementary tool, but not as a replacement for regulatory oversight, for assessing compliance with the ACA's and final rules network adequacy standards for QHP certification.

Section 5B of the NAIC Model requires a carrier to file an "access plan" with the State insurance commissioner. The review of a carrier's "access plan" is one component of determining compliance with the NAIC Model's requirements and is part of a process known as "Network Adequacy Analysis." This analysis typically is performed by State Insurance Department personnel, which also involves the review of the carrier's actual networks in order to confirm that there is adequate access to all providers and facilities in a carrier's service area without unreasonable delay or the need to travel an unreasonable distance. The process also accounts for differences in provider availability, capacity to treat patients, provider types (specialties), facilities and practice referral patterns. Although general guidelines, including ratios of patients to providers, distance traveled and waiting times for appointments can be helpful measures in this process, effective analysis also generally accounts for differences between suburban, urban and rural areas; general provider availability and the interrelationship between various providers in treatment of a patient requires a more complete analysis of the network to assure that there are no direct or indirect barriers to access. For those States with existing network adequacy standards, in reviewing a carrier's access plan, these States may need to consider the impact on network adequacy given the expected increase in enrollees.

When developing a network analysis approach, regulatory staff should have a general familiarity with or request information about:

1. General Provider Availability in a given geographic area. Consideration should be given to what providers and facilities are located in a given area. General availability will vary depending on population and urban density and the provider's willingness to enter into provider contracts under reasonable terms and conditions. It should also be kept in mind, as part of the network analysis, that network adequacy considerations may have to be modified depending on a State's specific geographic makeup.

2. Medical care referral patterns and hospital admission privileges. Network analysis must include a review of the hospital admission privileges of providers as well as typical referral patterns for a given community or area. This information may be obtained from the State's health department. Hospital admission privileges are typically gathered as part of the carrier's provider credentialing process. Analysis must confirm that providers that require the use of facilities including hospitals, ambulatory surgical centers or specialty treatment facilities are able to admit their patients to network facilities. As an example, obstetricians must have admitting privileges to network hospitals for delivery services.

3. Hospital based providers, such as radiologists, pathologists, emergency room physicians, may not be part of the same network as the facility. Absence from the network may result in an inadequate network for these services. This is particularly the case if the hospital providers hold an exclusive contract with the facility.

[9] The ACA uses the term "issuer" instead of "carrier." The term "carrier" used in this white paper is consistent with the term "issuer" in the ACA.

[10] For more information about NCQA's health plan accreditation standards related to network adequacy, please see its website at: http://www.ncqa.org.

[11] For more information about URAC's health plan accreditation standards related to network adequacy, please see its website at: http://www.urac.org.

© 2012 National Association of Insurance Commissioners

4. Geographical barriers may exist that serve to impede access to care and the analysis should not rely on a simple mileage factor to determine accessibility. Examples of geographical barriers include mountain ranges and rivers or other bodies of water.

5. The location and availability of essential community providers as well as mental health and substance abuse providers is not addressed in the NAIC Model. However, as previously mentioned, inclusion of essential community providers is required for QHP certification in §156.230(a)(1) of the final rules.

6. The availability and access to centers of excellence for transplant and other medically intensive services as well as the availability of critical care services such as advance trauma centers, burn units, etc. If a carrier does not have such providers in their networks, then arrangements must be made by the QHP issuer to assure access to these specialized services.

7. The availability of provider types as well as the capacity of providers to accept new patients is a critical component of understanding the network. It is also imperative to recognize that different health plans may be including the same provider or facility in a network, thereby reducing the overall capacity to accept new patients from a single QHP issuer.

In depth review of network adequacy should occur at the time a network is established and at least annually. In addition, issuers should be required to submit notification at least quarterly of general changes in their network as well as prompt notice of a potential loss of a material provider such as a hospital or multi-specialty clinic. An overarching goal of network review is to assure that the network provides access to the participating providers in order to deliver the services promised under the benefit contract. If such access is not available, then the carrier must make arrangements acceptable to the state insurance department or other accountable entity that the services are provided at no greater out-of-pocket expense to the enrollee. Because non-participating providers may balance bill their patients for the amount of charges in excess of the carrier's allowed amount, any alternative arrangement must recognize the possibility of greater out-of-pocket expense, resulting in the possibility of issuers basing their payments on billed charges rather than "allowed amounts" or usual and customary fees.

IV. Minimum Network Adequacy Processes.

The network adequacy processes outlined in this white paper are designed so that either an Exchange or a State insurance department can perform those functions. However, where a State insurance department either has or will be implementing network adequacy standards for the outside market, for purposes of administrative efficiency and consistency between the markets, a State insurance department performing functions for both the Exchange for QHP certification and the outside market would be desirable.

A. Review of Health Carrier's Provider Networks.

i. Timing

A health carrier shall seek approval of a service area when initially entering into a new service area market. Once approved a health carrier must maintain an adequate network. A State shall perform regular reviews of the carrier's approved network to ensure adequacy. The State shall have the flexibility to determine the frequency of a network adequacy review, performing network service area reviews when regulatory concerns arise due to consumer complaints, market conduct activities and other department regulatory functions.

ii. Areas of Network Adequacy Review

A health carrier shall maintain a network that is sufficient in number and types of providers to assure all services will be accessible without unreasonable delay. In a State's review of an adequate network, it must also ensure the inclusion of the following within the network:

- Essential community providers;
- Mental health and substance abuse providers; and
- Providers that offer essential health benefit services.

However, this requirement should not be interpreted as an any willing provider requirement.

Other State considerations could include:
- Geographic distribution of providers within a service area;
- The area's population density;
- Time and/or distance to access providers; and
- Location of predominantly low-income, medically underserved individuals' population.

States may consider using tools that measure network adequacy such as OptumInsight (formerly Geo-Access) or Quest Analytics, checklists, time travel analysis, critical care hospital locations, U.S. Census and all other applicable tools. The initial implementation of the new ACA and PHS Act network adequacy rules may gain efficiencies with the use of a State specific streamline review process that includes for QHP certification specific review criteria pertaining to essential community providers and mental health and substance abuse providers for network-based carriers with previous state approval.

Given that network adequacy evaluation is a component of the QHP certification process, States may also want to consider the potential to leverage the NAIC's System for Electronic Rate and Form Filing (SERFF), which is being modified with the intent to be able to support plan management for Exchanges. There are plans underway to enable the ability to submit network adequacy data through SERFF, either through a third party submission or by the carrier during the plan filing submission process.

iii. Adequacy Standards

The burden of network sufficiency shall lie with the health carrier requesting the new service area or certification as a QHP for the Exchange. The health carrier shall demonstrate its adequacy by providing supporting documentation that demonstrates its network sufficiency. A health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees.

Sufficiency may be determined by states using reasonable criteria that may include but is not limited to; provider-covered person ratios by specialty; rural/urban geographic accessibility; appointment waiting times; hours of operation; primary care provider (PCP) covered person ratios; availability of PCPs and high utilization provider specialties; provider acceptance of new patients; hospital access, and patient referral patterns in the requested service area.

There are no specific requirements in either the NAIC Model or the final rules that specify the minimum distances for access to providers or minimum time frames in which to access the providers. Due to the geographic variability of many States, a standard distance or timing may prove to be difficult. States may consider using urban and rural access time standards when reviewing provider access. If no statewide standard exists, measuring adequacy may be accomplished by comparing the health carrier's network to the geographic region served by the applicable provider types. States may give consideration of the relative availability of health care providers in the service area. When considering access to rural geographic areas, States may consider a health carrier's adjacent service area networks that may augment providers if a provider deficiency exists within the service area.

If a health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the State insurance commissioner.

To ensure that a health carrier possesses an adequate network within a requested service area, the States may require that carriers submit a detailed listing of its network provider specialties, locations, acceptance of new patient status, total unduplicated providers, and all other applicable categories using electronic filings. These requirements should be applied uniformly to all health carriers offering QHPs on an Exchange.

B. Review of Contracts Between Health Carrier and Providers/Intermediaries.

As part of the processes the States should consider in determining network adequacy, States should consider reviewing the contracts that carriers have with providers and intermediaries to create and maintain their provider networks.

Section 6 of the NAIC Model sets forth requirements that a carrier must address in its contractual and other dealings with participating providers. These include the requirement of a "hold harmless" provision in the carrier's contract with providers to ensure that providers will not seek payment from enrollees if the carrier or intermediary should become insolvent or fail to pay the provider for any reason. This section also requires a continuation of care provision in the contract between the carrier and the participating provider. The contract provision must set forth the arrangements for continuing covered services to enrollees for a specified period if the health carrier or the intermediary should become insolvent or cease operations.

Among the other provisions in Section 6 of the NAIC Model that the States, as part of their review, should consider having carriers include in their contracts are provisions:

1) Prohibiting providers from attempting, under any circumstances, to collect from an enrollee any money owed to the provider by the carrier;

2) Prohibiting carriers from using standards to select providers that would allow the carrier to avoid providers serving potentially high-risk populations;

3) Requiring carriers to make their provider selection standards available for review by the State insurance commissioner; and

4) Prohibiting a carrier from penalizing a provider for reporting in good faith to State or federal authorities any act or practice by the carrier that jeopardizes patient welfare.

Although not expressly included in the NAIC Model, given the shared responsibility of providers to report timely to carriers of any changes in office locations, their capacity to no longer accept new patients and other pertinent information related to network adequacy, States may also want to permit carriers to include such reporting requirements in their provider contracts. States may also want to permit the inclusion of continuity of care commitments to accept plan payment for courses of treatment in process until completed if the provider leaves the network.

The NAIC Model defines an intermediary as "a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network." Section 7 of the NAIC Model sets out the contracting requirements between a carrier and intermediary. One important provision in that section is a requirement that intermediaries and participating providers comply with all of the NAIC Model's applicable requirements for the relationship between carriers and providers. Another important provision in this section of the NAIC Model specifies that the carrier retains the statutory responsibility for monitoring the provision of covered benefits to enrollees and that the carrier cannot assign or delegate that legal responsibility to the intermediary. Other provisions of this section establish record keeping and related requirements intended to ensure that the carrier and the State insurance commissioner have appropriate access to the books and records of intermediaries.

C. Review of Access Plans.

Subsection A above outlines processes and standards for review of a carrier's network adequacy. Those regulatory processes are intended to incorporate the review criteria for purposes of this component of overall network adequacy. Incorporating the network adequacy review, as outlined in Subsection A above, within the access plan filing allows a panoramic view of the carrier's overall network adequacy. Those items in the access plan for review on an annual basis, at a minimum, should include the following:

i. Health carrier's network.

While the access plan should have the provider network information, additional items should be reviewed in addition to the count of the number and type of providers in the network. Even where the network has sufficient numbers and types of providers overall, individual situations of a lack of network adequacy can occur. Those circumstances can include a hospital or other facility being in-network, but particular providers treating patients at those facilities being non-network (anesthesiologists for example), the person's provider of choice leaving the network during the course of treatment or during a period in which choice of primary care providers is not available, and geographic disparities in the availability of providers. Regulatory options for dealing with a lack of adequacy in these narrower circumstances may include in-network coinsurance

and copayments and allowing for the provider to continue under the network contract for the course of treatment for affected enrollees.

ii. Provider network types.

Determinations on network adequacy generally consider both the number of providers and specialties as well as the provider network types. HMOs may provide in-network only coverage, except in the case of emergencies. PPOs may provide coverage for both in-network and out of network coverage, with the higher level of coverage provided when obtained in network (or in the case of an emergency). Other network arrangements have evolved, for example HMO issuers offering Point of Service (POS) plans which provide for coverage outside of the network, and PPOs offering Exclusive Provider Organizations (EPOs) which provide for in-network coverage only, except in the case of emergency.

Network adequacy determinations focus on adequate number of network providers to address the health needs of the enrolled or prospective enrolled members. So in the case of HMOs, PPOs, POS plans and EPOs the analysis is to assure adequacy of those networks. When the plan includes one of those network types in a tiered network arrangement and only if the same network providers are included no additional network adequacy analysis should be required. If the tiered network contains different providers in each tier, then it is important that the network analysis focus on the preferred tier to assure that there are a sufficient number of providers in the tiers to provide adequate access.

Tiered network arrangements may encourage enrollees to utilize the highest tier providers for services or key services, such as “Centers of Excellence”.

iii. Health carrier’s procedure for making referrals.

The NAIC Model contemplates a review of the carrier's procedures for both in-network and out-of-network referrals and stipulates that the review of the access plan should involve determining what processes and procedures are in place to carry out this requirement, but does not provide any specific standards as to what processes and procedures should be required. In order to determine whether the procedures are appropriate it is necessary to understand the plan requirements for referrals. If, for example, a primary care provider referral is required, then the procedures that the enrollee must use to obtain the referral must be outlined. Likewise if there are differences in out-of-network as opposed to in-network referrals, those differences need to be specified. Finally, a review should identify how enrollees are notified of the referral requirements and a determination as to whether those methods of notification are adequate.

iv. Health carrier’s process for monitoring and assuring ongoing network sufficiency.

A health carrier's network is never static. In order to ensure it meets the minimum standards for network adequacy on consistent basis, a carrier must maintain a system for monitoring its network and develop procedures to react to impending and existent changes in its network that impair adequacy. This would entail a regulatory review of the procedures for monitoring as well as what procedures are in place to as to when and how to take corrective action as it applies to its network.

v. Health carrier’s efforts to address enrollees with special needs.

The NAIC Model requires as a part of the access plan that the carrier develop a process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of the enrolled population. In addition to looking at the needs from an overall enrollee population standpoint the access plan review should include a review of the carrier's efforts to address the needs of those with limited English proficiency and literacy. This would of necessity include providing the services of professionals who can communicate to and for the enrollees with special needs. The review would involve determining what processes and procedures are in place for those with special needs and specificity as to what services are available to such enrollees.

vi. Health carrier’s methods for assessing enrollee satisfaction.

There are two common measures of assessing enrollee satisfaction with their plan, enrollee complaints and enrollee satisfaction surveys. The review should entail a determination as to how the carrier reviews and maintains enrollee complaints and how it uses this information to measure satisfaction. In addition to determining if and how often a carrier surveys satisfaction and how it uses the results to determine enrollee satisfaction, the regulatory review might include an examination of the survey document and the survey results.

© 2012 National Association of Insurance Commissioners

vii. Health carrier's method for informing enrollees of plan features.

Section 5 the NAIC Model contemplates the following as it relates to methods of informing covered persons:

"The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care."

Therefore, not only must there be the existence of a grievance system, processes for changing providers and approval of emergency and specialty care be identified, but there must also be a review of how the carrier notifies enrollees of those features. At a minimum, the existence of the right to file a grievance, change providers in certain circumstances, and when and how emergency or specialty care may be accessed should be incorporated into the carrier's policy form. Additional information relating to these processes should be available upon request and accessible via the carrier's website.

Although not in the NAIC Model, but required under the Exchange final rules in45 CFR §156.230(b), QHP issuers must make their provider directories for a QHP available to the Exchange for publication online and to potential enrollees in hard copy upon request. The provider directory must also specifically identify those participating providers not accepting new patients. States should ensure compliance with these requirements as part of its review. States may consider relying on standards set by national Accreditation entities, such as NCQA[12] and URAC[13], for addressing provider directory information in the Exchange. In addition, for compliance with this requirement and the requirement under 45 CFR §155.205(b)(1)(viii) that the provider directory be made available to the Exchange as part of the comparative standardized information on each available QHP required to be on an Exchange website, the States may want to consider providing a direct link on the Exchange website to the QHP issuer's provider directory.

viii. Health carrier's system for ensuring coordination and continuity of care.

One aspect of coordination and continuity of care that presents unique challenges in the Exchange environment is the transition between Medicaid and QHPs. Due to Medicaid eligibility guidelines, certain enrollees will frequently be in a transition mode between the two types of coverage. The provider of choice that the enrollee sought care from while on Medicaid may or may not be part of a QHP carrier's network. If not a part of the QHP network, enrollees who are in the course of treatment are especially vulnerable when considering what level and type of coordination and continuity of care should be utilized. Strategies designed to minimize disruptions in the care provided to such enrollees are critical to enhancing the quality of care intended for coverage in the exchange. Strategies may include requiring in-network benefits while a new enrollee is in the course of treatment and limited based network agreement for treatment of specified enrollees.

ix. Health carrier's procedure enabling enrollees to change primary care providers.

One of the challenges for enrollees is the protean nature of provider networks. Their provider of choice may for various reasons leave the network. Furthermore, an enrollee's provider preference may change over time. If the carrier's plan requires use of a primary care provider as a gatekeeper, then allowing enrollees to switch primary care providers is an important provision in any network arrangement.

In the access plan filing, a review of what the carrier's procedures relating to changing primary care providers is normally within the scope of review. The NAIC Model, includes a general provision requiring carriers to disclose their process for enabling enrollees to change primary care providers, but does not specify what procedures would be acceptable. At a minimum, in implementing this standard, States may want to considering applying a reasonableness test to determine if the procedures are designed to allow enrollees to switch based upon designated circumstances (such as a provider leaving the network) or at designated time intervals (such as annually upon open enrollment). States also may want to consider

[12] For more information about NCQA's health plan accreditation standards related to network adequacy, please see its website at: http://www.ncqa.org.

[13] For more information about URAC's health plan accreditation standards related to network adequacy, please see its website at: http://www.urac.org.

conducting a regulatory review of consumer complaints and consumer satisfaction surveys to help determine if the process is, in practice, performing as outlined in the procedures.

x. Health carrier's plan for providing continuity of care in the event of provider contract termination.

Continuity of care, depending upon the nature of the care needed, may be critical for an enrollee's health. Provider disruption can also be very problematic when the course of treatment does not involve an immediate life threatening situation but involves very strong enrollee provider preference such as pregnancy.

At a minimum, a carrier must provide notice to enrollees of provider terminations. In addition, specific regulatory standards may be appropriate to allow for the enrollee to continue care with the provider for a specified period of time, such as 90 days, with the applicable provisions of the terminated provider contract applying to care for the affected enrollee. Another option would be to allow the enrollee in the case of pregnancy to continue treatment through postpartum care with the provider once a certain stage of the pregnancy has been reached such as the second trimester.

The access plan review would take into account specific standards required for continuity of care and review the carrier's plan to determine if it is reasonably designed to meet those standards for continuity of care.

D. Enforcement.

There are multiple regulatory responses, as outlined in the NAIC *Market Regulation Handbook*, available to regulators when identifying compliance issues associated with network adequacy. The regulatory response chosen may vary depending upon the severity and nature of the problem, the preferred regulatory strategy or strategies of the state and the nature of the state's health care delivery system. No one response will necessarily fit every state or fit a particular state for all circumstances. This multivariate approach is contemplated by the general nature of the enforcement section of the NAIC Model. Specifically Section 10 of the model includes the following: "… the commissioner may institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act." Therefore, each of the following approaches or methods should be not be viewed as separate and distinct alternatives for a state to adopt to the exclusion of other options, but rather a list of regulatory options available depending upon the facts and circumstances of each particular situation.

i. Notice and an opportunity to correct.

A lack of network adequacy can in some circumstances be correctable. There may be additional providers that can be added to the network to provide the desired level or type of provider availability to enrollees. This method would typically involve a regulatory notice, either formal or informal, to the carrier specifying how the carrier's network is inadequate and request that the carrier take appropriate remedial steps. That notice could contain a timeline for bringing the network's adequacy into compliance.

ii. Restricting the carrier's service area.

This approach may be appropriate in circumstances where notice and opportunity to correct has not brought about the desired level of network adequacy. This approach may be appropriate where a review of the availability of providers in that area in question may make a viable network unworkable in a particular area. This approach is prospective and would specify that the carrier would not be able to continue to sell the network product(s) in question in the areas where the network is no longer determined to be adequate. Depending upon the nature of the State's authority, this could be accomplished by a notice of withdrawal of approval of the network in part or in whole or it could involve a hearing process under the State's administrative procedures act.

iii. Requiring in-network benefits.

For particular areas or for particular types of providers where the network is inadequate, the State's regulatory response may be that the carrier is required to base an enrollee's responsibility for any coinsurance, deductibles or copayments related to such treatment on in-network benefits. This may be an appropriate regulatory response in instances where particular types of providers are unavailable due to either inadequate numbers of providers accepting patients or an unwillingness to contract.

iv. Disapproval of policy forms containing the inadequate network.

If a carrier's network proves to be inadequate on a state-wide basis, an option may be to withdraw approval or disapprove the carrier's network policy forms, effectively precluding the sale of new policies.

v. Formal administrative penalties.

There may be more acute problems as it applies to network adequacy such as intentional violations or a pattern and practice of noncompliance. In such circumstances, a State may wish to initiate more formal administrative action. Many States have authority to issue temporary cease and desist orders. If the actions of the carrier are particularly egregious, a State may wish to consider whether the action in question warrants a monetary penalty or even revocation or suspension of the carrier's license.

V. Conclusion.

As noted in this white paper, the Exchange final rules provide the States with considerable flexibility in fashioning network adequacy standards for QHP certification whether a State decides to establish a SBE or enter into a Partnership Exchange with HHS to carry out the plan management functions in a FFE. This white paper provides a framework that the States may consider in fashioning its network adequacy standards and in developing procedures and processes for implementing those standards.

© 2012 National Association of Insurance Commissioners

APPENDIX A

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

****

(c) Responsibilities of the Secretary-

(1) IN GENERAL- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum--

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION- Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

****

APPENDIX B

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

Subpart C – Qualified Health Plan Minimum Certification Standards

*****

§156.230 Network adequacy standards.

(a) General requirement. A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards –

(1) Includes essential community providers in accordance with §156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) Access to provider directory. A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

§156.235 Essential community providers.

(a) General requirement. (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act[14]; and

[14]Section 340B(a)(4) of the PHSA (Prescription Drug Pricing program, which provides drugs at deeply discounted prices to certain health care providers) defines those entities qualified to receive discounted drugs, which includes federally-qualified health centers, family planning projects receiving grant funds under Title X of the PHSA, Ryan White Care Act providers furnishing HIV/AIDS services, state AIDS drug purchasing assistance (ADAP) programs, black lung clinics, hemophilia diagnostic treatment centers, urban Indian health clinics, Native Hawaiian Health Centers, STC and tuberculosis treatment clinics, public hospitals receiving disproportionate share adjustment payments under Medicare, children's hospitals, critical

© 2012 National Association of Insurance Commissioners

(2) Providers described in section 1927(c)(1)(D)(i)(IV)[15] of the Act as set forth by section 221 of Pub. L. 111-8.

(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) Payment of federally-qualified health centers. If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

****

access hospitals, and rural referral centers and sole community hospitals meeting disproportionate share adjustment payment thresholds. See 42 USC §256(a)(4): http://www.law.cornell.edu/uscode/text/42/256b.

[15]See 42 USC §1396r-8 – Payment for covered outpatient drugs: http://www.law.cornell.edu/uscode/text/42/1396r-8.

Appendix C

COMPARISON OF

NAIC MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT AND EXCHANGE ESTABLISHMENT FINAL RULE

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
Section 4. Applicability and Scope	**Subpart C – Qualified Health Plan Minimum Certification Standards**
This Act applies to all health carriers that offer managed care plans. The term "managed care plan" is defined broadly in section 3O to mean a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. As defined, a "managed care plan" would include HMOs as well as PPOs.	Applies to qualified health plans (QHPs).
Section 5. Network Adequacy	**§ 156.230 Network Adequacy standards.**
	(a) A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards –
No equivalent provision.	(1) Includes essential community providers in accordance with § 156.235.
A. A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services covered persons will be accessible without unreasonably delay. For emergency services, covered persons shall have access 24/7. Sufficiency shall be determined in accordance with this section, and may be established by reference by any reasonable criteria used by the carrier, including: provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technology advanced or specialty care. (1) In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the	(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
commissioner. (2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration. (3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons.	
N/A	(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.
B. Access plan. A health carrier shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the managed care plans that the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following: (1) The health carrier's network; (2) The health carrier's procedures for making referrals within and outside its network; (3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans; (4) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities; (5) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services; (6) The health carrier's method of informing covered persons	No equivalent provision

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care; (7) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning; (8) The health carrier's process for enabling covered persons to change primary care professionals; (9) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and (10) Any other information required by the commissioner to determine compliance with the provisions of this Act.	
No equivalent provision.	(b) A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP must identify providers that are not accepting new patients.
	§ 156.235 Essential community providers.
No equivalent provision.	(a) (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. (2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section. (3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.
No equivalent provision.	(b) Alternate standard. A QHP issuer described in

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
	paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.
No equivalent provision.	(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law: (1) Health care providers defined in section 340B(a)(4) of the PHS Act; and (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111-8.
No equivalent provision.	(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.
No equivalent provision.	(e) Payment of federally-qualified health centers. If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.
Section 6. Requirements for Health Carriers and Participating Providers	No equivalent provision
A health carrier offering a managed care plan shall satisfy all the requirements contained in this section.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services. B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary. D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section. E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier. F. (1) Health carrier selection standards for participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act]. Selection criteria shall not be established in a manner: (a) That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization. G. A health carrier shall make its selection standards for participating providers available for review by the commissioner. H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs. I. A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to a covered person. J. A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier. K. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records. L. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of a termination within fifteen (15) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier. N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions. O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services. P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare. Q. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier. R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier. S. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this Act.	
Section 7. Intermediaries	No equivalent provision.
This section describes the requirements that must be contained in a contract between a health carrier and an intermediary. The term "intermediary" is defined in section 3N to mean a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	*ACA Establishment of Exchanges and Qualified Health Plans Final Rule*
Section 8. Filing Requirements and State Administration	No equivalent provision.
A. A health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries. B. A health carrier shall submit material changes to a contract that would affect a provision required by this statute or implementing regulations to the commissioner for approval [cite period of time in the form approval statute] days prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection. C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved. D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.	
Section 9. Contracting	No equivalent provision.
A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations. B. All contracts shall be in writing and subject to review. C. All contracts shall comply with applicable requirements of the law and applicable regulations.	
Section 10. Enforcement	No equivalent provision.
A. If the commissioner determines that a health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner may institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.	

NAIC Managed Care Plan Network Adequacy Model Act (#74)	***ACA Establishment of Exchanges and Qualified Health Plans Final Rule***
B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination.	

W:\National Meetings\Summer\2012\Cmte\B\ExchangesSG\Network Adequacy White Paper Adopted by Exchanges Subgrp 6-26-12.docx

© 2012 National Association of Insurance Commissioners

Exchanges Plan Management Function: Accreditation & Quality
DRAFT: June 15, 2012
As adopted by the Exchanges (B) Subgroup Accreditation & Quality Team on June 15, 2012

Underlining and overstrikes show changes from the 6/15 draft distributed prior to Team adoption.

Any comments on this draft should be sent only by email to Jane Sung at jsung@naic.org by COB on **Thursday, June 21, 2012**.

Outline:

1. Introduction
2. Summary of Federal Requirements
3. Accreditation Requirements
    a. Requirement to Oversee Assessment and Ratings of Health Care Quality and Outcomes
    b. Quality Reporting Requirements of QHP Issuers
    c. Sharing of Accreditation Information on QHP Issuers with Exchanges
    d. Requirement to Establish Time Frames for Accreditation
    e. How Well Does Accreditation Line Up with Policy Forms?
    f. Dental Plans
    g. Co-ops
4. Quality Elements in the Exchanges
    a. QHP Quality Improvement Strategies
    b. Requirement to Oversee Implementation of Enrollee Satisfaction Surveys
    c. Requirement to Support a Website That Provides Standardized Comparative Information on Quality Ratings
    d. Quality Best Practices and Related Issues
5. Distinctions Based on Exchange status

1. Introduction:

The Patient Protection and Affordable Care Act (ACA) provides for the establishment of American Health Benefit Exchanges (Exchanges). An Exchange must offer only Qualified Health Plans (QHPs) certified by the Exchange to qualified individuals and qualified employers. To participate in an Exchange, QHPs are required to meet accreditation standards and must implement a quality improvement strategy. The ACA addresses the obligations of the Secretary of Health and Human Services (HHS), the Exchange, the State, the issuer, and the QHP itself.

As part of a national quality strategy, Exchanges will have a significant role in: ensuring that QHPs become accredited and implement quality improvement strategies; providing plan ratings based on quality and cost; and providing patient satisfaction data. The purposes of these requirements are to improve the quality of health care, ensure that QHPs are focused on promoting quality improvement, and improve transparency so that consumers can compare plans based on quality as well as price.

This paper is intended to provide a resource to help states understand the obligations of the Exchange with regard to accreditation and quality. The paper also addresses situations where states have options, including situations where options may exist but federal guidance on specifics is not yet available.

2. Summary of Federal Requirements

The ACA quality and accreditation requirements are excerpted at the end of this paper for easy reference. Federal law obligates the Exchange to be responsible for certain quality and accreditation elements. With regard to quality and accreditation, the Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, among many other Exchange dues and responsibilities that are beyond the scope of this paper. The Exchange website must provide standardized comparative information on each QHP, including quality ratings and results of enrollee surveys.

QHP issuers must be accredited by an accrediting entity that meets HHS standards and reflects a variety of quality parameters such as clinical quality, access, satisfaction, among others. A QHP issuer must receive such accreditation within a time period

© 2012 National Association of Insurance Commissioners

established by an Exchange, if not already accredited. A QHP issuer must adopt a quality improvement strategy that incorporates increased reimbursement or other incentives for improved health outcomes, prevention of hospital readmissions, improved patient safety, reduced medical errors, wellness, and reduced healthcare disparities. An accredited QHP issuer is required to authorize its accrediting entity to share information with HHS and the Exchange. An accredited QHP issuer must maintain its accreditation for as long as it offers QHPs on the Exchange.

3. Accreditation Requirements

a. Requirement to Oversee Assessment of Health Care Quality and Outcomes

An Exchange must oversee assessment of health care quality and health outcomes. This requirement is at least in part fulfilled by assuring that QHPs are accredited.

Accreditation is an obligation of the QHP issuer.[1] If the QHP issuer does not become accredited within the specific time frame or the QHP issuer does not remain accredited, the QHP will not be certified. An issuer that is not accredited by a recognized accrediting entity on the basis of local performance of its QHP will not be certified to sell coverage through the Exchanges. Exchanges are obligated to oversee this assessment of health care quality and outcomes.[2]

The ACA does not name a specific accrediting entity but requires that the accreditation must be awarded by an organization that is formally recognized by HHS. There are currently two nationally recognized organizations, the National Committee for Quality Assurance (NCQA) and URAC, that have evolved over the last 20 years for the express purpose of accrediting health plans.[3] The Accreditation Association for Ambulatory Health Care (AAAHC) that has focused primarily on accrediting ambulatory care facilities, but also has over thirty years of experience with accrediting health plans and is recognized by CMS as a deemed accrediting organization for Medicare Advantage Plans.[4] As of the drafting date of this paper, other accrediting entities have not been recognized by HHS or made themselves known to state insurance regulators.

In a proposed rule[5], HHS announced a two-step process for recognizing accrediting entities. In phase one, HHS proposes to recognize NCQA and URAC on an interim basis, subject to certain conditions.[6] In phase two, HHS intends to establish an application procedure, standards for recognition, a criteria-based review of applications, public participation, and public notice of the recognition for entities seeking to become a recognized accrediting entity.[7] If an accrediting entity is not included in the final regulation on recognition of accrediting entities, it is anticipated that they would need to go through the federal recognition process described in the phase two process.

States may wish to consider whether there is a role for state recognition of accrediting organizations. Although the ACA and federal regulations require accreditation to be made by an HHS recognized entity, it is unclear whether there could also be a role for state recognition. Allowing federal and state certification under uniform federal standards may be a desirable way to balance the goals of ensuring that all accrediting entities meet the same standards, while also allowing state flexibility to certify accrediting entities that may be state specific or otherwise better suited to state rather than national recognition. This could potentially serve the goal of giving issuers more choices in accrediting entities and preserve the role of states in selecting accrediting entities.

---

[1] The Affordable Care Act of 2010 (ACA) (Public Law 111-148, as amended by Public Law 111-152), Section 1311(c)(1)(D)(i).

[2] Establishment of Exchanges and Qualified Health Plans, Final Rule, 77. Fed. Reg. (March 27, 2012), 45 CFR §155.200(d). The Final Rule states "The Exchange must…oversee implementation of…" assessment and ratings of health care quality and outcomes in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act".

[3] For more information about the history and activity of each of these organizations, please see their websites: www.ncqa.org and www.urac.org.

[4] For more information about the history and activity of the AAAHC, please see its website: www.aaahc.org.

[5] Recognition of Entities for the Accreditation of Qualified Health Plans, Proposed Rule, 77 Fed. Reg. 33133 (June 5, 2012).

[6] The conditions are specified in §156.275(c)(2)-(4) of the Proposed Rule on Recognition of Entities. The Proposed Rule noted that NCQA meets and URAC is planning to meet, these conditions.

[7] This future rulemaking will be 45 CFR §156.275(c)(1)(ii).

© 2012 National Association of Insurance Commissioners

The ACA does not preclude the possibility of recognition of organizations other than NCQA and URAC, including AAAHC, state-recognized entities or state-specific organizations to fulfill the accreditation purposes. It appears possible that a state could have a unique state-specific accreditation body that could seek HHS or state recognition.

In order to earn accreditation from an HHS recognized accrediting entity, a QHP issuer is evaluated in a review that includes quality improvement activities, credentialing of providers, network adequacy standards, utilization management practices, providing information to consumers, enrollee satisfaction surveys, and assessment and ratings of health care quality and outcomes. Accrediting entities typically evaluate health plans in an initial application process, an ongoing oversight process, and a recertification process.

In overseeing this process, State-operated Exchanges could consider adopting a similar approach as HHS in allowing a choice of qualified accreditation entities, including those designated now and in the future by CMS. Such an approach would allow QHP issuers flexibility to choose an accreditation entity that best meets their needs and could reduce costs for issuers since there would be competition between accreditors. Alternatively, states may want to choose one accreditation program, as a number of states do for their Medicaid programs. This could allow for consistency in evaluation, quality measure collection and approach to scoring plans. It should be noted however, that states are able to require uniform measure sets, even if multiple accrediting bodies are operating in a state.

A key question to be addressed is how well current accreditation processes fulfill ACA requirements. Both NCQA and URAC have provided crosswalk materials outlining where their specific accreditation standards correlate to ACA requirements. Similar crosswalk information is also available from AAAHC. States may wish to consider an arrangement where accreditation by one or more of the national organizations will be presumed to show compliance with additional QHP requirements beyond the baseline requirement that all QHPs be accredited. However, States should not cede regulatory authority so they can take action if they determine that additional oversight is required.

Although the ACA requires an Exchange to address certain quality-related issues (including evaluating quality improvement strategies, overseeing implementation of enrollee satisfaction, assessments, comparative ratings and outcomes), there may be an opportunity to realize considerable administrative savings, as well as valuable consumer protection, by deferring to the organizations that already address these dimensions as part of their accreditation programs, and have decades of experience as well. ~~Currently, fifteen states provide that nationally recognized accrediting entities may apply for recognition as a "deemed accreditor" for health plans consistent with the approach in those laws.~~ Accreditors report that currently as many as 41 states have some level of accreditor recognition. State certification of accrediting entities, if utilized, should be limited however to the state in which it is granted.

Exchanges should also align and prepare to be able to receive and evaluate the data that would be necessary to fulfill accrediting and quality obligations. Accreditation is a tool for regulators and purchasers that does not serve as a replacement for regulatory oversight, but is a complement to state review. It offers as an objective evaluation of critical quality activities (e.g. quality improvement, credentialing or provider directories) not currently included in a state's plan audit processes. For areas where accreditation overlaps with existing state requirements (e.g. utilization management/review) the review can help Exchanges and their state regulatory partners in the assessment of initial and ongoing qualification.

States that decide to use the results of accreditation to satisfy some state requirements may wish to be careful to ensure that QHP certification processes do not duplicate the activities of accrediting entities or establish differing regulatory requirements, which could add to administrative costs. States should consider the extent to which data submitted on the accreditation survey may be used to fulfill other quality reporting standards.

b. Quality Reporting Requirements of QHP Issuers

While quality reporting requirements for QHP issuers and Exchanges will be the subject of future federal rulemaking, HHS has indicated support for an approach which allows for harmonization of measures across programs. In guidance on federally facilitates Exchanges, HHS stated that they intend "…to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the Affordable Care Act, and quality reporting requirements under Medicare and Medicaid."

In the interim, the ACA and the final Exchange rule require that QHP issuers must "be accredited on the basis of local performance by an accrediting entity recognized by HHS in the following nine categories:

(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set [HEDIS];
(ii) Patient experience ratings on a standardized CAHPS survey;
(iii) Consumer access;
(iv) Utilization management;
(v) Quality assurance;
(vi) Provider credentialing;
(vii) Complaints and appeals;
(viii) Network adequacy and access; and
(ix) Patient information programs

Accreditation programs must include clinical quality measures. In recent proposed rules, CMS put forward the following criteria that clinical measures must meet to satisfy the accreditation clinical quality measure requirement:

- Span a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care;
- Include measures that are applicable to adults and separate measures that are applicable to children;
- Align with the priorities of the National Strategy for Quality Improvement in Health Care
- Only include measures that are either developed or adopted by a voluntary consensus standards setting body (such as those described in the National Technology and Transfer Advancement of Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A-119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards; and,
- Be evidence based.

While the clinical quality measures for NCQA and URAC have similarities and differences, both have undergone initial review by CCIIO and, thus far, appear to meet HHS requirements. Prior to issuing this proposed rule and identifying NCQA and URAC for potential recognition, CCIO has worked to become fully aware of the current standards and clinical quality measures employed by both NCQA and URAC. A final review and approval of both URAC's and NCQA's programs including measures, will be performed by HHS prior to announcing formal recognition in a final rule to be published in the *Federal Register*.

This chart summarizes the measure set domains for the two accrediting entities, NCQA and URAC, that were named in the proposed rule:

URAC Measures	**NCQA (HEDIS®[8]) Measures**
• Patient centeredness • Coordination of care • Care efficiency • Effectiveness of care • Patient safety • Health plan management and administration • Systemness or health information technology integration • Health care disparities	Measures scored in accreditation: • Prevention and screening • Respiratory conditions • Cardiovascular conditions • Diabetes • Muculoskeletal conditions • Behavioral health

Detailed clinical quality measure sets for both URAC and NCQA are available at their respective websites: www.ncqa.org and www.urac.org. In addition, information about the AAAHC quality measure sets can be obtained by contacting AAAHC at info@aaahc.org.

It should also be noted that, while NCQA has developed and maintained the HEDIS measure set, URAC's program can also accept HEDIS measures for issuers already using that system of reporting. NCQA also has a system for collecting and auditing non-HEDIS quality measure data and can work to collect non-HEDIS or CAHPs quality data.

[8] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

© 2012 National Association of Insurance Commissioners

Under the ACA, states may require quality measures in addition to those required by the accrediting entities. URAC's program allows for states to supplement its requirements in this manner. States may also be interesting in asking plans to address certain state-specific data that is not included in reports from accreditors. For example, states with a significant mining industry may ask health plans in that state to report data and improve the quality of health care services related to illnesses and injuries associated with mining activities. However, states should consider balancing the imposition of any new quality measures with increased compliance costs.

c. Sharing of Accreditation Information on QHP Issuers with Exchanges

45 CFR §156.275(a)(2) requires QHP issuers to "authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, **together with any survey related information that HHS may require**[bolding added], such as corrective action plans and summaries of findings." NCQA does provide states with quality measure results. On the other hand, URAC routinely provides states with a copy of the accreditation report, and gives them an opportunity to receive additional information. The accrediting entities recognize that the ACA requires an increased level of information sharing than has occurred in the past, and goes beyond what the accrediting entities currently make publicly available.

In their proposed rule, HHS proposes that, when authorized by an accredited QHP issuer, the accreditation entities provide certain data elements to the Exchange during the annual certification period or as changes occur to the data throughout the coverage year. These data elements include: name, address, Health Insurance Oversight System (HIOS) issuer identifier, unique accreditation identifier(s) of the QHP issuer and its accredited product(s) and type(s) which have been released. In addition, for each accredited product type: the HIOS product identifier; accreditation status, survey, type or level; accreditation score; expiration date of accreditation; and clinical quality measures and CAHPS measure survey results.[9]

The accrediting entities have expressed interest in working with the federal government, the NAIC and state Exchanges to provide necessary plan accreditation information with the QHP issuer's authorization. In doing so, it is anticipated that the accrediting entities will put in place any necessary data agreements before sharing the information.[10] The proposed rule also provides that Exchanges will be permitted to enter into these types of data sharing agreements if they choose to require additional information, and asks for additional comment on whether accrediting entities should be required to provide this additional information upon request from an Exchange.[11]

At a minimum, state regulators should receive sufficient information to ensure ACA compliance. Even if an Exchange is able to use the results of accreditation to satisfy some of the oversight requirements, the Exchange should arrange to have access to the data sets that are collected for accreditation purposes. If Exchanges review any other data that may be proprietary, or require HIPAA privacy and security protections, the Exchange should observe the HIPAA minimally necessary standard, and ensure the protection of confidential or proprietary data.

States should also consider which is the appropriate agency to receive such information, as it may not always be the state insurance department. State insurance regulators are likely already familiar with the SERFF (System for Electronic Rate and Form Filings) system for form and rate filings. The NAIC is currently in ongoing discussions with NCQA and URAC regarding SERFF's role as a data conduit in order to present data in a way that is helpful for state review. The NAIC's Market Conduct Annual Statement (MCAS) may also be a potential data sharing platform in the future if very large data sets are involved. However, because MCAS is not currently used for health insurance, the development and refinement of a health application for MCAS could be a lengthy endeavor. Both SERFF and MCAS are tools well known to state insurance regulators, but for states where the Exchange is not overseen by the DOI or in states where there is a federally facilitated Exchange, these platforms may not be the obvious first choice of the Exchange. HHS has a growing familiarity with SERFF, although state Medicaid and public health agencies are unlikely to be familiar with SERFF. States may wish to consider the use of these platforms as a means to harmonize with overlapping DOI and Exchange activities.

[9] This is included in the Proposed Rule on Recognition of Entities as §156.275(c)(5).
[10] The type of data agreement may vary depending on the use of the information. For example, if a state Exchange intends to publicly report information from an accreditation review, a different data agreement may be needed than if a state were intending to use the information solely for QHP certification purposes.
[11] This is included in the Proposed Rule on Recognition of Entities.

© 2012 National Association of Insurance Commissioners

d. Requirement to Establish Time Frames for Accreditation

For QHP issuers that are not already accredited, Exchanges are required to establish a uniform period following certification of a QHP within which the issuer must become accredited.[12] In determining a time frame to achieve accreditation, state insurance regulators should be aware of the reasons that some health plans are not currently accredited. Accreditation has traditionally been driven by public and private purchasers requiring accreditation of plans in order for the plans to participate in the market, for the plans to receive preferential contracts and to provide or supplement oversight. Prior to the ACA, some plans decided not to pursue accreditation due to cost. State or regional provider-sponsored plans are less likely to have the preferential contract opportunities or market incentives to dedicate resources to earning formal accreditation. These plans may be aware of the accreditation evaluation standards and measures, and strive to comport themselves following those standards, although it is not possible to determine whether the non-accredited plans are, in fact, meeting industry standards and measures and monitoring quality.

States may wish to analyze the status of their non-accredited issuers to determine if sufficient criteria exist (based on the plan's documented efforts to operate like an accredited plan) to provide some kind of monetary or technical assistance for those plans to get them to formal accreditation. This may be an especially important consideration for the new co-ops, which have no previous experience operating as a health plan, let alone an accredited health plan.[13] It is reasonable that states may be concerned about providing assistance to such smaller and newer plans. However, more established insurers who are already accredited and issuers currently undergoing the accreditation process may have objections to the competitive disadvantage posed by assistance to newer and smaller issuers. In addition, state Exchanges should carefully consider, if such an issuer does not have the resources to complete initial accreditation, whether they would have difficulty funding the ongoing costs of maintaining the operational infrastructure to meet the accreditation standards and cost of renewal accreditation fees. In addition, Exchanges may want to weigh this expense against other more pressing needs, given scarce resources.

The accrediting entities are also aware of the challenges facing new plans, such as the co-ops, and plans that are not currently accredited but are interested in pursuing accreditation. New issuers will not have a history of complex case management files that can be reviewed or a history of claims that can be used to report clinical quality measures. ~~Both NCQA and URAC~~ All three known accrediting entities (NCQA, URAC and AAAHC) have provisional or interim accreditation programs to accommodate these types of situations.[14]

In guidance on federally facilitated Exchanges, HHS announced that non-accredited QHP issuers will be required to schedule an accreditation in their first year of certification and be accredited by completion of the second year of certification. The guidance also indicates the federally facilitated Exchange will accept NCQA or URAC accreditation of a commercial or Medicaid QHP in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification. This approach is designed to accommodate the needs of new entrants and Medicaid QHPs seeking certification as a QHP.

In establishing a time line or grace period, states should be aware that the accrediting entities have indicated that the typical accreditation process for a previously unaccredited issuer takes an average of 18 months to prepare and an additional 3 months for the accreditor review process. For issuers not already accredited, the January 1, 2014 timeframe is achievable since URAC and NCQA both offer provisional or interim accreditation that could be granted in that time frame.

~~One interpretation of the ACA is that currently non-accredited issuers should achieve accreditation by January 1, 2014. Since the accrediting entities have indicated that the typical accreditation process takes an average of 18 months to prepare and 3~~

[12] 45 CFR § 155.1045.

[13] 45 CFR §156.515(c)(2) states "Loan recipients must offer a CO-OP qualified health plan … in every individual market Exchange ... If offering at least one plan in the small group market, loan recipients must offer a CO-OP qualified health plan in each SHOP ..."

[14] URAC grants provisional accreditation if the plan meets standards for policies and procedures, but does not have sufficient operational or consumer enrollment to receive full accreditation. NCQA has created an Interim and First Accreditation programs for new or currently unaccredited issuers and will first review policies and procedures, then review plan files and performance once the plan builds a history of enrollment. AAAHC's Early Options Survey (EOS) program is for plans in operation for 6 months or less, and plans are granted accreditation but must then undergo an additional interim survey during the accreditation term.

~~months for accreditor review, issuers currently not accredited should be working now to get accredited in time to begin offering QHPs on the Exchanges. For issuers not already accredited, the January 1, 2014 date is achievable for NCQA's Interim and First accreditation, but not likely achievable for NCQA's First accreditation with performance measures as there may be no underlying enrollment to support reporting of HEDIS and CAHPS information.~~

~~Another interpretation of the ACA is that states can establish a scheme in which issuers that are not currently accredited can become accredited within a certain time frame, as HHS had indicated that they will do for the federally facilitated Exchange. In establishing this "grace period" states should bear in mind that the accreditation organizations have indicated that 18 months is the average length of time necessary to become accredited. As noted above, this 18 month period varies by plan readiness. NCQA's full review process takes 3 months, but will be less for Interim Accreditation.~~

As of the date of this paper, several states have already established Exchanges, and have had varying experience in establishing time frames for accreditation. Arizona's Exchange allows issuers to have one year from date of application to sell a product in their Exchange to demonstrate accredited status. Arizona's decision was based on informal work with health plans and consumer advocates and was informed by the fact that most non-accredited issuers were already well on their way towards accreditation.

States will also need to determine the manner in which they establish the time frame, including whether it will require a rule or statute. Arizona simply published its decision. Exchanges in other states might find it necessary to establish the time frame in a more formal manner, such as via bulletin, regulation or statute.

States may also need to consider what will occur if an issuer attempts but fails to achieve accreditation by the expiration of the required time frame. Historically, the formal accreditation process was sufficiently resource intensive that issuers would not pursue accreditation if they were not reasonably confident they would succeed. Issuers may also have feared negative publicity resulting from an accreditation denial. URAC has corrective-action requirements for organizations undergoing accreditation review and that NCQA provides feedback to plans on areas with poor performance and allows plans second review if plans are denied accreditation initially. There are some built in measures to manage situations of denied accreditation, however states should also consider ramifications if decertification is required. For example, if denied, an issuer can have an additional 6 months to correct its performance and then undergo an expedited review by the accreditor.

A related topic that states should consider are other consequences resulting from decertifying a QHP due to failure to achieve accreditation within the specified time period. For example, while an individual may still have guaranteed renewability rights under HIPAA, if their plan is decertified for failure to achieve accreditation, their plan would no longer be available on the Exchange. Similarly, issues surrounding state subsidies should also be considered. If an enrolled individual's chosen plan is de-certified, subsidies are not available outside the Exchange even though HIPAA gives those individuals a right to guaranteed renewability. States may also want to consider implications for small employers purchasing coverage in the SHOP Exchanges.

States may wish to inquire with accrediting entities about timing based on the volume of issuers in their states that have approached them about accreditation since enactment of the ACA. In those states that currently have many of the plans accredited for other commercial, Medicaid or Medicare products there will not be a large influx of plans, and the accrediting entities may perform a shorter and limited review of those plans that are currently accredited. State regulators may also want to keep in mind that additional accreditation entities may seek to play a larger role in accreditation of issuers to meet demand and preserve competition.

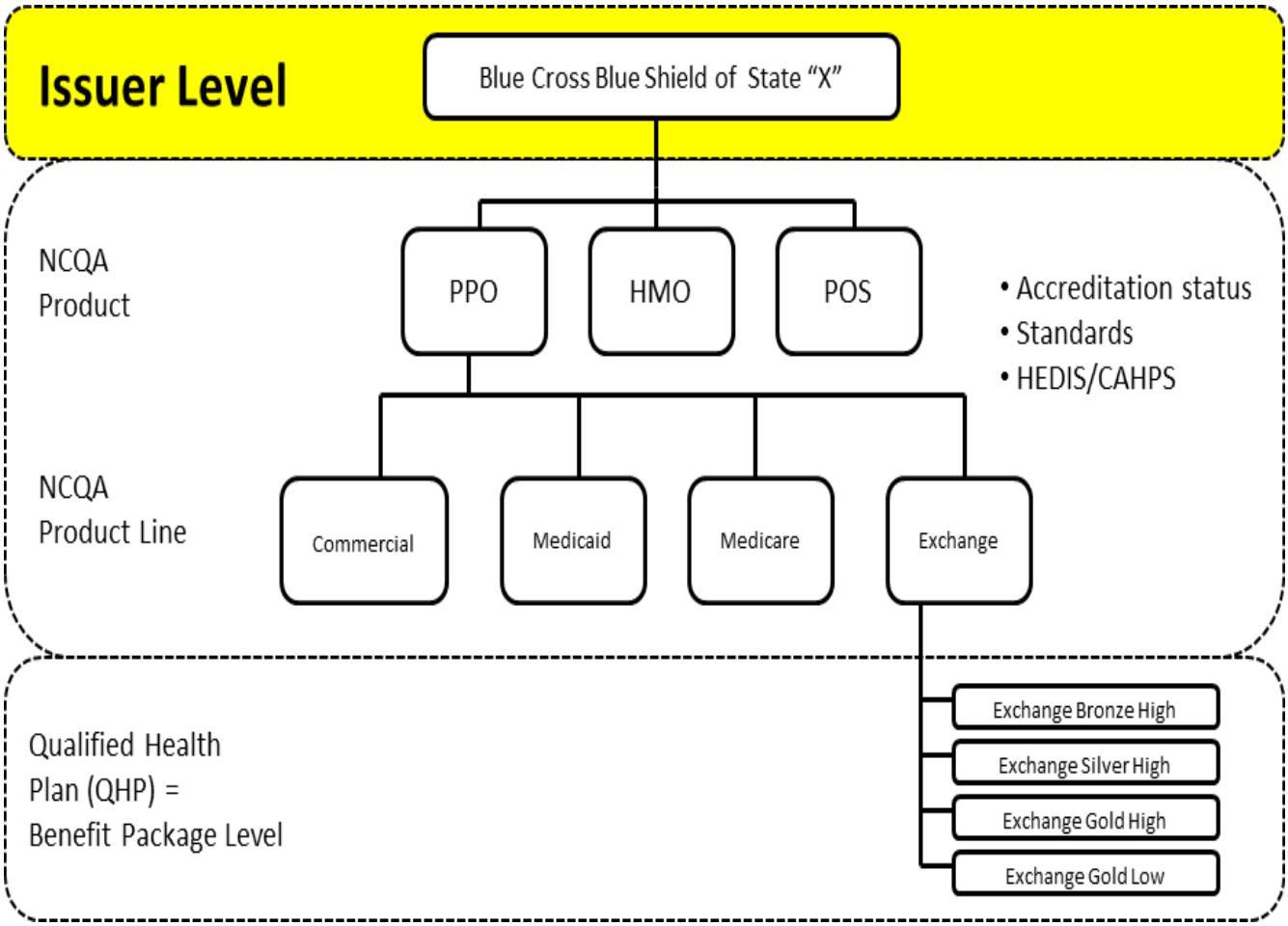
e. How Well Does Accreditation Line Up with Policy Forms?

There is considerable confusion in the ACA, related to federal regulations and various external information sources in how the terms "plan" and "product" are defined and used. For state insurance regulators, there may not be much if any distinction for regulatory purposes between these terms. Existing federal laws such as HIPAA, MHPEA and ERISA, and now the ACA, attach different meanings to these terms. To complicate matters, URAC and NCQA accreditation status is awarded to entities that may or may not be recognizable to state insurance regulators. It is clear from materials available from URAC and NCQA that accreditation could be issued to in a variety of ways: to an insurance company, a holding company, a single product or product line within a company but NOT the whole company, one geographic part of a company's total geographic territory, etc. Accrediting entities have expressed interest in working with the NAIC to match levels of accreditation to NAIC codes.

Currently, each URAC accreditation attaches directly to a state licensed issuer and applies to all lines of the issuer's business in a given state (e.g., QHP, commercial, Medicaid). So, for example, in the case of a national insurer that operates QHP issuers in multiple states, a URAC accreditation certificate number is not issued to the parent company. Instead, each state-licensed QHP issuer operated by the parent company receives a separate on-site review by URAC and receives its own unique URAC accreditation certificate.

In conducting the on-site review, URAC verifies that the name of the legal entity seeking accreditation is directly matched to a state insurance license. URAC also conducts a review to ensure that each product offered by the issuer (e.g. HMO, PPO, POS) and every product line (QHP, commercial, Medicaid) meets URAC accreditation standards as well as any state specific requirements. When URAC issues an accreditation certificate, it is specific to a state-licensed issuer and the certificate lists each product and product line that is included in the accreditation. URAC has indicated that they could also list on the certificate the state license identifier and NAIC code for the accredited entity. However, states should verify that the accreditation achieved is the appropriate level for qualification for the Exchange.

The following chart, supplied by NCQA, demonstrates what level NCQA accreditation and quality data collection occurs:



The challenge with this approach, for state insurance regulators, is that it does not resemble or correlate to state licensure, market regulation, or solvency laws, which are the general parameters by which state insurance regulators recognize a "plan". For example, in many states, licensure as an insurance company precludes the sale of HMO products, and vice-versa. Licensure as an HMO precludes the sale of insurance products. You would not have one company that delivered both PPO and HMO products under the same license. Therefore, the accreditation that NCQA's chart indicates actually would apply to at least two separately licensed entities in the eyes of the state insurance regulators. Yet only one accreditation has been awarded from NCQA.

© 2012 National Association of Insurance Commissioners

In many cases, it may not be easy for states to identify which insurance policies or products or plans line up with an accreditation and which ones do not. This is an area where SERFF might be useful. SERFF staff have worked closely with state and federal officials to adapt SERFF to meet new needs under the ACA. When making a policy form filing in the SERFF system for state approval purposes, the SERFF system could be adapted to reflect whether or not the company proposes to use the form(s) in that filing in or out of the Exchange, or both, as well as the evidence of accreditation status necessary if the form is for purposes of supporting plans sold through the Exchange. If necessary, states could establish state-specific submission requirements in SERFF, although doing so might create a lack of uniformity across states.

In their June 1, 2012, proposed rule, HHS proposed that accreditation should be done for each product type offered by a QHP issuer in each Exchange, based on data submitted by the issuer that is representative of the population of each qualified health plan in that Exchange product type.[15]

Consumer groups note that QHP accreditation, rating and reporting should tied as closely as possible to the particular plan in which an individual is enrolling, in order to permit consumers to make plan comparisons based on quality and the most transparency. They oppose accreditation at the holding company level.

Both NCQA and URAC have demonstrated unhesitating willingness to work closely with state and federal regulators to assure smooth implementation of the ACA requirements. This cautionary note is simply to advise state insurance regulators to pay close attention to the details of accreditation awards.

~~e~~f. **Dental plans**

Stand-alone dental plans offered in an Exchange are considered to be a type of QHP. These plans must meet consumer protection standards, such as offering benefits without annual and lifetime limits.[16] However, the federal rule recognizes the unique nature of stand-alone dental plans and permits Exchanges to establish standards that are specific to stand-alone dental plans. The final rule also establishes that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the stand-alone dental plans covers only pediatric dental benefits. To the extent that accreditation standards specific to stand-alone dental plans do not exist, such plans would not have to meet the requirement that QHPs not already accredited must become accredited within the uniform period established by Exchanges.[17]

There are currently no accreditation standards specifically for dental plans. It does not appear that such standards are likely to be developed by the health plan accrediting entities specifically for dental plans. Dental plans believe, and urge, that accreditation standards should not be applicable to dental.

States should be aware that URAC does currently accredit ~~several~~ a few dental plans to varying degrees. URAC's accreditation is offered in modular format, for specified activities, such as utilization management for example. These can be applied to a broad range of entities that perform utilization management, including dentistry. Therefore, some of URAC's accreditation awardees are dental plans that have earned accreditation in a module applicable to the business of operating a dental plan (such as utilization management). States may wish to consider if a particular URAC module is reasonable to expect a certified dental plan to obtain. In considering this option however, states should keep in mind that extremely few dental plans have any accreditation, and that for pediatric-only dental plans, the costs and administrative burden of accreditation may outweigh any benefit.

[15] 45 CFR §156.275(c)(2)(iii).
[16] 45 CFR §155.1065.
[17] Exchanges Final Rule, Provisions of the Proposed Regulation and Analysis and Response to Public Comments, p. 18412 describing §155.1065 and §155.1045.

~~f~~g. Co-ops

Neither the ACA nor federal regulations regarding co-ops provide an exception for co-ops in terms of obtaining accreditation for their QHPs, or for complying with quality reporting requirements. Because co-ops are intended to have no connection to any existing insurance plans, co-ops will therefore also have no experience, no maturity with data collection and reporting, and no statistically valid pool to sample, or from which to pull data. The federal regulations establish a phase-in time frame for co-ops to earn accreditation which mirrors the phase-in time frame extended to all unaccredited plans. However, given co-ops' lack of claims experience, the application of the accreditation and quality requirements to co-ops will be particularly challenging. URAC's modular options for accreditation, as discussed above in relation to dental plans, may be a suitable and appropriate route for co-ops.

4. Quality Elements in the Exchanges

The federal regulation requires Exchanges to evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting.[18]

a. Requirement to Evaluate Quality Improvement Strategies

The ACA requires QHP issuers to implement a quality improvement strategy. This is a requirement separate from the accreditation process. Exchanges are required to evaluate these quality improvement strategies.[19] As of the date of this paper, HHS has not issued additional guidance, although such guidance is anticipated. At present, this paper will assume that Exchanges will collect data from QHP issuers that shows health status and health outcomes.

HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that state-based Exchanges may adopt a similar approach prior to final regulatory standards. It is anticipated, for example, that HHS will propose that reporting requirements related to all QHP issuers will start in 2016. We understand HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The QHP-specific quality rating would be available for display in 2016 open enrollment for the 2017 coverage year. In the interim, a federally facilitated Exchange will display existing CAHPS data that are available for the same QHP product types and adult/child populations.[20] Federally facilitate Exchanges will not display other data drawn from the accreditation data, such as clinical measures results.

HHS intends to engage in rulemaking for quality reporting and disclosure requirements for all Exchanges. HHS also intends to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the ACA, and quality reporting requirements under Medicare and Medicaid).

The statutory language regarding quality improvement strategies refers to "market based incentives". These are defined as "increased reimbursement" or other incentives for specified outcomes or implementation of certain activities. Therefore, it appears that, at a minimum, "quality improvement" means more money for achieving outcomes or implementation activities. The use of the term "reimbursement" appears to assume the incentive is aimed at those who are reimbursed by health plans. In most cases, medical providers are reimbursed by health plans. It appears that the intent of the ACA is that QHP issuers will pay providers more if providers demonstrate achievement of desired outcomes. "Other incentives" can certainly mean almost anything, including but not limited to reduced out-of-pocket costs for health plan members.

Although accreditation programs could be used to demonstrate how plans are meeting quality improvement strategies, it is unclear, pending further federal guidance, whether accreditation will be considered sufficient to meet such quality improvement strategies. Both URAC's and NCQA's health plan accreditation programs include standards related to operation of an effective internal quality improvement program which, in part requires analyzing performance based on quality measures, and conducting corrective action and follow-up based on these findings.

[18] ACA, Section 1311(c)(1), 1311(c)(3), and 1311(c)(4).
[19] 45 CFR §155.200(d) states, "*Quality activities:* The Exchange must evaluate quality improvement strategies…in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act."
[20] For example, HMO Adult CAHPS results for HMO QHPs, or Child CAHPS results for child-only QHPs.

Consumer groups suggest that the goal of establishing quality improvement strategies is to help provide incentives for providers to provide, and for consumers to choose, the highest quality, highest value health plans and providers. For providers, these may include incentives to implement patient-centered care initiatives that focus on improving health outcomes, preventing readmissions, improving care coordination, advancing patient safety, reducing medical errors, and reducing disparities in care. For consumers, this would encourage the use of services and programs that improve health and may include the use of patient-centered tools designed to discourage utilization of expensive services that do not add value when good alternatives exist. QHPs may be able to demonstrate quality improvement strategies by making a commitment to higher reimbursement for primary care, increased access to primary care services, and adopting strategies towards achieving a coordinated, patient-centered, value-based delivery system.

States may want to address state-specific health issues in their review of QHPs' quality improvement strategies, and to ensure that the strategies are consistent with the three-part aim identified in the National Quality Strategy: better care, healthy people and communities, and affordable care.[21]

Consumer groups have suggested that HHS establish a standardized set of metrics that the NAIC can adopt to ensure comparability across QHPs and state Exchanges. However, insurers have raised concerns that quality improvement strategies will not be comparable across plans because of population differences and socioeconomic factors and therefore would not be an accurate reflection of the effectiveness of such programs. One potential challenge to quality reporting in the Exchange relates to the expected influx of individuals who have not previously had access to coverage. These individuals will likely have unmet health needs that will affect initial efforts to improve quality. At least initially, measurements of quality improvement are expected to be unreliable as a significant volume of previously uninsured people are introduced into the system. Guidance related to federally facilitated Exchanges provides for a phase-in of quality reporting requirements to account for this initial instability.

In order to assist state Exchanges in evaluating quality improvement strategies, states may also want to consider some potential tools such as SERFF, All-Payer Claims Databases, and MCAS (described earlier in the paper).

1. SERFF

The System for Electronic Rate and Form Filings (SERFF) is an NAIC-owned, internet-based tool used by 49 states, the District of Columbia and Puerto Rico as well as more than 3,400 insurers, for purposes of submitting, receiving, reviewing and approving insurance company product filings (e.g., rate, form, rule, and advertising). The SERFF system has automated the historically manual, paper-intensive filing process. Today, it is estimated that more than 95% of all product filings travel through the SERFF system. NAIC SERFF staff have been actively working with state insurance regulators, insurers, the federal government and other third parties, such as URAC and NCQA, to explore adaptations that would support health plan management functions which states may elect to perform in a health insurance Exchange regardless of the exchange model implemented (state-based, partnership or full federally facilitated exchange). State insurance regulators and the health insurance industry agree they would benefit significantly in terms of administrative consistency and support if the SERFF system could be modified to support QHP issuer accreditation and quality improvement data. SERFF staff has already proven that they are willing and able to modify the SERFF system to support new functions related to the federal health insurance reforms in other areas, notably in support of health insurance rate review functions and data reporting to the federal government.

Current plans are underway to ensure SERFF will serve a role in the new Exchange environment. Details related to the role of SERFF, as the primary plan management tool have been evaluated. Phase 1 of this initiative was approved as part of the NAIC's 2012 budget process and Phase 2, while currently underway, will be formally approved in the upcoming 2013 budget process. Modifications to the SERFF system will be funded by the states through their federal grant funds, either for exchanges or rate review.

[21] For more information about the National Quality Strategy, view: www.ahrq.gov/workingforquality/ngs/.

2. All-Payer Claims Databases

Some states have implemented an All-Payer Claims Database (APCD) which could potentially be used to evaluate quality improvement strategies and oversee plan quality.[22] APCDs are enjoying some popularity among policymakers because of the potential to gather, control, analyze and manipulate a tremendous amount of public health information.

However, it is important to note that thus far those are claims databases and do not collect quality information on quality initiatives or outcomes. For purposes of this paper, both the medical provider community and the health insurance industry expressed significant concern with the state of development of APCDs and the use of APCDs in the 14 states that have enacted legislation to collect claim or remittance information.

To address some of the complex data challenges, the Accredited Standards Committee X12 and the APCD Council are currently attempting to develop a national standard or standards for reporting from APCDs. Though the X12 standards may clarify some reporting issues, we understand these standards may not address other issues such as inconsistent data definitions among payers, which is one of the major impediments to using APCDs information for comparative quality reporting purposes. The technology is considered to be still under development and it may be many years before APCDs can be expected to serve a significant role in state health planning.

b. Requirement to Oversee Implementation of Enrollee Satisfaction Surveys

Specific reference is made to Consumer Assessment of Healthcare Providers and Systems (CAHPS) and HHS plans to develop an enrollee satisfaction survey based on CAHPS.[23] CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The survey is a set of instruments established and maintained by the Agency for Healthcare Research and Quality (AHRQ). However, AHRQ does not administer the survey. It is publicly available and is nationally recognized as a valid and uniform instrument for surveying consumer satisfaction with health care service delivery and financing systems.

NCQA currently uses CAHPS surveys. URAC has routinely accepted CAHPS data as part of meeting is standards and, with the release of the current URAC Health Plan Accreditation Program (Version 7, 2011), URAC now requires CAHPS reporting.

The ACA requires Exchanges to "oversee implementation of enrollee satisfaction surveys".[24] The Exchange must also post enrollee satisfaction survey results on the Exchange website so that the public can compare satisfaction across plans. States can elect to deem an accredited plan to meet any state specific standards for surveying consumer satisfaction.

Several different survey instruments are available including "Health Plan," "Clinician and Group," "Hospital," and others. One survey instrument that does not currently exist is "Exchange." Therefore, where the ACA and associated regulations require state Exchanges to "oversee" surveys of consumer satisfaction, it appears this refers to surveys of consumer satisfaction with the health plans specifically sold as QHPs through the Exchanges. It does not appear that Exchanges must directly administer such surveys, but Exchanges are responsible for overseeing surveys administered by QHPs on their own membership. This is another area, however, where it would be questionable for Exchanges to duplicate the work already being carried out by the accrediting entities. To the extent permitted by future federal guidance, Exchange activity in this area should defer to accreditation standards. If anything, Exchanges may wish to voluntarily undertake their own customer satisfaction surveys, specifically because there is currently no CAHPS instrument specific to "Exchange".

c. Requirement to Support a Website that Provides Standardized Comparative Information on Quality Ratings

It is anticipated that further regulatory guidance will be issued before Exchanges are required to implement a quality rating system. It is anticipated that HHS intends a phased approach to the quality rating provisions in which quality ratings in 2014 would be predicated on generally available and collected metrics and measures, and moving to a QHP-specific rating in 2016.

[22] For more information about APCDs, readers may evaluate information publicly available from www.apcdcouncil.org and www.x12.org.
[23] For more information, see www.cahps.ahrq.gov.
[24] 45 CFR §155.200(d) and ACA Section 1311(c)(4).

Once implemented, it is part of the obligation of Exchanges to oversee implementation of "assessment and ratings of health care quality and outcomes, information disclosures, and data reporting."[25]

Numerous organizations across the country have websites providing comparative information on health plans. Quality reporting information on such comparative websites, in conjunction with cost information, will assist consumers in making decisions based on value. The Massachusetts Health Connector web site, which includes data on accreditation and quality, is one resource that states may wish to look as they design and implement a quality rating system.[26] Another helpful example may be the Getinsured.com website, which also displays accreditation information.[27] A third useful tool is the Consumers CHECKBOOK plan compare tool.[28]

There are additional requirements in the ACA and Exchange regulations on what the Exchange website should support, but for purposes of this paper, the focus is on allowing consumers to compare plans on a quality and price basis, where certain minimum required plan features are expected to be the same across all plans, such as coverage for preventive services and essential health benefits. State exchanges may want to develop their quality initiatives closely in concert with the development of the web portal and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

When thinking about providing quality information to Exchange enrollees on websites, NCQA has suggested two phases of presenting the quality information on websites. In the early years, there will be limited quality information available because there is no Exchange population to measure. In this first phase of the Exchange, the websites can report how a plan performed on accreditation. URAC urges that, since access to health plan quality information is essential to consumers and that this information would be the most widely available to consumers when provided through the Exchange websites.

c. Quality Best Practices and Related Issues

States have a variety of options to evaluate and adopt best practices in healthcare and health plan quality oversight. There are a number of organizations devoted to improving quality in the health care context. AHRQ, described above, is the lead federal agency responsible for improving the quality, safety, efficiency and effectiveness of healthcare for Americans. Other federal agencies, as well as some state-based organizations and private and public-private partnerships are also involved in quality-related activity.

While this paper is focused on accreditation and quality requirements relating to Exchanges, state regulators have other responsibilities related to insurer quality and reporting under the ACA. Implementation of these related areas should be carefully coordinated. Section 2717 of the ACA requires HHS to develop reporting requirements for plans regarding coverage provisions and provider reimbursement structures intended to improve outcomes, reduce hospitalizations, and improve patient safety, among other goals. Sections 2715(a), 1311(e) and 2718 also require insurers to report data to the Exchange, the state insurance department, and HHS. State insurance departments may also want to carefully monitory quality improvement activities for which carriers claim expenses in the numerator of their medical loss ratio calculations under Section 2718.

Accrediting entities offer information and guidance on best practices. According to NCQA, 41 states currently use its accreditation information in their oversight of health plans. Of those, 37 apply it to commercial plans and 29 apply those requirements for Medicaid contracted plans. Commercial state regulators vary in their use of accreditation but the most commonly recognized standards include the areas of utilization management and credentialing.

There is an NAIC health plan quality model (#71 – dated 1996). One state (Nebraska) has adopted it in total, and 26 states are identified as having adopted it in part, although in some cases the requirements only apply to HMOs.

Many states have a long history of using elements (e.g. utilization management and credentialing) of or whole quality programs (health plan accreditation) from accreditors. State Medicaid programs have historically been more active in review of health plan quality than state insurance regulators, through state Medicaid managed care programs. States can tap their

[25] 45 CFR §155.200(d).
[26] www.mahealthconnector.org/portal/site/connector/
[27] www.getinsured.com
[28] www.checkbook.org/plancompare/

Medicaid managed care programs for guidance and support in developing quality oversight programs applicable to commercial health insurance.

In Tennessee, the TennCare program participated in a webinar with Academy Health and NCQA regarding quality. While states should consider the differences between Medicaid and commercial insurance markets, the TennCare officials offered the following items as important "lessons learned" in their 15+ year history of overseeing a state-wide effort at improving quality for Medicaid beneficiaries:

1. Access to reliable encounter data as quickly as possible is extremely important. Hard data is needed to dispel misinformation.
2. Quality requirements should be spelled out for health plans – e.g., accreditation requirements and timelines and performance measure reporting requirements. Accreditation takes time so clear milestones should be established to assess progress toward the goal. Consider pay-for-performance arrangement to reward plans for accreditation level received.
3. Independent, external review (EQRO, an accrediting entity like NCQA or URAC) goes a long way to quelling stakeholder concerns.
4. Required reporting of standardized, evidenced-based performance measures for MCOs allows tracking trends over time and for comparison to national norms (e.g. HEDIS).
5. Consider developing a state level survey that will allow you to track issues of interest to the state over time. This would be in addition to MCO level surveys like CAHPS.
6. Pay for Performance incentives tied to specific performance measures can be used effectively to target attention to your highest priorities.
7. Network monitoring should include three components:
    - Establishment of network standards for various provider types (e.g., geographic, appointment time)
    - Tracking compliance with standards based on network information self-reported by MCOs.
    - An audit process to validate MCO self-reported information
8. Tracking and analysis of enrollee appeals can be an important quality monitoring tool.

The Medicaid Health Plans of America (MHPA) offers guidelines for Medicaid managed care programs in specific clinical issues to enhance the overall health of Medicaid populations. Their web site also offers access to a wide range of clinical, administrative and policy publications, many at no cost. Other public and private organizations, from consulting firms to research organizations to advocacy groups, offer a wide range of papers, discussions, research articles, webinars and other resources for little or no cost, exploring a wide range of issues in health plan quality improvement strategies. Common themes that appear to recur in much of this literature include:

- The importance of data collection and state-of-the-art data systems that can support powerful analysis .
- An emphasis on clinical quality measures, with somewhat less information and guidance on administrative quality improvement approaches.
- An emphasis on behavioral incentives for medical providers and patients, beyond clinical excellence – in other words, the best clinical care can be ineffective if not accompanied by incentives that remove administrative barriers to delivery. Proper and timely communication between providers and patients is an important goal.
- Achieving an appropriate balance between data reporting and collection and minimizing unnecessary and unhelpful administrative burdens. The public wants standardized, comparable health plan information, often in highly specialized areas such as treating children with autism or longevity following cancer treatment. The public also wants privacy protection and affordable care. These two things actually work against each other and will require constant monitoring and perpetual re-balancing.

5. Distinctions Based on Exchange Status

Exchanges may be entirely state-operated, or states may develop partnerships with HHS to share certain responsibilities. Even if the Exchange is entirely federally facilitated, states should be aware of the quality and accreditation issues. States with existing state law requirements for health plan accreditation and quality may be well positioned to manage Exchange operations related to these requirements.

Regardless of the Exchange status, state insurance regulators will play a modified role in health plan oversight. Where the Exchange is operated by the state, the role of state insurance regulators will not change as much as might be the case with a federally facilitated Exchange, but there will still be a change. For example, in areas of market conduct and consumer support, state insurance regulations may be superseded by new Exchange requirements. Insurance regulatory interactions with Medicaid managed care plans and state Medicaid agencies will be dramatically different. Even in the area of health plan

solvency, insurance regulators will be dealing with the financial impacts of new plan growth, new plans in the market place (particularly co-op plans with no prior insurance experience), and large numbers of new entrants into the insurance market. Although the ACA includes no new financial solvency requirements, state insurance regulators will be wise to keep close track of the financial stability of health plans operating in a fundamentally different market than has existed prior to the ACA.

In states where there is a partnership Exchange, state insurance regulators will develop new relationships with their federal partners for exchange of information and resources. In addition to supplying information to federal partners, state insurance regulators will have a new opportunity to receive information from federal partners regarding the behavior of health plans in the new market place. The history of state insurance regulators working together will serve states well in designing relationships with federal partners that are both responsive to unique needs from state to state, and also uniform where necessary and appropriate.

Finally, state insurance regulatory relationships with regulated health plans, and with consumers, will continue to be critical. Particularly with regard to the role of accreditation, the ability of state insurance regulators to evaluate health plan quality, and the impact of new reporting requirements, states' ongoing communication with industry and consumers will remain a significant component and will continue to demand significant resources from state insurance regulatory agencies. This will be true regardless of which type of Exchange is established in a state.

© 2012 National Association of Insurance Commissioners

PPACA Quality and Accreditation Requirements related to Exchanges
Critical "musts", "shalls", and "requireds" are highlighted in the excerpts below from ACA and from subsequent federal regulations, related to Exchanges and QHP accreditation and quality. The highlighted excerpts formed the basis for the organization of this paper.

SEC. 1311

…
(c) Responsibilities of the Secretary-
(1) IN GENERAL- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—
…
(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or
(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;
(E) implement a quality improvement strategy described in subsection (g)(1);
…
(g) Rewarding Quality Through Market-Based Incentives-
(1) STRATEGY DESCRIBED- A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for--
(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
(D) the implementation of wellness and health promotion activities; and
(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

Provisions from federal regulation 45 CFR Sec. 155.1045 and 156.275 for Accreditation, and Sec. 155.200, 155.205, and 156.200 for Quality

§ 155.1045 Accreditation timeline.
The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

§ 156.275 Accreditation of QHP issuers.
(a) *General requirement.* A QHP issuer must:
(1) Be accredited on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:
(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;
(ii) Patient experience ratings on a standardized CAHPS survey;
(iii) Consumer access;
(iv) Utilization management;
(v) Quality assurance;
(vi) Provider credentialing;
(vii) Complaints and appeals;

(viii) Network adequacy and access; and
(ix) Patient information programs, and
(2) Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange 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.
(b) *Timeframe for accreditation.* A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with § 155.1045 of this subchapter. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.

Subpart C—General Functions of an Exchange

§ 155.200 Functions of an Exchange.
(a) *General requirements.* The Exchange must perform the minimum functions described in this subpart and in subparts D, E, H, and K of this part.
(b) *Certificates of exemption.* The Exchange must issue certificates of exemption consistent with sections 1311(d)(4)(H) and 1411 of the Affordable Care Act.
(c) *Oversight and financial integrity.* The Exchange must perform required functions related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act.
(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.
(e) *Clarification.* In carrying out its responsibilities under this subpart, an Exchange is not operating on behalf of a QHP.

§ 155.205 Consumer assistance tools and programs of an Exchange.
(a) *Call center.* The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section.
(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:
(1) Provides standardized comparative information on each available QHP, including at a minimum:
(i) Premium and cost-sharing information;
(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;
(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;
(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;
(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;
(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;
(vii) Transparency of coverage measures reported to the Exchange during certification in accordance with § 155.1040; and
(viii) The provider directory made available to the Exchange in accordance with § 156.230.
(2) Publishes the following financial information:
(i) The average costs of licensing required by the Exchange;
(ii) Any regulatory fees required by the Exchange;
(iii) Any payments required by the Exchange in addition to fees under paragraphs (b)(2)(i) and (ii) of this section;
(iv) Administrative costs of such Exchange; and
(v) Monies lost to waste, fraud, and abuse.
(3) Provides applicants with information about Navigators as described in § 155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.
(4) Allows for an eligibility determination to be made in accordance with subpart D of this part.
(5) Allows a qualified individual to select a QHP in accordance with subpart E of this part.
(6) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost sharing reductions.
(c) *Accessibility.* Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—
(1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.
(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including
(i) Oral interpretation;

(ii) Written translations; and
(iii) Taglines in non-English languages indicating the availability of language services.
(3) Inform individuals of the availability of the services described in paragraphs (c)(1) and (2) of this section and how to access such services.
(d) *Consumer assistance.* The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in § 155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate.
(e) *Outreach and education.* The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability programs to encourage participation.

§ 156.200 QHP issuer participation standards.
(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.
(b) *QHP issuer requirement.* A QHP issuer must—
(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;
(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, § 155.705 of this subchapter;
(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;
(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;
(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;
(6) Pay any applicable user fees assessed under § 156.50; and
(7) Comply with the standards related to the risk adjustment program under 45 CFR part 153.
(c) *Offering requirements.* A QHP issuer must offer through the Exchange:
(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act; and,
(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.
(d) *State requirements.* A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs.
(e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

© 2012 National Association of Insurance Commissioners

Draft: 6/26/12
As adopted by the Exchanges (B) Subgroup, 6/26/12

NAIC Form Review White Paper

Introduction

Under the Affordable Care Act (ACA), an American Health Benefit Exchange will be established in each ~~s~~State, either by the ~~s~~State or the federal government, in time to operate beginning January 1, 2014.[1] Some ~~s~~States where there is a Federally Facilitated Exchange (FFE) may opt to handle plan management functions for the Exchange, including certification of Qualified Health Plans (QHPs), by entering into a State Partnership agreement. Regardless of the type of Exchange operating in a ~~s~~State, ~~s~~State regulators should be aware of important changes that impact the requirements of form review, whether coverage is offered inside or outside an Exchange. This paper discusses those requirements, while focusing in large part on considerations for ~~s~~State Departments of Insurance (DOIs) that plan to handle or participate in QHP certification for either a ~~s~~State-operated Exchange or an FFE.

Plans offered in the Exchanges must be QHPs that meet certain federal requirements laid out in the ACA and subsequent regulations,[2] as well as any additional QHP certification requirements that might be imposed by the S~~s~~tate. Additionally, QHP form documents must meet the applicable requirements that a state might adopt on insurance forms. Since review of a QHP for certification is akin to the form review process already performed by the various ~~state Departments of Insurance (~~DOIs~~),~~[3] the DOIs may also determine, as part of, or concurrently to form review, if plans may be certified as QHPs, and are thereby eligible to be sold in the Exchanges.

The form review process for QHPs will be the same for individual coverage and small employer coverage offered in a ~~s~~State-operated Exchange, though there may be some differences in applicable requirements. For example, all non-grandfathered plans in the individual and small group markets (inside and outside of an Exchange) will be required to be guaranteed issue.[4] They will also be required to include the Essential Health Benefits (EHBs) and will be required to comply with the actuarial value (AV) and cost sharing standards in the ACA.[5]

~~State~~ DOIs responsible for, or assisting with, QHP certification will also need to verify that each issuer selling on the Exchange is offering at least one gold QHP and one silver QHP.[6] The issuer must also offer a child-only plan at the same level of coverage as any QHP.[7] Due to the fact that only non-grandfathered plans may be sold in the Exchanges, grandfathered plans will not be reviewed for certification requirements~~,~~.

Provisions Unique to QHPs

The Exchange regulations promulgated by HHS apply some special provisions to QHPs sold in the Exchanges. These provisions include, but are not limited to, requirements for the following: offering plans to deliver federally financed cost-sharing reductions for low-income individuals[8], enrollment periods[9], termination of enrollment[10], grace periods[11], minimum offering of gold, silver and child-only plans[12], network adequacy[13], service areas[14], quality accreditation of plans[15], and the

[1] ACA §1304(b)(1)
[2] ACA §1301 and 45 CFR §156.200-295
[3] Some state insurance regulators may go by different names, or responsibility may be divided among more than one entity. The term 'DOI' in this paper is used to refer to all of these arrangements.
[4] PHSA §2702
[5] ACA §1302(a)
[6] ACA 1301(a)(1)(C)(ii)
[7] PHSA 2707(c)
[8] ACA §1402
[9] 45 CFR §156.265
[10] 45 CFR §156.280
[11] 45 CFR §156.270(g)
[12] 45 CFR §156.200
[13] 45 CFR §156.235
[14] 45 CFR §155.1055

© 2012 National Association of Insurance Commissioners

segregation of funds for coverage of elective abortion services[16]. State insurance regulators' review of QHP policy documents will need to account for these special requirements which may differ from existing state standards. States may wish to consider applying many of the QHP specific standards in federal law (such as open enrollment periods and minimum offering standards) to issuers both inside and outside the Exchange market, as a means of making market rules consistent and minimizing the risk of adverse selection.

Multi-State Plans

The ACA required the U.S. Office of Personnel Management (OPM) to enter into an agreement with at least two issuers to offer multi-state plans on the Exchanges of every ~~s~~State in the individual and small group markets.[17] Though multi-state plans are deemed to be QHPs and the Exchanges must allow them to be offered, nothing in the law preempts state insurance regulators from ensuring that these plans, which may only be sold by licensed issuers, meet all applicable ~~s~~State laws. The form review process for multi-state plans will therefore not be appreciably different from the form review process for any other plan sold in the individual or small group market, except that communication with OPM will be necessary. Additional information regarding the requirements for multi-state plans will be available when OPM releases regulations for this program.

CO-OPs

The ACA creates a program to help create new, private non-profit health issuers, called ~~Consumer-Oriented and Operated Plans~~Consumer Operated and Oriented Plans, or "CO-OPs."[18] CO-OPs will be able to offer health plans through the Exchanges. An Exchange must recognize a health plan offered by a CO-OP if the plan is deemed certified by CMS or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO-OP QHPs as set forth in the ACA and except for an exception, all ~~s~~State specific standards established by an Exchange for QHPs operating in that Exchange.[19] The form review process will not differ from the form review process for any other QHP. It should be noted that CO-OPs must be licensed as issuers in each ~~s~~State in which they operate and are subject to ~~s~~State laws and regulations that apply to all similarly situated issuers.

Dental Coverage

In addition to QHPs, the ACA permits stand-alone dental plans to be sold on Exchanges.[20] While dental-only coverage is considered an excepted benefit under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is not subject to most of the insurance reforms in the ACA, the federal Exchange regulations do apply cost-sharing limits and prohibitions on annual and lifetime limits to pediatric dental coverage offered through the Exchanges and apply the same certification standards to qualified dental plans (QDPs) as apply to QHPs, except for those that cannot be met because QDPs offer pediatric dental benefits.[21] Due to the fact that QHPs may omit coverage for pediatric dental benefits if dental-only coverage is available in the Exchanges, QDPs~~Qualified Dental Plans~~[22] ~~(QDPs)~~ will likely provide a portion of the EHBs, so ~~s~~States may want to consider which provisions, beyond the federal requirements, should be applied to them, as a matter of ~~s~~State law. In the absence of federal guidance on what federal requirements would apply, some provisions that the ~~s~~States may want to consider will include guaranteed issue, guaranteed renewability, rating rules, and rescissions, among others.

---

[15] 45 CFR §156.275
[16] 45 CFR §156.280
[17] ACA §1334
[18] ACA §1322
[19] 45 CFR §156.520(e) of the HHS final rule on CO-OPs says health plans offered by a loan recipient may be deemed certified as a CO–OP qualified health plan to participate in the Exchanges for two years and may be recertified every two years for up to ten years following the life of any loan awarded to the loan recipient if it meets all State-specific standards established by an Exchange for qualified health plans operating in that Exchange, except for those State-specific standards that operate to exclude loan recipients due to being new issuers or based on other characteristics that are inherent in the design of a CO–OP. ~~*(Change Recommended by BCBSA)*~~
[20] ACA §1311(d)(2)(b)
[21] 45 CFR §155.1065
[22] While the term "Qualified Dental Plan" does not appear in the ACA, the NAIC's *American Health Benefit Exchanges~~*~~ Model Act* (#929) uses this term to refer to stand-alone dental products sold on Exchanges.

© 2012 National Association of Insurance Commissioners

Other provisions may be difficult to apply to QDPs. There is considerable uncertainty about how the presence of QDPs in Exchanges will affect the calculation of AV for QHPs that do not offer pediatric dental benefits, and about how AV requirements will apply to QDPs. According to representatives of dental plans, metal tiers could be difficult to apply because a silver plan, with a 70% ~~actuarial value~~AV, would include cost-sharing well in excess of what is commonly sold on the market today and would not be desirable to consumers. However, dental plans will have to change in many cases to adjust to new requirements, in particular because those offering pediatric dental coverage must ensure they do not have annual or lifetime limits on the dollar value of such coverage, which is an EHB. Additionally, while the pediatric dental portion of the EHB may be provided through a QDP, the ACA and related regulations indicate that actuarial value may be calculated not for individual dental plans but based on EHB coverage as a whole. The summary of benefits and coverage (SBC) was not developed with dental plans in mind and may not be appropriate for QDPs. HHS has not to date proposed an alternative SBC document for QDPs.

Grandfathered Plans

Plans in effect on the date of enactment of the ACA (March 23, 2010) may be considered grandfathered plans, and are therefore exempt from most of the law's requirements, if significant changes have not been made to them.[23] The major provisions of the ACA that apply to the form review of all grandfathered health plans include the elimination of lifetime dollar limits on EHBs, the prohibition of rescissions except in the case of fraud or intentional misrepresentation of material fact, and the extension of dependent coverage for children until age 26.[24] Grandfathered health plans in the small and large group markets must also comply with limitations on annual dollar limits on EHBs and, as of January 1, 2014, the prohibition on preexisting condition exclusions (the prohibition on such exclusions for children under age 19 went into effect on September 23, 2010).[25]

Changes to the Form Review Process

While the ACA makes sweeping changes to the substantive requirements that the form review process is designed to verify compliance with, the process itself will remain the same in many respects. For most provisions of the ACA, form reviewers will be verifying that the policy documents either contain required elements, such as extended dependent coverage for adult children up to age 26[26], or do not contain provisions that violate prohibitions or restrictions in the law, such as prohibitions on preexisting condition exclusions[27] and limitations on cost-sharing[28]. State regulators are already very familiar with this type of review, even if the substantive requirements will be new. The Appendix at the end of this paper contains summaries of some of the major new requirements, prohibitions, and restrictions that form reviewers may be looking for in policy documents.

Other reforms in the ACA, however, will require important changes to the way that issuers file policy forms and the ~~s~~States review them. Most significantly, while forms are currently filed and evaluated at the product level, several provisions of the ACA will require analysis at the plan level.

A *product* is a package of benefits that an issuer offers that is reported to State regulators in an insurance filing[29]. A single product filing may include many different plans, each of which is a discrete pairing of a package of benefits and a particular cost sharing option (not including premium rates or premium quotes).[30] It should be noted that a product, as defined in the federal EHB guidance, does not include a cost-sharing structure.

Product filings typically include:

- Contracts (also referred to as evidence of coverage or policies)
- Certificates (also referred to as member handbooks)

---

[23] Conditions under which a plan will lose its grandfathered status are specified in federal regulations, at 45 CFR 147.140.
[24] 45 CFR 147.140(d)
[25] 45 CFR §147.140(e)
[26] PHSA §2714
[27] PHSA §2704
[28] ACA §1302(c)
[29] 45 CFR 159.110
[30] *Ibid.*

© 2012 National Association of Insurance Commissioners

- Summary of Benefits (also referred to as explanation of benefits, schedule of benefits)
- Riders or endorsements that alter the provisions of the contract

In addition to the use of riders or endorsements to alter provisions of the contract, the language of one or more product filings may include bracketed material where individual plans differ from one another. Such filings are often accompanied by statements of variability presenting form reviewers with more information about these differences. For most provisions of the ACA, this approach will continue to work well, allowing regulators to review common policy provisions in an efficient manner. Other provisions, particularly those dealing with the cost-sharing[31] and actuarial value of plans[32], must be reviewed on a plan-by-plan basis. For this reason, issuers will most likely need to submit the necessary information for review of these provisions on a plan-by-plan basis, indicating which product filings these plans are based upon. States should evaluate if and how their form and related rate review processes should be amended to accommodate a plan level review in addition to a form, product, or market level review.

For those plans that are intended as QHPs, some additional requirements will apply, mainly related to procedures for enrollment and disenrollment through the Exchange, though states may also impose their own QHP certification requirements. DOIs may need to coordinate the form review process for compliance with these requirements with the Exchange, which is addressed in more detail in the "Interactions with Exchanges and other Entities" section of this paper. Also, ~~s~~States with use and file dispositions may need to consider how to adjust that process to address QHP certification, since someone in the ~~s~~State must review each plan to ensure it meets all state and federal requirements before it can be sold as a QHP on the Exchange.

Because of the changes that will be occurring in the form filing and review processes and because of the increased volume of filings leading up to 2014, ~~s~~States may want to consider issuing bulletins and guidance on changes to the form filing and review process in order to ensure that issuers are aware of what the new requirements are and to assure a timely and uniform review process. Some ~~s~~States require form filings to be accompanied by rate filings. For purposes of ACA-related form review, ~~s~~States may consider de-coupling form review from rate review to allow form review to proceed with the related rates filed subsequently. This could assist with workflow while also ensuring that rates accurately reflect the product design in the approved forms.

A number of ACA provisions will require review procedures that are well outside of those currently employed by ~~s~~State regulators in the form review process which merit a separate discussion:

Essential Health Benefits (EHBs)

Plan compliance with EHB requirements will most likely be determined in much the same way that the ~~s~~States currently enforce mandated benefit laws. For QHP products to be offered on the Exchange, ~~s~~States initially may want to consider streamlined workflow processes, as suggested elsewhere in this paper, to ensure appropriate review but also timely approval for initial Exchange offerings.

The major difference will be that issuers will, unless a ~~s~~State prohibits it, be allowed to make actuarially equivalent substitutions of benefits within each of the ten required service categories.[33] From the preliminary information currently available, it is likely that products offering benefits that vary from a ~~s~~State's benchmark package will need to be accompanied by a demonstration of equivalent value in each category using actuarial methodology following accepted standards of practice. This demonstration may include a description of the methodology used by the issuer to make the equivalence determination, as well as data used to support the determination. Evaluation of these filings will likely require substantial actuarial resources, depending upon how complex and subjective the process is. It should be noted that nothing in the statute or the guidance would appear to prevent a ~~s~~State from limiting or prohibiting these substitutions. States with limited resources in form and actuarial review may wish to consider how such limits or prohibitions may facilitate the ~~s~~State's review of insurance forms and plans for use after 2014.

---

[31] ACA §1302(c)
[32] ACA §1302(d)
[33] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Frequently Asked Questions on Essential Health Benefits Bulletin," February 17, 2012, p. 3.

© 2012 National Association of Insurance Commissioners

NOTE: Additional guidance from HHS will be needed regarding whether ~~s~~States can limit or prohibit benefit substitutions and how to evaluate benefit substitutions, as the current guidance is both incomplete and preliminary in nature.

Actuarial Value and Cost-Sharing Reductions

While additional guidance and a completed AV calculator[34] will be needed before specific regulatory processes can be developed, states will likely require form filings for each plan to include a disclosure of how benefits were defined and entered into the AV calculator. Additionally, although information issued by HHS indicates that ~~s~~States will verify AV using the calculator for each plan inside and outside the Exchange, ~~s~~States may wish to consider requiring filings to include a printout of the inputs and results from the AV calculator (if the calculator allows this functionality) in order to facilitate the submission and review/approval process, provided future federal guidance permits such. This will allow the ~~s~~States to use the calculator to verify the plan's AV or to review the submitted results, and may dispense with the need for actuarial staff to review AV calculations for plans without features, such as tiered provider networks with expected utilization spread across tiers and some value-based insurance designs, that cannot be easily captured in a calculator. In these cases, issuers may also need to provide their methodology for augmenting the results of the AV calculator. Evaluation of this supplemental information will require additional actuarial resources that are not today used in the form review process. To the extent that the calculator can be designed with an API or other interface that allows programmatic access to the calculator by the System for Electronic Rate and Form Filing (SERFF), the ~~s~~State regulatory workflow could be streamlined by automating this verification process. Additionally, the ~~s~~States may wish to consider the use of issuer attestations and certifications in certain instances in order to reduce the volume of plans whose AV must be independently confirmed by the ~~s~~State.

NOTE: Additional federal guidance and a completed AV calculator are needed before specific regulatory processes can be developed.

Discriminatory Benefit Design

The ACA prohibits discriminatory benefit designs that would discourage enrollment by individuals with significant health care needs.[35] The bulletin issued by HHS in December 2011 indicates that this prohibition will also be incorporated into EHB regulations to satisfy the requirement that EHBs not discriminate against individuals because of their age, disability, or expected length of life.[36]

NOTE: HHS has indicated that it is in the process of developing an electronic tool that it will use in a federally facilitated Exchange to determine QHP compliance. It is unclear yet whether a ~~s~~State in a partnership Exchange must use the federal tool or whether it may use its own procedures.

This tool may be made available for use by State-Based Exchanges (SBEs), though ~~s~~States wishing to use their own procedures and tools for enforcing these prohibitions would be free to do so.

Meaningful Difference

HHS has indicated that as part of QHP certification process related to "being in the best interest of the public," that "meaningful difference" between QHPs on the FFE will be performed in order to assure that QHPs within a single metal level and issuer have some meaningful difference in benefit design. States with SBEs may wish to perform a similar analysis in order to help address risk avoidance through benefit design.

"Consumer Best Interest"

The ACA provides that in addition to other certification requirements, an Exchange must determine if a QHP is in the "best interest" of qualified individuals and qualified employers.[37] States have significant discretion in determining what criteria will be ~~be~~ considered in making this determination. State insurance regulators performing QHP certification may wish to

[34] --, "Actuarial Value and Cost-Sharing Reductions Bulletin," February 24, 2012, p. 6.
[35] ACA §1311(c)(1)(A)
[36] ACA §1302(b)(4)(B)
[37] ACA §1311(e)(1)(B)

© 2012 National Association of Insurance Commissioners

coordinate with their Exchange which entity should perform this part of the QHP certification process. Issues of ~~s~~State insurance regulator authority and possible conflicts of interest may hinder ~~s~~State insurance regulators ability to perform this part of certification.

Resource Considerations

Implementation of the ACA in 2014 is likely to require that additional resources in the DOI be devoted to the form review process for QHPs in the Exchange and for health plans outside the Exchange. The ~~s~~State may require additional actuarial resources, such as actuaries, actuarial students, or administrative staffing, in order to accommodate the review of new and revised plan designs, the accuracy of actuarially equivalent substitutions of EHBs, the assessment of the actuarial value, the implications and effects of cost-sharing reductions, and discriminatory benefit design analysis.

In addition to new actuarial resources, the DOI and other ~~s~~State agencies will need adequate professional and administrative staffing to review new and revised forms, as well as to ensure compliance with new and existing state and federal laws. -In particular, the period leading up to the October 2013 initial open enrollment period will likely be quite busy as issuers prepare QHP filings to be sold on the Exchange. In addition to the increased number of filings, the ACA's new requirements may cause some confusion, extending the amount of time needed for review. As filers and reviewers become accustomed to the new requirements over time, the process will likely become more efficient. In the interim, ~~s~~States may want to implement tools to streamline the process by updating their current product review standards through statutory or regulatory amendments, on-line state specific standardized checklists, or other on-line filer tools to assist the health care industry in submission of plans to states for review. Additional training for industry filers and state form review and actuarial staff will be paramount in order to ensure a good knowledge base for the most efficient and consistent review of products and plans.

Interactions with Exchanges and other Entities

Once the form review process at the DOI has been completed, it is important to consider how ~~the Department~~ it will interact with the Exchange in order for an issuer to have plans available for purchase. These interactions should be carefully designed, keeping in mind the amount of time involved for a DOI to complete its policy form and rate reviews, followed by a review to determine if a plan should be certified as a QHP. Bypassing any redundant work flows will be necessary to assure the accuracy of plan information displayed on an Exchange. Electronic processes for communication between DOIs and an Exchange will also be imperative to ensure timely and accurate QHP approval processes.

In all Exchange options as described below, a state retains its regulatory authority for plan review for compliance with all state laws. An entity that performs both plan form review and QHP certification will most likely be able to significantly reduce the timeline and resources necessary for a QHP to be offered on an Exchange. When an entity other than a DOI performs QHP certification, the DOI will still review the plan for compliance with all state and federal insurance laws. Another entity, the federal government or the Exchange (whether ~~s~~State-operated or a federal-~~s~~State partnership), will also have to review the plan for compliance with QHP certification requirements. Issues to be resolved and decisions made will then need to be communicated and reconciled among all entities. Communication between the DOI and Exchanges may be facilitated through SERFF in order to leverage existing technology that is already in use today. HHS has made a commitment to working with the NAIC so that SERFF can be leveraged by SBE and ~~p~~Partnership ~~s~~States to perform certain plan management functions, including QHP certification, benefit and rate data collection and reporting associated with QHP submissions. HHS has also committed to working with the NAIC to ensure that in the FFE, issuers will not be overly burdened by duplicative data entry and ~~s~~States may continue to utilize existing technology to perform regulatory review of forms and rates to confirm that benefit and rate information intended for display within the FFE is consistent with that which was approved by the ~~s~~State.

State-Based Exchange

A SBE will offer the greatest amount of flexibility for the ~~s~~States and will need to determine which entity will certify a plan as a QHP. The DOI is familiar with similar processes and is best suited for an effective and efficient review for QHP certification; however, a ~~s~~State may alternatively vest QHP certification responsibilities with the Exchange or some other entity, particularly if it pursues a selective contracting Exchange model. If some or all of the QHP certification is to be undertaken by the Exchange or another entity, insurance departments may consider recommending their proven, effective and efficient processes as guidance to assist with timely approval of QHPs to be offered on the Exchange. Processes for loading QHPs onto an Exchange once they have been properly filed, reviewed, and approved by a DOI and have received QHP

certifications should be streamlined. Again, incorporating SERFF into the Exchange's plan management infrastructure will help facilitate this process.

Partnership Exchange

A ~~s~~State that enters into a Partnership Exchange will have the option to retain plan management responsibility, which includes QHP certification, or to delegate plan management in its entirety to the federal government. In a Partnership Exchange where the ~~s~~State maintains plan management, the interaction between the ~~s~~State and a FFE will be similar to the interaction with a SBE. Once the certification process is complete, the ~~s~~State would need to communicate that fact to HHS via SERFF or some other method.

Federally Facilitated Exchange

The federal plan management process is not yet fully defined. In a FFE a ~~s~~State will retain existing form and rate review responsibilities for compliance with state laws, though plans intended for sale on the Exchange will likely undergo an additional, subsequent round of review by HHS for QHP certification purposes.

Multi-State Plans and OPM

States will review plans for compliance with all ~~s~~State laws, while OPM will likely review them for compliance with the terms of its contractual requirements with multi-state plans.

NOTE: How interactions such as communication and reconciliation between a ~~s~~State and OPM will be accomplished is unknown until when OPM releases regulations governing multi-state plans.

Use of SERFF

Over the past ten years the ~~s~~States have worked to improve the process for issuers to submit their rate and form filings to DOIs. The NAIC has assisted in this process through Speed to Market initiatives and the submission of electronic rate and form filings via SERFF. SERFF can play a role in Exchange administration for regulators who need to implement new requirements, husband resources and integrate regulation inside and outside of Exchanges.

States can continue to use SERFF for form review as they establish their ACA-related requirements for health insurance forms. SERFF can be an avenue for each ~~s~~State to configure and publish its new substantive and procedural requirements. For example, with regard to benefit design, when a ~~s~~State has decided on its EHBs, the ~~s~~State can maintain a list of its EHBs in SERFF to function as a compliance checklist for issuers and regulators. As an example with regard to consumer protection and transparency, SERFF is one of the places where a state can inform issuers how that ~~s~~State will treat the federally required SBC: as a form subject to review, as supporting documentation, or as an informational item. A ~~s~~State can also use SERFF to instruct issuers whether forms must be redlined to show ACA-related changes from previously approved versions, whether supplemental benefits or non-discrimination provisions should be flagged for state reviewers, and how other ACA requirements apply in that state. States using SERFF will need to review federal ACA requirements and related final rules in relation to their state requirements, update those respective standards accordingly, and re-post within SERFF.

While not yet available, enhancements to SERFF that are currently underway will enable the S~~s~~tates to use SERFF not only for form and rate review but to review QHP applications, certify QHPs to participate in Exchanges, and carry out related oversight functions, such as renewing, monitoring, recertifying, and decertifying QHPs. It is envisioned that an issuer that wants to base a QHP on an insurance product it already offers in a state will have the ability to "build" a QHP in SERFF using forms and rates that the ~~s~~State has already accepted, depending on the ~~s~~State's existing requirements.

This QHP-building capability is one way to bridge the gap between products and plans. This capability also will minimize the duplication of submission efforts for issuers, as well as the duplication of form review and enforcement efforts for State regulators. However, issuers and regulators should expect that the initial rounds of QHP applications may require new and revised forms and rates, with efficiency increasing as the number of QHPs increases. Finally, if QHP forms and related information reside in SERFF along with non-QHP forms and information, regulators will have consistent, simultaneous access to health insurance products on and off the ~~e~~Exchange. This will facilitate any parallel and cross-walked reviews required by ACA.

© 2012 National Association of Insurance Commissioners

APPENDIX: 2014 ACA Rules and Regulations that will Impact Form Filings

The following summarizes federal law and regulations relating to market reforms found in the ACA that are effective on January 1, 2014. As noted, some market reforms are specific requirements related to QHPs only. States may wish to analyze existing state protections against the federal standards in light of the preemption provisions of the ACA.

Benefit Design Requirements

Essential Health Benefits (EHB)

The ACA requires that all non-grandfathered individual and small group plans, inside and outside the Exchange, provide coverage for the EHBs outlined in §1302(b) of the Act. This section provides that the EHBs include items and services within the following 10 benefit categories:

1. ~~a~~Ambulatory patient services;
2. ~~e~~Emergency services;
3. ~~h~~Hospitalization;
4. ~~m~~Maternity and newborn care;
5. ~~m~~Mental health and substance use disorder services including behavioral health treatment;
6. ~~p~~Prescription drugs;
7. ~~r~~Rehabilitative and habilitative services and devices;
8. ~~l~~Laboratory services;
9. ~~p~~Preventive and wellness services and chronic disease management~~.~~; and
10. ~~p~~Pediatric services, including oral and vision care.

HHS issued a bulletin in December 2011 that outlined a process for the ~~s~~States to select a benchmark plan from the following list whose benefits will constitute the EHBs for the individual and small group markets for the State for calendar years 2014 and 2015:

- ~~t~~The largest plan by enrollment in any of the three largest small group insurance products in the ~~s~~State's small group market;
- ~~a~~Any of the largest three ~~s~~State employee health benefit plans by enrollment;
- ~~a~~Any of the largest three national FEHBP plan options by enrollment; or
- ~~t~~The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the ~~s~~State.

HHS has also advised that a ~~s~~State may select only one of the benchmark options as the applicable EHB benchmark plan across its individual and small group markets, both inside and outside of the Exchange. If the selected benchmark package does not include services from any one of the required categories, the state must supplement the package as outlined in the bulletin issued December 16, 2011 or as may be outlined in future guidance or rules with the benefits in that category from another one of the benchmark plans or from another source. HHS also defined the largest plan by enrollment in the largest small group product as the default benchmark should a ~~s~~State not make an election.[38]

HHS guidance has indicated that plans will be permitted to make actuarially equivalent substitutions within each of the 10 categories specified. At this point, whether a ~~s~~State can limit or prohibit such substitutions is not clear. Nonetheless, companies requesting actuarially equivalent substitutions will be expected to provide supporting documentation and detailed demonstrations that the form meets all required EHB categories; and include additional demonstrations if actuarially equivalent substitutions are made within any of the categories.

[38] For full details on HHS' specification of the default EHB benchmark plan, please see:
Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2011, p. 11
Additional details are expected in forthcoming EHB regulations.

States may accept a certification of compliance from issuers requesting actuarially equivalent substitutions and/or request review by an actuary. Where applicable, the Sstates may require statements of variability and/or copies of previously approved forms with "tracked-" changes.

Dental Plan Benefits

A plan may not be excluded from the Exchange for failure to provide pediatric dental benefits if a stand-alone dental plan (QDP) is available on the Exchange.

Benefit limits

Currently, annual limits on the dollar value of EHBs are restricted and lifetime limits on the dollar value of EHBs are prohibited. In 2014, issuers will additionally be prohibited from imposing annual limits on the dollar value of EHBs. This limitation does not apply to any individual or group plan for specific covered benefits that are not EHBs to the extent that such limits are otherwise permitted under applicable federal or sState law.

Mental Health Parity (MHPAEA)

Section 1311(j) of ACA states "Section 2726 of the Public Health Service Act (PHSA) shall apply to QHPs in the same manner and to the same extent as such section applies to health insurance issuers and group health plans." In turn, Section section 2726 of the PHSA applies to a "group health plan or a health insurance issuer offering group or individual health insurance coverage[39]." Therefore, the requirements of the Mental Health Parity and Equity Addiction Act (MHPAEA) must be applied to all plans of health insurance coverage whether issued inside and outside of the Exchange, to an individual or through an employer group.

The MHPAEA requires plans that cover mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations upon mental health and substance abuse treatment services that are more restrictive than the predominant requirements and limitations that apply to substantially all medical and surgical services. Financial requirements includes deductibles, copayments, coinsurance, and out of pocket maximums. Although the MHPAEA regulation excludes aggregate lifetime and annual dollar limits from the meaning of financial requirements, the ACA requirements for annual and lifetime dollar limits includes mental health and substance abuse disorders as part of the EHBs.

Additionally, mental health and substance abuse services may not be subject to separate cost-sharing requirements, and if a plan provides for out of network coverage of medical and surgical services, it must also provide out-of- network coverage for mental health and substance abuse treatment.

Cost-Sharing Limitations

Subsection 1302(c) of the ACA and section 2707 of the PHSA, as added by the ACA, address the restrictions on cost-sharing that may be applied to non-grandfathered health plans. The law limits cost-sharing under a health plan to the maximum cost-sharing allowed for high-deductible health plans in 2014 (currently $5,950 for individual/ $11,900 family). In subsequent years, the limitation on cost-sharing is indexed to the rate or average premium growth. Additionally, deductibles for plans in the small group market are limited to $2,000 individual / $4,000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.

NOTE: Additional information regarding cost sharing limitations should be provided as further guidance is released.

[39] PHSA §2726

Prohibition on Discriminatory Benefit Design

HIPAA protections already in effect for the small employer market include these same health status-related factors with the exception of "any other health status-related factor deemed appropriate by the Secretary." In addition, the benchmark plan that will be in place in 2014 will be reviewed and approved by HHS; therefore, the benchmark plan will include eligibility provisions that comply with this requirement. When issuers make substitutions in the benchmark, ~~s~~States will need to conduct an in-depth form review to ensure that benefit design substitutions are not discriminatory. In the absence of HHS-established guidelines governing benefit design prohibitions that have the effect of discouraging the enrollment of individuals with significant health needs in a particular plan, some ~~s~~States may choose to require company certification of compliance in this area. A related provision prohibits the use of health status-related factors by issuers. For more information on that provision, see XXXXXXX.

NOTE: States will look to HHS for additional guidance or rules regarding the prohibition of plans that employ discriminatory plan design.

Prohibition on Preexisting Condition Exclusions

Since September 23, 2010, issuers have been prohibited from excluding coverage for preexisting conditions for children under age 19. This prohibition applies to all health benefit plans and health insurance policies except for grandfathered individual market policies.

For plan years beginning January 1, 2014, the prohibition on preexisting condition exclusions will extend to people of any age, but will still not apply to grandfathered individual market policies. This prohibition will apply to all other health benefit plans and health insurance policies sold inside and outside the Exchange and will also apply to Qualified Dental Plans.[40]

It is not expected that issuers will need to submit any additional supplemental information. However, the regulating state will need to perform an appropriate review of the forms to ensure the presence of required provisions and the absence of prohibited language.

Network Adequacy/Service Areas

Section 156.230 of the final Exchange regulations require that a QHP include within its provider network a sufficient number of *essential community providers*, where available, that serve predominantly low-income, medically underserved individuals. This section defines *essential community providers as* those health care providers defined in section 340B(a)(4) of the ~~Public Health Service Act~~PHSA.

At a minimum, QHP plans should ensure a sufficient choice of providers in a manner consistent with applicable network standards of section 2702 (c) of the ~~Public Health Service Act~~PHSA, provide information to enrollees and prospective in-network and out-of-network providers, and include those defined *essential community providers* as referenced previously.

Furthermore, states with tribal organizations may wish to explore designating Indian Health Service providers as essential community providers.

NOTE: Additional federal guidance may be forthcoming relating to adequacy of essential community providers.

Considerations include the need to address how QHPs respond to areas with recognized shortages of health providers (especially rural and remote areas); provider participation; reimbursement levels; requirements for health issuers and participating providers; filing requirements and state administration; network and provider disclosure to insured and enforcement.

Reviewers of QHP-related forms that include in and out-of network provisions should be mindful of descriptions of service areas, and consult current statutes governing managed health care arrangements along with the ACA directives.
A separate White Paper deals with network adequacy issues in greater depth. For more information, please see that paper.

[40] 45 CFR 155.1065

Abortion Services and Separation of Funds

The ACA requires QHPs to segregate funds in a separate allocation account to pay fo r coverage of certain elective abortion services that cannot be paid for with federal funds. A QHP issuer satisfies this requirement if it issues an itemized bill that separates the costs of abortion coverage from the costs of all other coverage, collects the required separate payments through a single transfer of funds in response to the itemized bill, and maintains "allocation accounts" in line with current industry practice. A QHP issuer must collect separate payments *only* from individuals receiving premium assistance credit; therefore, the segregation requirements apply only to these individuals. QHPs must also submit a plan to the ~~s~~State Insurance Commissioner that details its process and methodology for complying with these requirements.

Reviewers of forms with the provision for abortion coverage should be mindful of such statutory and regulatory requirements and any relevant ~~s~~State laws.

Individuals in Clinical Trials

Effective January 1, 2014, the ACA requires that if a "qualified individual" is in an "approved clinical trials," the plan cannot deny coverage for related services. Plans are not required to cover treatments that fall outside the designated class of approved clinical trials, and plans may not deny coverage because a member is participating in an approved clinical trial conducted outside of the ~~s~~State in which the member lives.

A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate or the individual provides medical and scientific information establishing that their participation is appropriate.

An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

In connection with expenses, "routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan's network area unless out-of network benefits are otherwise provided under the plan.

If a participating provider is participating in an approved clinical trial, the plan may require the individual to participate in the trial through that participating provider if the provider will accept the individual as a participant in the trial.

Many ~~s~~States may already mandate coverage for clinical trials relating to cancer and other diseases or conditions. The ACA provision extends to life-threatening conditions. State coverage mandates should be examined to ensure that they are consistent with these federal requirements.

© 2012 National Association of Insurance Commissioners

Consumer Protection and Transparency Requirements

Guaranteed Availability

Effective 2014, Section 2702 of the PHSA requires each QHP issuer to accept every qualifying employer and individual that applies for coverage and who works or resides in its state. However, issuers may restrict enrollment to open and special enrollment periods and enrollment periods for qualifying events.

Currently effective for plan years starting 6 months after enactment, plans must already comply with the requirement providing coverage to enrollees up to age 19.

Regulators should review QHP forms to assure that prohibited provisions are not included.

Guaranteed Renewability

Section 2703 of the PHSA, as amended by the ACA guarantees the renewability of insurance coverage. An issuer that offers health insurance coverage in the individual or group market must renew or continue in force coverage at the option of the plan sponsor or individual. An issuer may only non-renew or cancel coverage in the event of nonpayment of premiums, fraud, violation of participation or contribution rates, market exit, movement outside the service area, or cessation of association membership.

Forms will be reviewed to ensure continued compliance.

Enrollment

QHPs within the Exchange must provide an initial open enrollment period, an annual open enrollment period and a special enrollment period for triggering events. Such dates must be clearly defined. Enrollments as a result of birth, adoption, or placement for adoption must be effective on the date of birth, adoption or placement for adoption. Additionally beginning in 2014, issuers in the exchange must provide a written notification of annual open enrollment to each enrollee.

Forms will need to be revised, or an endorsement/amendment form(s) will need to be attached to current forms. Regulators will need to review such forms for compliance with these required provisions and notification(s). Additionally, application/enrollment forms and possibly marketing materials may also require review to determine compliance with the updated enrollment requirements.

NOTE: States will need to consider additional, anticipated federal guidance on open enrollment periods outside an Exchange.

Termination of Coverage

Section §155.430 of the final Exchange regulations sets rules establishing when individual's coverage in a QHP may be terminated, when an enrollee may terminate his or her coverage, the appropriate effective date of termination and proper notification of termination requirements.

Regulators will need to review QHP-related forms and any endorsements or amendments for compliance with these provisions.

Grace Periods

Section §156.270 of the final Exchange regulations requires a provision within the termination coverage section that directs QHP issuers to provide notice to all enrollees who are delinquent on premium payments. Individuals receiving an advanced premium tax credit, who lose coverage due to non-payment of premium must be provided a three-month grace period. The QHP must cover all allowable claims for the first month of the three-month grace period and may pend subsequent claims in the second and third months of the grace period. During the grace period a QHP issuer will continue to collect subsidy payments on the delinquent enrollee's behalf and return such payments of the premium tax credit for the second and third months of the grace period if the enrollee exhausts the grace period.
Regulators will need to review QHP-related forms and any endorsements or amendments to assure compliance with QHP grace period and proper notification requirements, and necessary disclosure regarding retention of premium tax credits.

© 2012 National Association of Insurance Commissioners

Regulators also must assure that the grace period is applied uniformly to all QHP enrollees in similar circumstances and that the QHP maintains proper records of the termination of coverage.

Waiting Periods

~~PHS Act section 2708~~Section 2708 of the PHSA sets rules prohibiting group health plans and coverage from imposing excessive waiting periods. A waiting period begins on the date the employee becomes a qualifying employee and must not exceed 90 days.

QHP forms must be revised to include an updated definition of a waiting period pursuant to section 2704(b)(4) to state: the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. NOTE this definition does not distinguish between Full-Time and Part Time employees.

Regulators must review forms for prohibited excessive waiting period provisions (also known as probationary periods) which may appear within application or enrollment forms.

Regulators must review forms, including application/enrollment forms, for prohibited excessive waiting period provisions (also known as probationary periods).

Prohibition on Utilization of Health-status Related Factors

The ACA requires that for plan years beginning January 1, 2014, non-grandfathered plans may not include in eligibility provisions or continued eligibility provisions, rules for eligibility based on any "health status-related factor." A "health status-related factor" means any of the following: health status, medical condition (physical or mental), claims experience, receipt of health care, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability, or any other health status-related factor deemed appropriate by the Secretary.

Non-Discrimination against Participants and their Beneficiaries Based on Race, Ethnicity, Nationality, Gender, Age, Disability, Sexual Orientation, Genetic Information and Religion

Under §1557 of the ACA and existing civil rights laws, no enrollee shall, on the basis of race, color, national origin, sex, age or disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, under any health program or activity, any part of which is receiving Federal financing assistance, including credits, subsidies, or contracts of insurance.

Some ~~s~~States may require a review of forms to assure prohibited provisions are not present. Some ~~s~~States may only require the issuer to submit written certification providing acknowledgement and assurance that the issuer does not discriminate based on Race, Ethnicity, Language, Nationality, Gender, Age, Disability, Sexual Orientation or Domestic Violence.

In any case, since §1557 of the ACA and existing civil rights laws apply broadly, Regulators must review application and enrollment forms for questions that may include any prohibited elements and the potential underwriting or eligibility determinations based on such responses. Issuers of QHPs are covered under §1557 of the ACA and other federal civil rights laws because they will receive insurance premium payments through federal premium credits, a form of federal financial assistance. In addition, Exchanges must also comply with §1557's of the ACA ban on discrimination as entities established under Title I of the ACA. Exchanges are, therefore, barred from allowing insurance companies that discriminate to participate in Exchanges because to do so would be to provide assistance to discriminatory policies themselves in violation of §1557 and other federal civil rights laws. Additional requirements in the ACA require that regulators be assured that SBC documents are provided in linguistically correct language. Additionally, actuarial memorandums and rate manuals may need to be analyzed for such non-discrimination underwriting practices.

Prohibition on Discrimination against Providers Acting within Scope of own Licensure or Certification

Plans may not discriminate against any provider acting within his scope of practice. However, this law does not require that a plan contract with any willing provider and does not prohibit tiered networks. QHPs must ensure a sufficient choice of providers in a manner consistent with network adequacy provisions.

This is an insurance plan/provider contract issue and it is not clear where this provision would be applicable within a QHP insurance coverage plan other than assuring that medical staff and facilities are sufficient enough for compliance with the provisions of preventive health benefits as it applies to ~~Woman's~~women's health services and screenings for infants, children and adolescents.

Additional guidance from HHS is needed.

Prohibition on Discrimination against Individuals Receiving Subsidies and Cooperating with Investigations

This section also prohibits issuer and health benefit plan discrimination against individuals because the employee receives a credit or subsidy, or because they provide information to investigators or cooperate in the investigation of a violation of the Fair Labor Standards Act, or objected to any activity the employee believed to be in violation of the Act.

Summary of Benefits and Coverage

A group or individual plan must provide without charge, a written uniform ~~Summary of Benefits and Coverage (~~SBC~~)~~ document for each benefit package, to individuals and beneficiaries, or plan sponsors upon receipt of an application, if there is a change in the SBC, or within 7 days upon request. Additional time period scenarios are also specifically defined.

An SBC is to be provided to participants and beneficiaries who enroll or re-enroll in group health coverage beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. In the individual market, these requirements are applicable to health insurance issuers beginning on September 23, 2012.

There are 12 content elements required to be within the SBC, including uniform standard definitions of medical and health coverage terms, a description of the coverage including the cost-sharing requirements such as deductibles, coinsurance, and copayments; and information regarding any exceptions, reductions, or limitations under the coverage, illustrative coverage examples, network provider information, contact information, and a clear disclosure that the SBC is only a summary.

Specific rules also regard the manner in which the SBC is to be provided, the appearance and format of the SBC and that it is to be delivered in a culturally and linguistically appropriate manner.

Some ~~s~~States have determined that the SBC is a form of advertising, outline of coverage, or marketing material and is therefore required to be submitted to the DOI for review and approval. Other ~~s~~States have determined that the SBC is not a part of the contract, and as such, there is no regulatory authority for review. States also may request the SBC to be submitted (perhaps as a variable template) for informational purposes thereby not taking review and approval action.

Any States that review of the SBC document may wish to confirm the benefits of the SBC reflect the covered EHBs, cost-sharing and AV (metal level) that the final approved rates and forms permit. The SBC can only be completed once the rate and form filings have been finally approved.

The SBC document may need to be modified for ~~Qualified Dental Plans~~QDPs, though HHS has not yet provided such a document.

Actuarial Requirements

A number of ACA provisions will likely require the ~~s~~States to devote actuarial resources to determine whether health insurance plans are in compliance with the law. Actuarially equivalent substitutions of EHBs, compliance with actuarial value requirements, and the provision of reduced cost-sharing to individuals with household incomes below 250% of the Federal Poverty Level (FPL) are all likely to require some level of actuarial analysis in the form review process.

Actuarially Equivalent Substitutions of EHBs

Of these three provisions, the most intensive actuarial work will most likely come from actuarially equivalent substitutions of EHBs. ~~Subsection~~Section 1302(b) of the ACA requires all health insurance plans sold through Exchanges to include EHBs, including benefits in each of 10 categories of services, as defined by the Secretary. ~~Subsection~~Section 2707(a) of the ~~Public Health Service Act~~PHSA, as added by section 1201 of the ACA extends this requirement to all plans in the individual and small group markets. In a bulletin issued on December 16, 2011, HHS signaled that it was considering permitting issuers with

"some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories." The bulletin suggested that these substitutions could potentially occur both within and across the 10 categories, though a subsequent FAQ document seems to limit them to those within a category. All substitutions must be actuarially equivalent; using the same measures defined in Children's Health Insurance Program (CHIP),[41] and must also comply with prohibitions on discriminatory benefit designs. Since the benefits of the EHB Benchmark as adopted by a ~~s~~State and approved by the Secretary, if required, should be non-discriminatory, ~~s~~States may wish to focus limited actuarial resources for discriminatory benefit design analysis upon plans that have utilized actuarial substitutions.

Actuarial Value

~~Subsection~~Section 1302(d) of the ACA requires non-grandfathered individual and small group health insurance plans, except for catastrophic plans, to fall within one of four "metal tiers" defined by the AV~~actuarial value~~[42] ~~(AV)~~ of the benefits offered by the plan relative to the full cost of the EHBs:

- Platinum: 90% AV
- Gold: 80% AV
- Silver: 70% AV
- Bronze: 60% AV

~~Subsection~~Section 2707(a) of the ~~Public Health Service Act~~PHSA, as added by section 1201 of the ACA extends this requirement to all plans in the individual and small group markets. Plans would be allowed a margin of +/- 2% of the required actuarial value for each metal tier. At a minimum, all issuers selling coverage through the Exchange must make available at least one plan in the silver level and one plan in the gold level.

~~Subsection~~Section 1302(e) of the ACA defines a catastrophic plan which is a permissible benefit design offered to certain qualified individuals that does not meet a specific AV but must comply with the maximum out-of-pocket limits.

On February 24, 2012, HHS issued a bulletin describing their intent to develop an actuarial value calculator that will be publicly available and based upon a single set of nationwide data reflecting the price of care and utilization patterns of non-elderly individuals in the individual and small group health insurance markets. States would be divided into three tiers, reflecting geographic variations in the cost and use of health care services, in order to more accurately calculate the AV of a plan sold in a specific market. Alternatively, ~~s~~States would be allowed to substitute their own data sets in order to gain further accuracy. Issuers would enter major cost-sharing features of each health insurance plan to be sold in the calculator, which would return the expected actuarial value of the plan.

Some ~~state~~ DOIs have considered using standard benefit designs on the Exchange, but the federal law does not require it and the majority of ~~s~~States will not standardize them. Each ~~state~~ DOIs will have the option to either develop specific benefit design for each of the metal plans that include the EHBs and cost-sharing or allow issuers to design the plan as long as it meets the required actuarial value. ~~State~~ DOIs will develop EHBs, but those do not reflect cost-sharing or metal tiers. Some state DOIs will require base metal plans offered inside the Exchange to be offered outside of the Exchange.

Some ~~s~~States have considered using standard benefit designs on the Exchange, but the federal law does not require it. Each ~~s~~State will have the option to develop specific benefit designs or benefit design parameters for each of the metal coverage levels, which could greatly increase consumers' ability to understand their coverage options and compare plans on the basis of price and quality. Alternatively, ~~s~~States could allow issuers broad leeway to design their products as long as they meet all applicable federal and ~~s~~State standards. EHB benchmark plans will not reflect cost-sharing or metal tiers. Some ~~states~~ DOIs will require plans offered inside the Exchange to be offered outside of the Exchange.

Consumer representatives have urged regulators to consider the potentially discriminatory effects of complex and unusual cost-sharing interactions. Representatives of health issuers, however, caution that overly broad caution could limit health plan innovation or the use of quality-driven networks and tiers. Consumer representatives also suggested that portions of the form

[41] 42 CFR § 457.431

[42] "Actuarial Value" is a measure of the percentage of expected health care costs a health plan will cover and can be considered a general summary measure of health plan generosity.

filing demonstrating actuarial value be subject to independent actuarial review and available to the public. Issuer representatives disagreed, citing a need to maintain the confidentiality of proprietary information and trade secrets.

Cost-sharing Reductions for Individuals below 250% of Federal Poverty Level (FPL)

Section 1402 of the ACA outlines requirements for QHPs to provide reduced cost-sharing for individuals with household incomes below 250% of FPL purchasing coverage through the Exchange. The actuarial value bulletin published by HHS in February 2012 also provides guidance for the provision of reduced cost-sharing. Each silver-level plan submitted to the Exchange must be accompanied by three variants providing AVs of 73%, 87% and 94%. These AVs would be verified in the same way as AVs for the metal tiers are verified. In addition, it must be verified that the reduced cost-sharing was achieved in accordance with federal requirements. According to the bulletin, cost-sharing must first be reduced by reducing the out-of-pocket limit to levels specified in annual guidance that will be provided by HHS, and then by applying adjustments to other cost-sharing factors. Nothing in the ~~law~~ ACA or federal regulations would prevent a ~~s~~State from being more specific, about how issuers offering silver plan variants must reach the higher AVs associated with the cost-sharing reductions. (Such ~~s~~State specifications would have to be consistent with the federal standards described above.) Some ~~s~~States may wish to consider such specifications, for example, as a way to ensure low-income people can access plans with up-front cost-sharing charges that are as low as possible, ease comparability of different coverage options for consumers, and simplify regulators' work in ensuring plans provide the required actuarial values. Like AVs for metal tier levels, the ~~s~~States will also need to ensure that the design of reduced cost-sharing variants does not violate prohibitions on discriminatory benefit design.

Additionally Section 1402 of the ACA provides that QHPs covering an American Indian/Alaskan Native whose family income is under 300% of the FPL shall not be subject to any cost-sharing under the plan. This provision is not specifically addressed in the AV bulletin, so additional guidance from HHS would be expected to address how the plans should be structured to comply with AV requirements.

W:\National Meetings\2012\Summer\Cmte\B\ExchangesSG\Form Review White Paper Team 6-26 Adopted by Subgroup.docx

Draft: 6/26/12
As adopted by the Exchanges (B) Subgroup, 6/26/12

Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage

Introduction

The federal Patient Protection and Affordable Care Act (the "Affordable Care Act," or ACA) provides for the establishment of American Health Benefit Exchanges ("Exchanges") to facilitate the purchase of health insurance by qualified individuals and qualified employers. [1] Under the ACA, for the States electing to establish a state-based Exchange, the Exchange must be established and meet certain minimum requirements by Jan. 1, 2014.[2] In States that do not establish a state-based Exchange (SBE), the ACA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an Exchange, known as a federally facilitated Exchange (FFE), for the residents of that State.[3]

In the proposed rules on "Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" published in the *Federal Register*, July 15, 2011, HHS announced the State Partnership federally-facilitated Exchange (PFFE) model. Under this model both HHS and the States will operate functions of the Exchange. HHS, however, will remain responsible for ensuring that the Exchange meets all of the standards and requirements under the ACA. As stated by HHS, the PFFE model is intended to give the States another option to tailor their Exchange to accommodate local needs and market conditions. In addition, the PFFE model is a way that the States can transition to fully operating their own SBE.

On Sept. 19, 2011, at a State Exchange Grantee meeting, HHS' Center for Consumer Information and Insurance Oversight (CCIIO) provided additional information to the States on PFFEs.[4] As provided at this meeting, States entering into a PFFE must agree under the terms of their grants to ensure State insurance department, Medicaid and Children's Health Insurance Program (CHIP) cooperation to coordinate business processes, systems, data/information and enforcement. Also, as part of a PFFE agreement, a State may choose to operate plan management functions and/or some consumer services, such as consumer assistance programs, using Exchange grant funding to establish framework, thereby maintaining existing relationships and allowing for easier transitions to SBEs in future years.

Specifically, under a PFFE, CCIIO indicated that a State may choose to operate the following Exchange functions: Option 1) Plan management functions, such as collection and analysis of plan information and plan monitoring and oversight; Option 2) Selected consumer assistance functions, such as Navigator program management or other in-person consumer function; or Option 3) Both selected consumer assistance and plan management functions.

HHS has indicated that, in a PFFE, the States must, in general, take an all or nothing approach to the plan management and consumer assistance functions. That is, a ~~s~~State must agree to take on all duties outlined under plan management and/or consumer assistance (with a few exceptions), or none of them.

Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options. In an FFE, consumer assistance and plan management functions will be performed by HHS.

These plan management and consumer assistance functions performed by a PFFE were further defined in the May 16, 2012 guidance as including: 1) licensure and solvency; 2) network adequacy; 3) rate review; 4) benefit design standards; 5) marketing and consumer information, which includes oversight of Navigators, review of marketing materials and the summary of benefits and coverage; 6) accreditation; and 7) quality ratings, quality improvement strategies and enrollee satisfaction surveys.

[1] Pub. L. 111-148), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010) ~~(ACA)~~
[2] ACA Sec. 1311(b)
[3] ACA Sec. 1321(c)
[4] http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf

© 2012 National Association of Insurance Commissioners

Scope

This paper is intended to explore the issues and options for implementation of certain provisions of the ~~law~~ACA and regulations issued to date regarding the management of marketing, the summary of benefits and coverage required to accompany each policy beginning in September 2012, as well as how agents, brokers and Navigators will be regulated and managed in regards to the ACA. This paper will not address issues concerning consumer outreach in general, nor will it address the many facets of issues surrounding agents, brokers and Navigators that do not directly involve how state DOIs will manage these individuals. Those issues may be addressed at a later date when more information has been released by HHS.

This paper expands on the white paper developed by the NAIC in April 2011 concerning agents and brokers and their involvement in the ACA, and includes final regulations on SBEs and the most recent guidelines released by HHS on May 16, 2012. Where this paper uses the term "regulation," it is referring to the final regulations regarding SBEs.

The issues and options identified in this paper will be useful to all States, but how ~~the~~a State addresses the issue will depend on whether the state decides to implement an SBE, an FFE, or a PFFE. Whenever possible, this paper will highlight the possible differences in approach a State may take depending on what type of Exchange is established, including all issues that implicate the involvement of the DOIs.

This paper is not intended to be used as a "best practices" guide, but rather a paper that outlines issues and options that States may face when establishing an Exchange. States should evaluate the needs and requirements of their local population and market condition when deciding how best to establish an Exchange.

This paper includes four topical sections: Navigators, agents and brokers, marketing, and Summary of Benefits and Coverage (SBC). Each section will first summarize the requirements and responsibilities found in the ACA and final regulations, then will discuss issues and options for States to consider when planning an Exchange. When applicable, the paper will outline the differences between States considering an SBE, an FFE, and a PFFE.

Navigators

Background information

The ACA requires Exchanges to establish Navigator programs through which entities that receive financial grants will conduct public education activities, distribute fair and impartial information, and perform related duties set forth in the law. The federal law and regulations provide some basic details about the responsibilities and roles of Navigators, but State policymakers have considerable flexibility and discretion to structure these programs in the manner they deem most appropriate.

The federal law and regulations do not specify the type or contents of the contractual agreements between Exchanges and Navigators. However, at a minimum, Navigators must carry out the following duties:

- Maintain expertise in eligibility, enrollment, and program specifications for the Exchange as well as public coverage options, and conduct education activities to raise public awareness of the Exchange;
- Provide information and services in a fair and impartial manner (including information about the costs of coverage and advance payments of premium tax credits and cost-sharing reductions), acknowledging other health programs;
- Facilitate selection of a qualified health plan (QHP), initiating the enrollment process;
- Provide referrals to any applicable office of health insurance consumer assistance or ombudsman or other appropriate State agency for any enrollee with a grievance, complaint or question regarding their health plan, coverage, or a determination under that plan; and
- Provide information in a manner that is culturally and linguistically appropriate, and ensure accessibility and usability of Navigator tools and functions in accordance with the American Disabilities Act (ADA).

The Exchange is free to require that Navigators meet additional standards and carry out additional duties consistent with the listed minimum duties.

Who can be a Navigator?

The federal law and regulations list the types of entities that may be Navigators. The regulations clarify that the Exchange must select entities from at least two of the following categories to serve as Navigators:

- A community and consumer focused nonprofit group;
- A trade, industry, and professional association;
- A commercial fishing industry organization, ranching and farming organization;
- Chambers of commerce;
- Unions;
- Resource partners of the Small Business Administration;
- Licensed agents and brokers; and
- Other public or private entities or individuals that meet the requirements, such as Indian tribes, tribal organizations, urban Indian organizations, and State or local human service organizations.

One of the two entities selected from the above list must be a community and consumer focused nonprofit group.

In order to be eligible to receive a grant from the Exchange an entity must:

- Be capable of carrying out the minimum duties required by federal law and regulation;
- Demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a QHP;
- Meet any licensing, certification, or other standards that are prescribed by the State and/or the Exchange;
- Not have a conflict of interest that bars the person from carrying out the duties of a Navigator; and
- Comply with the privacy and security standards established by the regulation.

Individuals and entities who do not receive grant funding may not be considered a qualified Navigator, as per HHS guidance.

Funding the Navigator program

Federal law requires that all funds for Navigator grants must come from the Exchange's operation funds generated through non-federal sources. The preamble of the final regulation dealing with SBEs notes that operational funds of the Exchange may be revenue received by the Exchange through user fees or other revenue sources, so long as the Exchange is self-sustaining. HHS also observes that public or private grants may be available to support certain Exchange functions, such as education and outreach, and indicates that such grants will be considered to be operational funds of the Exchange once they are received. The preamble also indicates that, to the extent that Navigators assist with Medicaid and CHIP administrative functions, such as assisting eligible individuals with enrollment in coverage, the Medicaid or CHIP agencies are permitted to claim federal funding for their share of expenditures incurred for such activities.

Prior to the establishment of Exchanges, ~~s~~States may use Exchange planning and establishment grants to fund activities related to the development of the Navigator program, such as:

- Conducting a needs assessment to identify populations that are likely to use Navigators;
- Identifying potential Navigator entities;
- Engaging stakeholders in the development of Navigator standards, grant guidelines, and plans for public education and outreach; and
- Designing Navigator training and certification programs.

Licensing, Certification and Training

The federal regulations require an individual or entity to satisfy any licensing, certification, and training standards established by the State or the Exchange in order to operate as a Navigator and receive Navigator funding. It is the responsibility of the States and the Exchanges to develop training standards to ensure the competency of Navigators, but the regulations do impose certain minimum requirements. Specifically, training standards must ensure that Navigators understand the following:

- The needs of the underserved and vulnerable populations;
- The rules and procedures for eligibility and enrollment;
- The range of public programs and QHP options available through the Exchange; and

- How to appropriately handle tax data and other personal information and comply with the regulation's privacy and security standards.

Although it is not required, the preamble to the final regulations strongly encourages Exchanges to implement ongoing and recurring training, as well as regular reviews and assessments of their Navigators. In addition, HHS has indicated that it may provide further guidance in the future.

The preamble also states that an Exchange may NOT require that any Navigators hold an agent or broker license, or maintain errors and omissions (E&O) coverage.

Prohibitions on Navigator Conduct and Conflicts of Interest

The federal law includes prohibitions on Navigators that are intended to prevent, minimize and mitigate possible sources of conflicts of interest, and the regulation further provides that a Navigator *must not*:

- Be a health insurance issuer, a subsidiary of a health insurance issuer, an association that includes members of, or lobbies on behalf of, the insurance industry; or
- Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees in a QHP or a non-QHP.

The preamble to the regulation notes that HHS intends for these prohibitions to apply broadly, including to any staff of an entity serving as a Navigator or entities that serve as Navigators for one Exchange while simultaneously serving in another capacity for another Exchange. The preamble also expresses concern that grants and other considerations provided by health insurance issuers to Navigators for activities unrelated to enrollment in health plans may present a significant conflict of interest for Navigators, although such grants are not inherently prohibited. Finally, HHS indicates in the preamble that "consideration," as used in connection with these prohibitions, should be interpreted to mean both (1) financial compensation, including monetary and in-kind compensation and grants, and (2) any other type of influence that a health insurance issuer could use, including gifts, free travel, and other items that may result in steering consumers to particular plans.

Exchanges must develop and publically disseminate conflict of interest standards to ensure the appropriate integrity of all entities and individuals carrying out Navigator functions. The preamble to the regulations urges the States to craft conflict of interest standards that address areas such as:

- Financial considerations;
- Non-financial considerations;
- The impact of a family member's employment or activities with other potentially conflicted entities;
- Navigator disclosures regarding existing financial and non-financial relationships with other entities;
- Exchange monitoring of Navigator-based enrollment patterns;
- Legal and financial recourses for consumers that have been adversely affected by a Navigator with a conflict of interest; and
- Applicable civil and criminal penalties for Navigators that act in a manner inconsistent with the conflict of interest standards set forth by the Exchange.

The preamble also clarifies HHS' view that conflicts of interest arise when a Navigator has a private or personal interest sufficient to influence, or appear to influence, the objective exercise of his or her official duties. HHS plans to release model conflict of interest standards in future guidance.

Considerations and Options for State Officials

Who are the best candidates to become Navigators?

As stated in the regulations, each Exchange must fund at least one Navigator entity that is a community and consumer focused nonprofit group. States might consider a range of community-based organizations, such as Kiwanis, parent-teacher associations, community health organizations, faith-based organizations, churches, earned income tax credit (EITC) assisters, peer-run nonprofit organizations, such as addiction and mental health help groups, and state Senior Health Insurance Information Programs (SHIIPs), which could include institutions with consistent interaction with the public provided that such entities also meet the eligibility criteria necessary to receive a grant from the Exchange, as set out earlier in this paper.

Information gathered as part of the Navigator application process can help the States determine which entities and individuals would be most instrumental in reaching all populations of the State. This information might include what types of services the entity currently provides, what populations they interact with most often, what methods they use to reach consumers (e.g. telephone, home visits, in-person appointments), and which geographic areas of the state they will serve.

Some ~~s~~States are considering allowing "safety net providers," including federally qualified health clinics and health departments, to be part of the Navigator program. States that choose to include these organizations may wish to define what constitutes a "safety net clinic" and should ensure that Navigators will provide unbiased information and do not act in a way that violates the rules set out by HHS regarding conflict of interest for Navigators.

The relationship between the Navigator entity and Navigator individual

States will need to determine the relationship that will exist between a Navigator entity and a Navigator individual, and what the State's involvement in that relationship will be. Some ~~s~~States are planning to require that the Navigator entity will apply for and receive the grant. The entity then may be responsible for the training and conduct of each individual Navigator, and will decide whether/how that grant money will be distributed.

Who will be responsible for training Navigator individuals?

States will need to decide what methods for training Navigator ~~-~~volunteers are most feasible for the population and geography of their State, taking consistency of that training into consideration. Some States are using their State SHIIP program as a model to address these issues. For example, Kansas is planning to centralize the training process, ensuring that all Navigator entities and individuals receive the same training from the same Exchange-approved individual or group. This will eliminate problems of inconsistency that can sometimes be found in a "train the trainer" process. However, States with a larger number of Navigators or a larger geographical area may need to consider other ways to ensure consistency while still being accessible in all areas of the State – perhaps via videos or online training programs. North Carolina plans to provide uniform training at designated sites across the ~~s~~State, similar to SHIIP training sites, and will also develop an online course to ensure that Navigator entities and individuals get the same training regardless of where they are located in the State.

What should be included in Navigator training?

States may need to evaluate the Navigator individuals in their State, including the specialized knowledge they already have and identifying the gaps in knowledge that exist. Navigator ~~-~~individuals should be trained on how to help consumers through the entire process of finding, evaluating and choosing a ~~qualified health plan (~~QHP~~)~~ in the Exchange marketplace (both electronically and on paper), including issues that may arise with the web portal and electronic enrollment process. Some issues that the States have identified as possible training topics include:

- Content knowledge
    - Basic health insurance concepts
    - QHP details
    - Non-Exchange plans
    - Specialty health plans[5]
    - Exemptions from the individual mandate
    - Premium tax credits and other tax considerations
    - Other insurance affordability programs
- Eligibility issues
    - Accessing information about eligibility and enrollment status
    - Eligibility for public assistance programs
    - Employment eligibility issues
    - Changes in eligibility (transition risk)[6]

[5] Specialty health plans include coverage such as vision, dental, hearing, chiropractic, behavioral, alternative medicine and cancer. As some specialty pediatric essential benefits differ from adult benefits under the ACA, some coverage coordination will be necessary.

[6] Transition risk is the tendency for some segments of the population to switch eligibility between Medicaid, premium tax credits and subsidies within the policy year. Navigators should be trained on how to provide enrollment and information to individuals that fall into this category, including: access to care; continuity of care; continued eligibility or ineligibility for

© 2012 National Association of Insurance Commissioners

    - How to help consumers with complex or mixed eligibility
- Enrolling consumers
    - Comparing plan options
    - Applying online (how to use the Exchange online portal)
    - How to apply via paper applications
    - Renewing coverage and re-enrolling consumers with lapsed policies
    - Changing plans when appropriate
- Counseling skills
    - Ethics
    - Cultural competency
    - Privacy and security for handling personal information
    - Communication skills
    - Evaluating the level and type of assistance the consumer needs
    - Assisting individuals with disabilities, including addiction or mental health issues
    - Making referrals and finding community resources
    - Conflict of Interest requirements

States may wish to consider setting up a resource center with a "1-800" number for Navigators to call for assistance, especially at the beginning of implementation of the Navigator program.

Licensing and Certification

States cannot require Navigators to be licensed insurance agents or brokers. However, HHS regulations confirm that Navigators should be certified or licensed as a Navigator in individual States. This certification or licensure should occur after fulfilling Navigator training requirements, and after demonstrating a command of the information and skills required to perform Navigator duties. States may wish to evaluate the process to ensure potential Navigators do not face overly burdensome requirements. Some States may wish to allow Navigators to be certified based on competency alone, not based on hours of training. If a State chooses to have Navigator individuals complete different types of duties (e.g. distinguishing Navigators on an individual Exchange and Navigators on the Small Business Health Options Program (SHOP) Exchange) that State may wish to vary the requirements based on the functions that particular Navigator will be responsible for. States may wish to evaluate what continuing education requirements they will provide for Navigators, including specialized topics, policy updates and strategies for conducting Navigator duties.

Kansas plans to certify Navigator individuals who successfully complete training. Navigator entities will apply for grant funds from the Exchange, and Navigator individuals will be trained and certified. They will require an initial 24 hours of face-to-face training and an additional 4 hours of online training, including pre- and post-testing. After the initial training and first year of work, Navigator individuals will be required to complete 8 hours of face-to-face training and 4 hours of online training annually to maintain their certification.

Monitoring Navigator Behavior and Performance

States will need to determine who will be responsible for monitoring Navigator behavior and performance. In some states Navigators may report either directly to the Exchange or to the DOI, or another organization altogether. Some states may wish to require Navigators to sign a code of conduct or ethics statement regarding the appropriate and fair delivery of service.

States may also wish to monitor Navigator conduct by requiring Navigators to report data on a defined set of measures, which might include: the number of individuals assisted; how many of those individuals were eligible for public programs or subsidies; which programs or plans consumers were enrolled in; demographic information; insurance history; and what level or type of assistance was required, including whether and where they were transferred for additional assistance. Keeping a record of this information may help the Exchange keep track of the work each Navigator is doing and ensure proper oversight of duties. The Community Service Society of New York is an example of an organization that currently practices this oversight process; the primary contractor in the consumer assistance program reviews a case sample from each contracting entity to monitor behavior and performance.

Medicaid, premium subsidies, and tax credits; exposure to tax liability for some portion of previous subsidy payments; exposure to higher costs of premiums, deductibles, and out-of-pocket expenses; and exposure to changes in coverage.

In Kansas, the Navigator entity will be responsible for ensuring that all individuals are trained properly. Any Navigator misconduct could result in the individual losing certification status and the entity losing its grant money. Complaints concerning Navigators would be monitored by the DOI through consumer complaints filed electronically, by telephone, by mail or in person. States with SBEs could consider providing Navigators with a portal that is separate from the portal used directly by consumers, and assigning each Navigator -individual unique number which would be recorded when signing into that -portal. The Navigator can use that identifying number to submit enrollment applications on behalf of the consumers and/or small businesses they assist and track eligibility and enrollment information. If a consumer reports misconduct, that individual could be traced through the Exchange through that identifying number.

There may be entities in the marketplace that will use Navigator names or create copycat Exchange websites to defraud and mislead consumers. States need to remain vigilant in identifying and disabling these entities in order to protect consumers.

Conflict of Interest Standards

HHS will provide the States with a conflict of interest statement template that can be used when certifying or licensing Navigators. States may also wish to consider whether they should incorporate additional or existing state laws or standards that govern Navigator conflicts of interest. States should consider establishing a standard procedure to prevent and mitigate conflicts of interest, such as an annual disclosure requirement and/or ongoing obligations to disclose new or actual conflicts. States may also wish to adopt measures to prevent the appearance of impropriety, and outline procedures for the review of possible conflicts of interest

Massachusetts has decided to incorporate its conflict of interest law and financial disclosure law into the operation of their Exchange, The Connector.

Recourse for Consumers

States should consider what recourse a consumer might have if he or she is harmed by a Navigator's actions. While States are prohibited from requiring Navigators to purchase ~~Errors and Omissions insurance~~ E&O coverage, -States may wish to determine ways in which consumers harmed by Navigator entities may seek redress.- Navigator entities may wish to voluntarily purchase an overarching liability insurance policy that would protect them and the consumer in the event of an error.

States may need to develop a process for handling Navigator-related complaints from consumers, with the ability to take appropriate action against Navigators when fraud or other improper conduct occurs. States may also wish to establish a process for reviewing awarded Navigator grants to detect and protect against malfeasance, waste, fraud, and abuse.

Navigator Compensation

States will need to decide how Navigator entities will be awarded grant money, and whether that process will include a performance-based system. States should consider establishing Navigator compensation that ensures proper linkage of performance and results. Some factors that the States may want to consider when evaluating Navigator performance include:

- The number of consumers assisted;
- The actual services provided to consumers;
- The time intensity of the service provided;
- The geographical location in which the Navigator is located; and
- Whether the Navigator serves a specific population (including populations of consumers with limited English proficiency, mental illnesses or disabilities).

In Kansas, compensation of Navigator individuals will be left up to the discretion of the Navigator entity.

Individual Exchange versus SHOP Exchange

States may choose to fund different Navigators that specialize in providing services to the SHOP and individual Exchanges, or may choose to have Navigators have different roles in the individual and SHOP Exchanges. States should consider the necessity of having some Navigators familiar with both markets to serve populations that may be interconnected (for example, if members of one family have varying coverage needs and eligibility statuses that are divided between the SHOP and individual Exchange). States should also decide if they plan to include Navigators in both markets. Maryland, for example, is planning to focus Navigators on the individual market and utilize agents and brokers to assist in the SHOP Exchange.

Considerations for SBEs, FFEs, and PFFEs

States that choose to run an SBE will have full control over Navigators within the parameters of the federal law and regulations. These States will determine training standards, hand out Navigator grants, and oversee the entire Navigator program, including what financing mechanisms will be used for funding Navigator grants.

States with an FFE will rely on the federal government to decide all aspects of the Navigator program.

Currently there is not a clear answer as to what will happen to Navigator programs in a PFFE. A State who chooses to run the ~~C~~consumer ~~A~~assistance option may determine some aspects of the program, including training standards and who will conduct the training. HHS has indicated that they may retain control of Navigator grants in a PFFE since the money would be coming from the federal government. States should consult directly with HHS about this issue and come to an agreement that will work for the individual State.

Agents and Brokers

Background

Under federal law, Exchanges have a great deal of flexibility to determine the role of agents, brokers and web-based entities in the marketplace.

The federal regulations make it clear that, with proper training, agents and brokers can enroll individuals, employers and employees in QHPs through the Exchange, as well as outside the Exchange.

The Exchange may also provide information regarding agents and brokers on its website. The regulations propose to allow agents and brokers to assist individuals in applying for advance payment of the premium tax credits and cost sharing reductions for plans offered through the Exchange (comments have been requested on this aspect of the regulations). The regulations make it clear that agents or brokers that enroll individuals in a QHP or assist individuals in applying for subsidies must comply with applicable State law related to agents and brokers, including State law related to confidentiality and conflicts of interest.

Agents and brokers who assist individuals in enrolling in QHPs or applying for subsidies must have entered into an agreement with the Exchange, the terms of which require agents or brokers to, at least:

- Register with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange;
- Receive training in the range of QHP options and insurance affordability programs; and
- Comply with the Exchange's privacy and security standards adopted consistent with the regulations.

The regulations allow agents or brokers to use their own website to complete the selection of a QHP, as long as the website, at a minimum:

- Meets all the standards for disclosure and display of QHP information set out in law and regulations;
- Provides consumers the ability to view all QHPs offered through the Exchange;
- Does not provide financial incentives, such as rebates or giveaways;
- Displays all the QHP data provided by the Exchange;
- Maintains audit trails and records in an electronic format for a minimum of 10 years; and
- Provides consumers with the ability to withdraw from the process and use the Exchange website instead at any time.

In addition, the regulations provide that a consumer may be enrolled in a QHP through the Exchange with the assistance of an agent or broker if the agent or broker ensures that the consumer is eligible for coverage and completes an application. The application must then be properly transmitted to the ~~insurer~~issuers through the Exchange website.

In order to receive a subsidy, consumers must enroll in coverage through the Exchange. As long as the agent or broker is certified to sell products through the Exchange, the consumer may receive that subsidy when enrolling with an agent or broker.

Considerations and Options for State Officials

Agents and Brokers as Navigators

Agents and brokers may be Navigators if they are not compensated directly or indirectly from- health insurance issuers for their work. States may wish to evaluate how this will affect their unique insurance environment and agent requirements.

Agents Selling on the Exchange

States should evaluate what training should be required of agents and brokers who wish to sell QHPs through the Exchange, including training on public -affordability programs, subsidy eligibility, and use of the web portal.

Additionally, States will need to consider how agents and brokers serving Exchange consumers will be compensated, and how the pricing of QHPs will remain the same both inside and outside the Exchange, whether or not an agent or broker was involved. Both the individual Exchange and the SHOP Exchange should be taken into consideration when making these decisions.

How Consumers will find Exchange-Approved Agents and Brokers

State Exchanges and DOIs will need to decide whether to provide consumers with a list or database of agents and brokers approved to sell on the Exchange. Maryland is planning to make a list of agents and brokers approved to sell Exchange products on the Exchange website, though consumers will not be referred to a specific producer or company.

Navigators in Maryland will be limited in what they can tell consumers about products offered outside the Exchange. Maryland has determined that only Navigators will be allowed to enroll consumers in public- affordability programs, and any agent or broker who encounters a consumer eligible for a public affordability program will be required to refer that consumer to a Navigator.

Agent Appointments and Selling on the Exchange

States may need to reconcile their producer licensing laws and rules with any Exchange Navigator certification or licensing requirements.

States will need to consider captive agent status under their licensing laws. In addition, the States may need to address State and ~~carrier~~issuer appointment requirements and review the ability of all agents and brokers to enroll consumers in all QHPs within an Exchange.

States will need to evaluate what is best for their market and determine what requirements, if any, will need to be met to allow agents and brokers to sell on the Exchange.

Agent Training

States will need to decide what kind of training will be required of agents and brokers before allowing them to sell plans on the Exchange and to what extent training will need to be incorporated into the continuing education requirements for agents to remain eligible to sell on the Exchange. Specifically, agents and brokers may need to be trained on:

- Tax subsidy calculation;
- Basic Medicaid and CHIP eligibility, and issues for mixed eligibility status families;
- Scope of what Navigators are allowed to do;

- Sensitivity to cultural differences and norms of minority populations;
- How to report exemptions from individual mandate;
- Eligibility issues for consumers with employer-based coverage;
- How to use the Exchange website; and
- Tax subsidies available for small businesses.

Training for agents in Kansas will be similar to the training required of Navigators, but with the option to test out of training over basic insurance concepts. Kansas is also planning to add Exchange-specific training to agent and broker required continuing education (CE) hours in order to stay eligible to sell on the Exchange.

Conflict of Interest Standards

States should consider what conflict of interest standards will apply to agents and brokers. States could gather information on the enrollment patterns of consumers who utilize an agent or broker versus those who do not to ensure that consumers are not being steered toward plans that offer agents and brokers the highest commission rate. States might also consider what recourse consumers would have if they are adversely affected by an agent or broker who violates this conflict of interest standard. HHS will provide a conflict of interest standard template for Navigators, and States may be able to adapt this language to suit agents and brokers as well.

Commission Structure for Agents and Brokers

States will need to consider how commission structures may change for agents and brokers who sell QHPs on the Exchange. Maryland and Utah have determined that traditional commission structures may remain in place, and Utah is planning to require agents and brokers to disclose their commissions to consumers.

Web-based Brokers in the Exchange

States may need to determine if web-based brokers require different regulations from traditional agents and brokers and, if so, what those differences would be, including conflict of interest standards. Since web-based brokers may use a website other than the Exchange portal, ~~s~~States should strive to ensure that all websites selling QHPs are built in a way that will not confuse consumers, perhaps including a disclaimer that the web-based broker website is not the official Exchange website. States should ensure that subsidy availability and regulations are clearly available on these websites.

Considerations for SBEs, FFEs, and PFFEs

In the general guidance issued May 16, 2012, CCIIO stated that HHS expects that licensed agents and brokers will continue to assist consumers in accessing health insurance, and will work with agents and brokers to promote enrollment through the Exchange. To the extent permitted by a State, an FFE will permit agents and brokers to enroll individuals in a QHP "through an Exchange" if the agent or broker ensures that an individual completes the eligibility verification and enrollment application using the Exchange website or another Exchange-approved website. HHS will provide licensed agents and brokers with a portal to the FFE website if applicable standards are met. HHS intends to work with web-based brokers that meet all applicable requirements.

In addition, HHS indicated that agents and brokers will be a primary channel small businesses use to access coverage through an FFE-SHOP Exchange. HHS also anticipates that agents and brokers will continue to be a primary point of contact for a variety of administrative, billing, and claims-related issues.

In an SBE, the role of agents and brokers will be determined by the State. However, States cannot shape the agent/broker role in a way that undermines the federal regulations that establish that a Navigator's role is to facilitate enrollment.

Marketing

Background

The ACA requires the Secretary of HHS to establish criteria for the certification of QHPs that require that plans, at a minimum, meet marketing requirements, and not employ marketing practices or benefit designs that discourage enrollment by people with significant health needs. The federal law and regulations require QHPs to follow State marketing laws.

Considerations and Options for State Officials

In this paper, marketing is considered to be the way that ~~insurers~~issuers and/or producers try to get consumers to buy a particular plan. Marketing should be considered separately from general consumer outreach intended to educate consumers about insurance or the Exchange in general.

Currently the States, in general, do not have specific marketing rules for traditional health insurance plans, beyond State unfair trade practices laws. States do reserve the right to review advertising materials at any time, but typically do not pre-approve advertising for traditional health insurance plans. Some ~~s~~States, including Florida, do make a distinction between invitations to inquire and invitations to contract. States may want to re-evaluate the current laws that govern insurance marketing to decide if additional regulation is necessary for plans sold inside and outside the Exchange.

Currently Utah does not have any additional regulation for marketing plans through their Exchange. However, they have had the need to specify that producers may not create an online website that looks like the official Exchange website, and must explicitly state that their website is not affiliated with the official Exchange portal.

Considerations for SBEs, FFEs, and PFFEs

States with an SBE will have the ability to control advertising inside and outside of the Exchange. Plans will continue to have to follow the Health Insurance Portability and Accountability (HIPAA) fair market rules and other marketing requirements. DOIs may want to put guidelines in place to ensure that products and rates are not constructed or marketed in such a way to discourage people away from the Exchange.

In an FFE, HHS will maintain control of marketing plans inside the Exchange. States will retain control of plans marketed outside the Exchange. HHS may wish to have a Memorandum of Understanding (MOU) with the state or contract with the state to share information to do this.

In a PFFE, ~~s~~States may be willing to take on some plan management functions, including marketing. If a ~~s~~State opts for a plan management PFFE, it will retain marketing oversight like an SBE. If a S~~s~~tate selects only a consumer assistance PFFE, HHS will have authority over the marketing of Exchange plans.

Summary of Benefits and Coverage

Background

The ACA requires all group health plans and individual ~~insurers~~issuers to provide a uniform Summary of Benefits and Coverage (SBC) disclosure to consumers for all private health insurance plans for plan years beginning after September 23, 2012. The uniform template requires ~~insurers~~issuers to include a description of the coverage, including:

- Cost-sharing for each category of benefits identified by HHS;
- Exceptions, reductions and limitations on coverage;
- The cost-sharing provisions of the coverage, including the deductible, coinsurance, and copayment obligations;
- The renewability and continuation of coverage;
- Coverage Examples that illustrate the costs for common benefit scenarios defined by HHS;
- A statement that the Summary of Benefits is only a summary;
- A contact number to call with questions and a website where a copy of the full policy for the plan can be obtained; and
- A website where consumers can access a standard glossary of insurance and medical terms.

In 2013, the Summary of Benefits and Coverage standard template will be updated to require ~~insurers~~issuers to include a statement about whether the plan provides minimum essential coverage and meets the affordability requirements for Exchanges. HHS will also provide up to four additional Coverage Examples in 2013 and ~~insurers~~issuers will need to implement these additional examples beginning on January 1, 2014.

Considerations and Options for State Officials

Purpose

The purpose of the SBC is to provide a uniform basis for comparing coverage options and to help consumers understand the benefits and costs under their coverage. States may not alter the SBC forms, but may require ~~insurers~~issuers to provide additional information to consumers.

If ~~s~~States find that additional disclosures are necessary, they may consider exploring one of the following:

- Continue to require complete disclosure documents to be distributed with duplicative information;
- Require the inclusion of an addendum with the SBC that contains additional non-duplicative information required by ~~s~~State law.

States will also need to include a required disclosure pursuant to Section 2709 of the PHSA (previously codified at Section 2713 of the PHSA and was part of the HIPAA disclosure requirements) that requires issuers to disclose the possibility that rates can go up. State DOIs may also wish to establish mechanisms to monitor the accuracy of the SBC disclosures submitted by ~~insurers~~issuers.

Conclusion

As noted in this white paper, the Exchange final rules and regulations provide States with some flexibility concerning Navigators, agents and brokers, and marketing within the Exchange. However, States are fairly limited in flexibility concerning the Summary of Benefits and Coverage. Many of the decisions that the States will have to make concerning the areas discussed in this paper will depend on whether the State establishes an SBE, an FFE, or a PFFE. States should use this paper to begin discussions with stakeholders and State agencies to best determine how Navigators and agents and brokers will be transitioned into the Exchange system, and to decide how best to regulate marketing and SBC requirements in their current insurance regulatory environment.

W:\National Meetings\2012\Summer\Cmte\B\ExchangesSG\Consumer Info White Paper Adopted Exchange Subgrp 6-26-12.docx

© 2012 National Association of Insurance Commissioners

Draft: 6-26-12
As adopted by the Exchanges (B) Subgroup, 6/26/12

Rate Review White Paper

The purpose of this white paper is to assist state policymakers with the implementation of the Affordable Care Act (ACA) provisions related to health insurance rating, rate filing, and rate review. The focus of the paper is the rate review requirements related to the certification of ~~Q~~qualified ~~H~~health ~~P~~plans (QHPs) in the Exchanges, but many of the ACA provisions impacting rate review apply to all plans in the individual and small group markets.

I. Introduction

The Affordable Care Act (ACA)[1] includes several provisions that will affect health insurance rating and rate review. These provisions include requirements for the review and disclosure of rate increases above certain defined thresholds, rating and underwriting requirements and limitations, programs to mitigate adverse selection and pricing risk, and additional requirements placed on plans offered through Exchanges. Though some of these provisions have already been implemented, those with a significant impact on rating will be effective for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by regulators, as applicable, in advance of January 1, 2014, and in the case of ~~Q~~qualified ~~H~~health ~~P~~plans (QHPs) offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013.

Issuers and State regulators will need to create a process for developing, submitting and reviewing rates that allow for potential differences between grandfathered and non-grandfathered plans, plans inside and outside the Exchange, plans by market if ~~s~~States have varying levels of review authority and effective rate review designations, and rate increases, where applicable, at or above defined thresholds (currently 10%) versus those under the defined thresholds. Additionally, rate review processes and requirements should be consistently applied for multi-state plans and ~~Co-op plans~~ Consumer Operated and Oriented Plans (CO-OPs) to maintain a level playing field. Rating and plan accounting will also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with medical loss ratio requirements, and any new federal or ~~s~~State taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new adjusted community rating requirements and underwriting limitations, pooling risks across products within a market (or in some cases across markets), and changes in the small group market.

The ACA also creates roles related to rate review for both the federal government and new Exchange entities. Exchange governance and functional responsibilities will vary across the ~~s~~States and may include various combinations of ~~s~~State regulators, Exchange entities and the federal government. The federal government will specifically play a role in rate review in cases where a ~~s~~State~~s~~ either does not have an "effective rate review program" or does not establish certified ~~s~~State-~~-~~based Exchange (SBE) or ~~plan management~~ ~~p~~Partnership Exchange~~s~~. The States might consider how to effectively and efficiently work with these various entities to ensure non-duplication, maintain consistency within the market, and mitigate issuer burden and consumer confusion.

II. Individual and Small Group Market Rate Review in the States before the ACA

State oversight of health insurance rates has, historically, varied substantially. While many ~~s~~States review proposed increases to determine if they are reasonable before they are used in the marketplace, other ~~s~~States lack the legal authority or resources to review rates prior to their implementation. Some States had no authority whatsoever to deny or reduce proposed rate increases.

A. Types of Rate Regulation

There are four main types of rate regulation in place in the individual and small group markets today:

[1] Pub. L. 111-148 (ACA), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010)

© 2012 National Association of Insurance Commissioners

1. ***Actuarial Justification:*** In markets with actuarially justified rating requirements, issuers must demonstrate a correlation between case characteristics and increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums within which plans may generally vary rates without providing justification. These are used by most ~~s~~States. Plans that vary rates in excess of these safe harbors may be required to submit data justifying their use of the characteristics in question.
2. ***Rating Bands:*** Particularly in the small group market, many ~~s~~States have implemented rating bands that limit the variation in premiums attributable to health status and other characteristics. Rating bands are either expressed as a ratio of the highest rating factor to the lowest (*e.g.* 1.5:1) or as the allowable variation above and below an index rate (*e.g.* +/- 25%). Rating bands may also take the form of composite rating bands that place limits on the combined effects of multiple case characteristics (*e.g.*, a composite rating band that allows 4:1 variation based upon health status, age, gender, industry, and group size combined).
3. ***Adjusted Community Rating:*** Adjusted (or modified) community rating laws prohibit the use of health status or claims experience in setting premiums. Other case characteristics, such as age and geography, may be used to vary premiums, though limits may be placed upon these factors as well.
4. ***Community Rating:*** "Pure" community rating laws prohibit the use of any case characteristics besides geography to vary premiums.

B. Commonly Used Risk Classifications

Following is a list of some of the more commonly allowed risk classifications. Use of these classifications varies greatly from state to state.

1. ***Health status and claims experience:*** The most direct way for issuers to base premiums on expected costs for an individual or group is to use health status information collected during the underwriting process or claims experience for policies being renewed. Most ~~s~~States that allow health status to be used for rating purposes in the small group market limit it using rating bands that vary from +/-10% to +/-60%. Premium increases due to changes in a business' health status may also be limited to 15% per year in many ~~s~~States.
2. ***Age:*** Because an individual's health status deteriorates as he or she grows older, leading to increased claims, age has become one of the most commonly employed case characteristics. Under the NAIC safe harbor guidelines, overall variation of 5:1 or less is reasonable in the small group market based upon the expected claims costs of 22-year-olds and 62-year-olds.
3. ***Gender:*** During childbearing years, women can be expected to incur medical costs that are more than 45 ~~percent~~% higher than men, excluding the costs of normal maternity coverage. The difference in expected claims narrows with increasing age and by their mid-50s men surpass women. At age 62, men can be expected to have costs that are at least 17~~ percent~~% higher than women.
4. ***Group size:*** Issuers often charge higher rates to smaller companies for a two main reasons: 1) it is more expensive to issue and service a policy for a very small business than for a larger one; and, 2) small employers purchasing coverage are more likely to have greater knowledge of their employees' potential future needs for health care services, creating a greater risk of adverse selection for the issuer. This risk is higher in a guaranteed issue environment where denial of coverage based upon underwriting criteria is prohibited, and businesses with 1-4 employees may be charged as much as 20% than those with 10-24 employees.
5. ***Industry and occupation:*** Working conditions and the type and lifestyles of workers may lead to higher claim costs in some industries than in others. The NAIC has adopted a safe harbor of 15~~ percent~~% for premium variation due to industry in the small group market. Occupation is also often used as a factor in the ~~non-group~~individual market.
6. ***Geographic location:*** The cost of delivering care varies dramatically from one area to another, and issuers often vary their rates by county or by ZIP-code using the employer's business address in the small group market, or the applicant's home address in the individual market. Safe harbors for geography have been set for each ~~s~~State, depending on the variation in medical costs within the ~~s~~State, and range from no variation in the District of Columbia to 1.9:1 in Florida. Not all ~~s~~States allow use of the safe harbor.
7. ***Duration of coverage:*** In medically underwritten, guaranteed-renewable markets, an issuer has the best picture of the health of enrollees on the date that they submit their application. Over time, enrollees' health may deteriorate from what it was at the time of application, leading to higher claims costs. To offset this, issuers in the individual market will often charge higher premiums to individuals who have been enrolled in the same plan for several years. This practice can encourage healthy enrollees who can pass medical

© 2012 National Association of Insurance Commissioners

underwriting to reapply in order to get the lower, new enrollee rate, exacerbating the very phenomenon it is attempting to fix.

8. ***Wellness:*** In recent years, several ~~s~~States have allowed ~~carriers~~issuers in the individual market to provide premium discounts or other incentives to individuals participating in wellness programs in order to encourage them to adopt healthier lifestyles. In practice, this has been a difficult policy to implement without allowing carriers a back-door way to use health status in setting premiums, and in at least one ~~s~~State where it is allowed no carriers are using it. State flexibility and further study of the best way to use wellness in setting premiums may be warranted.

C. Pooling of Risk

In applying rating factors, ~~carriers~~issuers will group policyholders into classes and blocks of business.

1. ***Class of Business:*** Issuers will maintain different "classes of business" that reflect administrative differences in how policies within them were sold or acquired by the company. For instance, a company may maintain one class of business composed of policies sold by its agents in the regular market, a second class of business may contain policies sold through a purchasing pool, while a third may be made up of policies that were acquired from another issuer. Most ~~s~~States limit both the number of classes that an issuer may maintain and the variation of premiums between classes. Most ~~s~~States with community rating or adjusted community rating disallow the maintenance of separate classes of business. The 1993 NAIC *Small Employer Health Insurance Availability Model Act*, which is the basis of most S~~s~~tates' small group rate regulation, limits carriers to nine classes of business and limits the index rate for the highest priced class of business to 120% of the index rate for the lowest priced class of business.
2. ***Block of Business:*** Issuers will also group business by the form of the policy, creating a block of business. In the individual market, ~~carriers~~issuers will also create "rating blocks" based upon initial health status classification. For instance, an ~~carrier~~issuer may group all new business that is charged a 25~~ percent~~% health adjustment into a single block and then apply experience adjustments to the entire block, rather than reunderwriting each renewed policy every year. When ~~carriers~~issuers stop actively selling a block of business, the result is a closed block, which can experience rate spirals as those who can pass medical underwriting purchase other coverage, leaving a pool of risk that becomes progressively sicker. In the small group market, limitations on the use of rating factors apply across all blocks of business.

D. Rate Review Processes

Many ~~s~~States use "prospective" regulation of rates, while others use "retrospective" regulation. Prospective regulation includes prior review and/or approval of rates, while retrospective regulation includes "file and use" where the rates go into effect, but the regulator can take action if the rates are later determined to be unreasonable under a standard such as one of the above. Retrospective regulation often relies on consumer complaints to indicate a problem with a company's rates.

The NAIC has several documents to provide guidance to the ~~s~~States in rate review, including the *Health Policy Rate and Form Filing Model* (#165), the *Guidelines for Filing of Rates for Individual Health Insurance Forms* (#134), and the *Small Group Rating Compliance Manual*.

Most ~~s~~States with rate review laws require that the company provide a qualified actuary's opinion that the rates are reasonable and comply with ~~s~~State law, as described in model #134. This allows the ~~s~~States to rely on the Code of Professional Conduct and the Standards of Practice that actuaries must follow. In addition, ~~s~~States often look at the whole financial picture of a company when reviewing rate filings.

Most ~~s~~States have different types of prospective or retrospective rate regulation for different comprehensive medical markets, such as individual, small employer, association group, employer-paid, blanket coverage, mini-medical coverage and state/local employee plans.

E. Filing of Rates

Forty-nine ~~s~~States, the District of Columbia and Puerto Rico use the NAIC's System for Electronic Rate and Form Filing (SERFF) for the filing of rates. While rating rules and policy requirements can differ greatly from ~~s~~State to ~~s~~State, SERFF helps companies by walking them through a checklist of ~~s~~State and federal requirements and then submitting their requests to the ~~s~~States.

© 2012 National Association of Insurance Commissioners

III. Rate Increase Disclosure and Review Requirements Under ACA

A. Background

The ACA reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHSA) relating to group health plans and health insurance issuers in the group and individual markets. Section 1003 of the ACA adds a new section 2794 of the PHSA ~~Act~~ [42 USCS §300gg-94]. In particular, this section:

1. Directs the Secretary of the federal Department of Health and Human Services (Secretary), in conjunction with the States, to establish a process for the annual review, beginning with the 2010 plan year, of ''unreasonable increases in premiums for health insurance coverage,''~~,~~

2. Requires health insurance issuers to submit to the Secretary and the State justifications for unreasonable premium increases prior to the implementation of the increases. Requires health insurance issuers to prominently post the submitted justification on their website~~.~~;

3. Requires the Secretary to carry out a program to award grants to the States during the 5-year period beginning with fiscal year 2010 to assist the States in reviewing and approving premium increases, and to establish centers to collect medical reimbursement information~~,~~;

4. For those States that are awarded grants, requires the Commissioner of Insurance to provide the Secretary with information about trends in premium increases and to make recommendations, as appropriate, to the State Exchange about continued participation in the Exchange by an issuer based on a pattern of excessive premium increases~~,~~;

5. Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States, must continue to monitor premium increases of health insurance coverage offered through the Exchange and outside the Exchange; and~~,~~

6. In determining whether to offer QHPs in the large group ~~health plans~~market through ~~the~~an Exchange after 2016, the States are required to take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange.

On December 23, 2010, the federal Department of Health and Human Services (HHS) published in the *Federal Register* a Notice of Proposed Rulemaking (NPRM) to implement section 2794 of the PHSA.[2] In announcing the proposed rulemaking, the Secretary addressed a letter to Insurance Commissioners stating:

> *"This proposed regulation recognizes and builds upon the traditional role the states have played in regulating insurance rates and complements existing State-based rate review processes. All proposed rate increases at or above 10 percent would be subject to review, and issuers in the individual and small group markets would be required to provide a justification to both the states and HHS to comply with Section 2794's requirement that such information be publicly disclosed prior to the implementation of the increase. States with effective rate review programs would review such proposed increases to determine whether they are in accordance with state law. In the small number of states that do not have the legal authority or resources to review rates, HHS would review proposed rate increases of 10 percent or more to determine whether they are reasonable, based on actuarial and other analyses that are currently used by many states to assess rate increases."*

On May 23, 2011, HHS published in the *Federal Register* a final rule ~~with comment period (76 FR 29964), in which HHS specifically solicited further~~requesting comments on amending the definitions of ''individual market'' and ''small group market'' in §–154.102 to include coverage sold to individuals and small groups through associations in all cases.[3]

[2] http://www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf
[3] http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf

© 2012 National Association of Insurance Commissioners

On September ~~1~~6, 2011, after consideration of the comments, HHS published in the *Federal Register* ~~amended~~amendments to the May 23, 2011 final rule to provide that individual and small employer policies sold through associations will be included in the rate review process, even if a State otherwise excludes such coverage from its definitions of individual and small group coverage.[4]

B. Application of Section 1003 to Issuers, CO-OPs and Multi-State Plans

1. Issuers

Section 1003 applies in the ~~I~~individual and small group markets. It does not apply to grandfathered health insurance coverage, nor does it apply to self-funded plans. This section will apply to QHPs offered in the Exchange beginning in 2014.

2. CO-OPs

Section 1322(a) of the ACA directs ~~CMS~~the Secretary to establish the CO–OP program to foster the creation of member-governed qualified nonprofit health insurance issuers to offer CO–OP QHPs in the individual and small group markets in the States in which they are licensed. The CO-OP program offers low-interest loans to eligible private, nonprofit groups to help set up and maintain health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly and high-quality health insurance options.

Starting January 1, 2014, CO-OPs will be able to offer health plans through the Exchanges. In addition to offering health plans through an Exchange, CO-OPs may also offer health plans outside of an Exchange. An Exchange must recognize a health plan offered by a CO-OP if it is deemed certified by Centers for Medicare & Medicaid Services (CMS) or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO–OP QHPs set forth in the ACA and except for a few narrow exceptions, all State-specific standards established by an Exchange for QHPs operating in that Exchange. Thus, it would appear that Section 1003 will be applicable to CO-OPs offering plans inside and outside the Exchange.

3. Multi-State Plans (OPM Plans)

The ACA authorizes the Office of Personnel Management (OPM) to enter into an agreement with issuers to offer multi-state plans in the individual and small group markets through ~~the~~an ~~e~~Exchange~~s~~. OPM must contract with at least one non-profit carrier and the plans offered as a multi-state plan are to be considered QHPs and the ~~e~~Exchange~~s~~ must allow them to be offered. However, nothing in the ~~law~~ACA exempts these multi-state plans from ~~s~~State laws or regulations. OPM is in the process of promulgating regulations relating to these plans.

IV. ACA Rules and Regulations that will Impact How ~~Carriers~~Issuers Price Health Plans and How States Perform Rate Review

The ACA includes several provisions that will affect health plan rating and rate review. Though some of these provisions have already been implemented (and are not explicitly covered below), those with a significant impact on rating will be implemented for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by State regulators, as applicable, in advance of January 1, 2014, and in the case of QHPs offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013. Note also that rates for non-grandfathered plans outside the Exchange will also be affected by the ACA market reforms, and that health insurance offered in the outside market may be issuing renewal notices as early as July 1, 2013, for plans effective after January 1, 2014. Therefore, rates will need to be approved months in advance of the October 1, 2013, date for Exchange enrollment.

Issuers and State regulators will need to create a process for the timely development, submission and review of rates that allows for potential differences between grandfathered and non-grandfathered plans; plans inside and outside the Exchange; and, plans by market if a ~~s~~State~~s~~ ~~have~~has varying levels of review authority and effective rate review designations. Delays in implementing rate increases could result in an inadequate premium being charged which could result in higher subsequent rate increases. Additionally, rate review processes and requirements should be consistently applied for multi-state plans and ~~Co-op plans~~CO-OPs to maintain a level playing field. Rating and plan accounting will

[4] http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf

also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with medical loss ratio requirements, and any new federal or ~~s~~State taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new rating requirements and underwriting limitations, pooling risks across products within a market (or in some cases across markets), new benefit requirements, and changes in the small group market.

It is clear that the significant number of unknowns that will require issuers to estimate, as well as the interplay of the new elements, present a challenge to issuers and State regulators.

Considerations for each of these issues are outlined below.

A. Underwriting Limitations

Issuers will be significantly limited in their ability to deny coverage or charge high premiums to individuals and groups with higher than average health risks. Underwriting provisions in ACA include:

- Guaranteed availability of coverage (non-grandfathered only): issuers must accept all individual and employer applicants, limited to open enrollment periods in the individual Exchange.
- Elimination of medical underwriting for non-grandfathered plans in the individual and group markets.
- Prohibition of pre-existing condition exclusions.

The impact of these changes on rates and premiums in most markets is expected to be significant. In addition, these provisions could lead to adverse selection if not sufficiently addressed by other provisions in the ACA or required by the S~~s~~tates.

B. Other Provisions Resulting in Demographic Changes

The ACA includes other provisions that are expected to have an impact on the population covered by health plans. The following provisions are expected to bring new entrants into the health insurance market:

1. ***Establishment of Exchanges:*** Exchanges will provide a mechanism for individuals and small groups to perform more standardized comparisons of available health plan options.
2. ***Individual Mandate:*** Individuals will be required to have health insurance or will pay a penalty, unless they are exempted for religious, affordability, or other allowable reasons.
3. ***Premium Subsidies and Cost-Sharing Reductions:*** For coverage purchased through the Exchange, federal subsidies will be available to individuals and families with household incomes up to 400% of the federal poverty level unless they have affordable minimum essential coverage available to them. Individuals and families with household incomes up to 250% of the federal poverty level will also be eligible for cost-sharing reductions.
4. ***Medicaid Expansion:*** The significant increase in the number of people eligible for Medicaid under the ACA will impact the demographics of the individual market.

The above provisions coupled with the underwriting limitations and rating requirements are expected to encourage previously uninsured individuals into the health insurance market. The relative health risk and expected cost of this population is a significant unknown. Issuers will need to work with regulators to develop reasonable assumptions related to the expected cost of these new enrollees.

C. Rating Requirements

The ACA also limits rating variations for non-grandfathered plans in the individual and small group markets, to the following:

1. ***Geographic Rating Area:*** States are charged with defining standard geographic rating areas, subject to approval by the Secretary ~~of HHS~~. The States will need to consider how narrowly to define geographic rating areas to balance affordability and access considerations for individuals in potentially high cost areas. The selection of geographic rating areas may also have an impact on risk adjustment in the state.

2. ***Age:*** Age factors will be limited to a ratio of 3 to 1 for adults; permissible age bands will be defined by the Secretary ~~of HHS~~ in consultation with the NAIC.
3. ***Benefit Coverage:*** Guidance with regards to flexibility related to benefit coverage factors has not been provided at the time of this writing. It is unclear, for example, whether benefit coverage factors could account for selection or utilization differences resulting either from group demographics or benefit design.
4. ***Family Structure:*** Guidance with regards to flexibility related to family structure factors has not been provided at the time of this writing.
5. ***Tobacco Use:*** Rating for tobacco use is limited to a ratio of 1.5 to 1. Note that HHS is still considering how tobacco use will be accounted for in the risk adjustment model they are developing. Use of tobacco rating factors may also have an impact on the affordability of health insurance. In addition, the most recent Internal Revenue Service (IRS) regulation on premium subsidies states that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.[5]

Note that the rating limitations above apply to large group insured, non-grandfathered plans beginning in 2017 if the ~~s~~State allows large group coverage to be offered through the Exchange.

Under the ACA, a ~~s~~State may further restrict use of rating factors, as long as the ~~s~~State law does not "prevent the application" of the federal law. For example, given that under the IRS regulation tobacco use penalties would not be reflected in the federal subsidy, and that such penalties are difficult to enforce, a ~~s~~State could prohibit rating based on tobacco use.

D. Risk Pools

The ACA also requires issuers to consider all enrollees in non-grandfathered plans within a given market (individual or small group) as part of a single risk pool. Grandfathered plans can be priced in their own risk pool. The States also have the option of merging the individual and small group markets into a single risk pool.

The States will need to consider how rates should be filed for effective dates starting in 2014. Since there will be a single risk pool in each of the individual and small group markets, the ~~s~~States may want to consider how the filing process may differ from historical methods, including evaluating whether or not all filings will need to be made on a plan basis in the future, or whether issuers may provide a single filing for non-grandfathered rates to reduce duplication.

Additionally, in those ~~s~~States that define small group as groups with 50 or fewer employees, the small group market will be expanded to include groups of up to 100 employees beginning in 2016.

E. Benefit Changes

Issuers of non-grandfathered plans will also need to price for several required benefit changes, including:

1. Coverage of ~~E~~essential ~~H~~health ~~B~~benefits (EHBs) that are expected to be defined at the state level by sometime in the third quarter 2012. Annual dollar limits will not be permitted on ~~Essential Health Benefits~~EHBs~~.~~;
2. Annual maximum out-of-pocket cost sharing for plan years beginning in 2014 will be limited to those in effect for health savings accounts in that year~~.~~;
3. Deductibles in small group plans will be limited; and
4. Non-grandfathered plans in the individual and small group markets (both inside and outside the Exchange) will need to meet actuarial value requirements such that each plan fits into a metal level of coverage (bronze, silver, gold, or platinum), except for the catastrophic plans offered to certain enrollees.

Note that the ~~s~~States may need to engage their actuaries as part of the form review process, to validate actuarial equivalence for benefit substitutions as defined in EHB guidance, along with verification of a plan's metal level.

F. Risk Mitigation Programs (Three Rs: Reinsurance, Risk Adjustment and Risk Corridors)

In order to mitigate selection and pricing risk for issuers, the ACA includes implementation of three risk mitigation programs. First is a temporary reinsurance program which reimburses non-grandfathered individual

[5] http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf

plans, both inside and outside the Exchange, for a portion of the cost of high cost enrollees. The aggregate amount of reinsurance payments will be fixed at a ~~s~~State level at decreasing amounts over three years (2014 through 2016). Second is a permanent risk adjustment program which will transfer funds from non-grandfathered individual and small group plans with a lower than average risk population to such plans with a higher than average risk population. The risk adjustment program will be budget neutral within each market (individual and small group) at the ~~s~~State level. Third is the federal risk corridor program.

The risk adjustment program is designed to equalize risks across plans within each applicable market. As a result, theoretically, all issuers should price their non-grandfathered individual and small group plans assuming they get an average risk population. In practice, however, risk adjustment is not perfect and does not account for all selection differences across plans. In addition, given other ACA changes, there is significant uncertainty related to what an average risk population will be, especially in the individual market. Once the market stabilizes and relative health risks across issuers are better known, plans should be able to price their plans based on anticipated risk adjustment payments and charges.

In the meantime, issuers will need to work with regulators to develop reasonable assumptions related to the impact of anticipated population changes in 2014. This pricing risk, based on high levels of uncertainty in the individual market, is intended to be addressed by ACA's third risk mitigation program, risk corridors. In this program, issuers participating in the individual and small group markets will be limited in their level of gains and losses for their QHPs in calendar years 2014 – 2016. Specifically, HHS will reimburse QHPs 50% of the difference between allowable costs and a target amount for differences between 103 and 108 ~~percent~~%, and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs in excess of 108~~ percent~~% of the target amount.

Conversely, HHS will charge 50% of the difference between allowable costs and a target amount for differences between 92 and 97~~ percent~~% and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs less than 92~~ percent~~% of the target amount. Risk corridors will be applied after reinsurance and risk adjustment. Issuers and regulators should consider the impact of risk corridors in determining reasonable levels of margin to include in rates for 2014 – 2016, as well as rate adequacy given the program subsidizes losses. Issuers and regulators will also need to consider the interaction of the risk mitigation programs with the calculation of medical loss ratio (MLR) rebates.

G. Medical Loss Ratio (MLR) Requirements

The ACA requires issuers to provide rebates to consumers if certain minimum ~~medical loss ratios~~MLRs are not met. Those ratios are, generally, 80% for the individual and small group markets and 85% for the large group market. A ~~s~~State may choose a higher level and several ~~s~~States have applied for and received adjustments that lower the ratio in the initial years (this applies to the individual market only). This requirement became effective calendar year 2011, with rebates paid by August of subsequent years.

Though the ~~medical loss ratio~~MLR requirement in ACA is a retroactive standard, some issuers may want to address the requirement prospectively in their rating to mitigate the risk of having to pay rebates. Note, however, that the MLR is calculated on a statewide aggregate level by segment, whereas rates are often at the plan level (and will be at the plan level of QHPs). Thus, some care should be taken when incorporating the MLR requirement into the rate review process and standards.

H. New Federal Taxes and Fees

Under the ACA, health insurance issuers will be required to pay new annual issuer taxes and fees beginning in 2014. Health insurance issuer excise taxes, calculated based on an ~~issuers'~~issuer's market share and using the previous calendar year premium as a proxy, are prescribed in the ACA[6] as follows:

Year	Amount (Billions)
2014	$8
2015	$11.3
2016	$11.3
2017	$13.9

[6] ACA §1406

© 2012 National Association of Insurance Commissioners

2018	$14.3
After 2018	Increased by premium growth

In addition, the non-deductible nature of the excise tax will require issuers to build in more than the actual fee amount into their premiums.

Other new fees or assessments that will likely be charged to health insurance issuers include: Exchange user fees; the reinsurance program assessment benefitting the individual market (totaling $25 billion from 2014-2016); the Patient Centered Outcomes Research Institute (PCORI) fee; and, in 2018, the excise taxes on high value health insurance that will apply in some cases.

I. Rating Inside and Outside the Exchange

Issuers offering QHPs in the Exchange must offer the "same premium rate" for plans offered inside and outside the Exchange and whether they're sold directly or through an agent. It is unclear what steps regulators will need to take to validate that this requirement is being met. The States may want to consider establishing a process that requires issuers to submit plan filings in the same manner both inside and outside the exchange.

The ACA includes additional rate review requirements for QHPs offered through the Exchanges. Exchanges are required to consider the following as part of QHP certification:

- A justification for a rate increase prior to the implementation of the increase;
- Recommendations provided to the Exchange by the State as required under the premium review grant program; and
- Any excess of rate growth outside the Exchange as compared to the rate of such growth inside the Exchange.

States with premium review grants are required to make recommendations to Exchanges regarding whether particular health issuers should be permitted to offer plans on the Exchange. This recommendation is based on a "pattern or practice of excessive or unjustified premium increases" and information regarding premium growth rates inside and outside of the Exchange. Those States that have not received a premium review grant can, of course, make the same recommendation to the ~~State-Based Exchange~~ SBE or the Federally Facilitated Exchange (FFE).

It is unclear at the time of this writing whether there will be a specific format for Exchange rate increase justifications, and whether those justifications need to be at a QHP level of detail, or some higher level (e.g., product or market). Concern exists over the granularity and credibility of the data should the justifications be required at the QHP level. Exchanges and regulators will also need to consider the measures to determine excess of rate growth outside the Exchange.

It is also important to note that issuers wishing to participate in Exchanges will need to submit plan level data as part of the QHP certification process. Some ~~s~~States may choose to review rates at the plan level outside the Exchange as well to ensure consistent processes across the markets. In addition, plans outside the Exchange will also need to meet the actuarial value requirements. If the ~~s~~States review actuarial values consistently inside and outside the Exchange, plan level data may need to be collected for the non-Exchange plans as well as the Exchange plans.

J. Small Group Considerations

The ACA has a specific definition of small group that might not be consistent with current ~~s~~State definitions. For example, the ACA counts employees using an average of the total number of employees on business days during the preceding calendar year, whereas some ~~s~~States may count only full time employees, or use some other counting method. Additionally, the ACA does not treat sole proprietors with no employees (other than a spouse) as small groups, which differs from their treatment in some S~~s~~tates.

The ACA definition applies to participation in the Small Business Health Options Program (SHOP) and calculation of the ~~Medical Loss Ratio~~MLR. States might consider aligning their definition of small group with that of ACA to avoid any confusion in the market.

© 2012 National Association of Insurance Commissioners

Another consideration in the small group market is the ability to set group-level rates in an employee choice model provided through the SHOP Exchange. It is unclear how group rates would be determined in an environment where employees of a given employer can select multiple plans from multiple issuers.

K. Rating of Grandfathered Plans

The ACA provides for the grandfathering of health insurance plans in which an individual was enrolled or was offered to a group on March 23, 2010.[7] While some provisions of the ACA do apply to grandfathered plans (e.g., MLR requirements, elimination of lifetime limits), the rating and benefit requirements, and many of the underwriting provisions above do not apply. The ACA also prohibits the ~~s~~States from requiring that grandfathered plans be pooled with non-grandfathered plans for rating purposes. Grandfathered plans are also not subject to the premium review disclosure requirements.

States will need to consider how to review rates for grandfathered plans. Grandfathered plans are not open to new groups or individuals. Because different coverage and rating rules apply to grandfathered plans, ~~s~~States may want to consider requiring separate filings for grandfathered vs. non-grandfathered plans.

L. Multi-State Plans and Co-Ops

The ACA directs the ~~Secretary~~Director of ~~the Office of Personnel Management (~~OPM~~)~~ to enter into contracts with health issuers (at least one must be a non-profit) to offer at least two multi-~~S~~state QHPs through each Exchange in each ~~s~~State.[8] It does not appear that multi-~~S~~state plans will go through the same certification process required by other plans offered through the Exchange. However, nothing in the ACA exempts multi-state plans from ~~s~~State laws or regulations.

The ACA also establishes ~~Consumer Operated and Oriented Plans (Co-Ops)~~CO-OPs to *foster the creation of qualified nonprofit health insurance issuers to offer QHPs in the individual and small group markets in the States in which the issuers are licensed to offer such plans.*[9] In those ~~s~~States where ~~Co-ops~~CO-OPs are established, they are required to be offered on the Exchanges and comply with all Exchange rules and other ~~s~~State laws and regulations.

The ACA requires a level playing field across health issuers, including multi-~~S~~state plans and ~~Co-Ops~~CO-OPs. Specifically, the ACA states, that *health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law… if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334, is not subject to such law.*[10]

There is nothing in the ACA that would preempt ~~s~~State laws and regulations for CO-OPs or multi-state plans. OPM has not yet published proposed regulations for the multi-state plans, but the NAIC has stated in a letter to OPM that multi-state plans will be required to comply with all ~~s~~State laws and regulations.

M. Stand-Alone Dental Plans

The ACA specifically states that stand-alone dental plans may be sold through the Exchanges. These plans must offer pediatric dental services, which are included as a required ~~Essential Health Benefit~~EHB in the ACA. The States will need to decide how rates for these plans will be reviewed and what rating rules will apply to them.

N. Wellness Program Discounts

In section 2705 of the ~~ACA~~PHSA, premium discounts for participation in wellness programs are allowed if they meet the criteria set forth in the ~~Public Health Service Act~~PHSA. How these discount programs interact with rating factors and their impact on the cost of coverage based on health should be considered by the ~~s~~States.

In addition, the most recent IRS regulation on premium subsidies states that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.

[7] ACA §1251
[8] ACA §1334
[9] ACA §1322
[10] ACA §1324

© 2012 National Association of Insurance Commissioners

V. Individual and Small Group Rate Review under the ACA

A. State Rate Review

1. Reporting of Certain Rate Increases

Prior to establishment of an Exchange, all issuers must submit rate increases in excess of the rate review threshold established in each ~~s~~State (currently set at 10% in every state) to the federal Health Information Oversight System, or HIOS. This requirement applies to all non-grandfathered products. States with ~~E~~effective ~~R~~rate ~~R~~review ~~programs~~systems will review the rates and determine whether rates are considered unreasonable. This determination and associated justification must be reported in HIOS. States that are determined to not have an ~~E~~effective ~~R~~rate ~~R~~review ~~process~~system will have those rate increases reviewed by HHS, though HHS has no authority to deny a rate increase.

Beginning in 2014, all QHPs in the Exchange will be required to report any rate increase to HIOS. Plans outside of the Exchange will only be required to report increases that exceed the threshold established in each ~~s~~State.

Under a state based system, it is assumed that the reasonable or unreasonable determination will be consistent with the ~~s~~State's own approval process. For example, if a ~~s~~State approves a filing, it will also find the rates to be "not unreasonable."

States receiving rate review grants have additional reporting requirements through HIOS. These include quarterly reports of the activity associated with the rate review grants, periodic conversations with CMS staff, and quantitative reports showing patterns of rate increases. SERFF has provided an interface with HIOS to allow states using SERFF to seamlessly report the rate activity in their quarterly HIOS reports.

2. Geographic Regions and Age Bands

States must report to HHS the proposed rating areas established for the individual and small group markets under Section 2701 of the PHSA. If a ~~s~~State does not establish the rating areas or HHS deems the rating areas inadequate, HHS will determine the rating areas for the ~~s~~State.

Section 2701 of the PHSA allows individual and small group market issuers to rate based on age provided that the age rates do not vary by greater than a 3 to 1 for adults. Age bands are required and the selected age bands must be approved by HHS after consultation with the NAIC. The NAIC Health Actuarial (B) Task Force has been working to develop guidance to HHS regarding the establishment of age bands.

As these provisions apply to products sold both on and off the Exchange, the ~~s~~States along with the NAIC should endeavor to establish the rating areas and age rating bands by the end of 2012 to provide adequate time for issuers to establish and submit rates for approval, both under ~~s~~State rating laws and as part of the QHP submission process. Time is critical: some issuers will need to submit rate filings as early as October 2012 in order to obtain approval by July 2013 for January 1, 2014, effective dates.

3. Consumer Disclosure

As required under ~~Per Section~~ §154.301 of the rate increase disclosure and review final rules,[11] ~~s~~States with ~~E~~effective ~~R~~rate ~~R~~review systems must post to ~~its~~their website Parts I and II of the Preliminary Justifications and provide a means for comments to be submitted on any proposed rate increases that exceed the state rate review threshold. The Center for Consumer Information & Insurance Oversight (CCIIO) has encouraged the ~~S~~states to provide links to the ~~C~~consumer ~~D~~disclosure forms on Healthcare.Gov rather than posting the ~~P~~preliminary ~~J~~justifications on their websites to ease the burdens on states to update the files on their own websites.

This process could be used to notify the Exchange of rate increases exceeding the ~~s~~State threshold. In addition, the website could be used to post rate increases for all QHPs to allow the Exchange to access all rate changes as part of their requirement to review patterns of rate increases. States should consider all options to

[11] http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf

communicate rate increases to the Exchange, especially those that leverage current processes and minimize duplicative effort.

4. General Rate Review Items

States will be motivated to maintain their "Effective Rate Review Program" status as it will be a sign to consumers that the ~~s~~State has a transparent premium oversight process and it will avoid the additional regulatory burden on health Insurance carriers of having to undergo both a ~~s~~State and federal rate review process.

The American Academy of Actuaries(AAA) has stated that effective premium oversight should be based on the following actuarial principles: health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges; premium oversight should be done in conjunction with issuer solvency oversight; premium oversight requires strong actuarial representation; appropriate risk-based capital (RBC) levels must be in place; premiums should be self-supporting and not subsidized by other lines of business; the premium- review process should be transparent and equitable for all issuers; the premium- review process should allow for adequate premiums that appropriately reflect past experience; and the premium review process needs to be coordinate between S~~s~~tate and federal regulatory entities.[12]

There are 13 areas of necessary review that are defined in the "Effective Rate Review Program" (45 CFR 154.301(a)(4)). One thing to keep in mind is that even if a ~~s~~State already reviews these items for reasonableness, they will now be required to examine the validity of the historical data underlying the assumptions used in rate development (45 CFR 154.301(a)(3)) and are expected to review the emerging actual experience in relation to the expected of each carrier as part of the rate review process (45 CFR 154.301(a)(3)). For many ~~s~~States, this will result in a more in depth actuarial review than they have performed previously.

a) The impact of medical trend, cost and utilization, and cost-sharing changes by major service categories

Since trend, cost and utilization, and cost-sharing will usually have the most material impact on proposed rates, this will be where the majority of the time is spent in the rate review process.

The States will need to perform trend analysis broken down by the required major service categories, and by unit cost vs. utilization pursuant to 45 CFR 154.301(a)(3). The medical trend will be analyzed at a more aggregate level, such as class of business. ~~Carriers~~Issuers need to submit the data used to develop the trend assumptions, prior projections of trend assumptions, and the actual trend realized in recent periods. In short, pricing actuaries are expected to report how well previous actuarial assumptions have compared to actual experience, and the basis for their current actuarial assumptions. This new requirement might be something that S~~s~~tate regulators are not accustomed to.

If there have been cost-sharing changes, ~~carriers~~issuers will need to show how the experience used for rate development has been adjusted and disclose the impact of the change. These disclosures could come in the form of changes in plan actuarial values or plan benefit factors.

b) The impact of benefit changes

Along with the impact on rates, carriers will need to show that they have adjusted the experience used in rate development. State regulators will need to be able to check that the effect of benefit changes ~~hasn't~~has not been double counted (once in the trend and again in the factors).

c) The impact of changes in enrollee risk profile

~~Carriers~~Issuers will be required to submit sufficient information to demonstrate that historical experience has been adjusted to reflect the anticipated enrollee risk profile.

[12] American Academy of Actuaries Premium Review Work Group comment letter to HHS regarding Section 2794 of the PHSA May 14, 2010

d) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase

Disclosing the impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase may help delineate what part of the rate increase request may be attributable to a prior misestimate. It should be noted that trend is calculated at an aggregated level and shouldn't differ by plan (with the exception of deductible leveraging). By breaking this out, this will help ~~the regulator~~State regulators better judge the reasonability of the filed rates.

e) The impact of changes in reserve needs

Reviewing the impact of changes in reserve needs will consist of a review of the completion factors used in reserve development. State ~~R~~regulators might want to evaluate the historical adequacy of the claim reserve by having ~~carriers~~issuers disclose how prior periods claim reserve compares with the actual claims paid. State ~~R~~regulators also might want to monitor the change in completion factors as this can skew trend estimations.

f) The impact of changes in administrative costs related to programs that improve health care quality and other administrative costs

Requesting that administrative costs related to programs that improve health care quality and other administrative cost be categorized in accordance with the federal MLR guidelines will allow the ~~s~~States to monitor the overall MLR level as defined by HHS. However, since some ~~s~~States have MLR targets that are independent of the federal guideline MLR requirement, they might choose to use their own reporting categorizations and definitions.

g) The impact of changes in applicable federal taxes, licensing or regulatory fees

~~Carriers~~Issuers should submit actual taxes, licensing or regulatory fees for a period corresponding to the base period used for claims experience as well as those anticipated during the projected period. If historical taxes, licensing and fee ratios vary materially from those used in pricing, an explanation should be given.

h) Medical loss ratio

~~Carriers~~Issuers should ensure their filed rates comply with applicable minimum medical loss ratio (MLR) requirements. Many ~~s~~States have established minimum MLRs on a prospective basis, often calculated as the present value of benefits divided by the present value of premiums. The federal government through the ACA has established a retrospective standard for minimum MLRs (see Section IV, item G). States should continue to enforce the ~~s~~State standards.

Some ~~s~~States have chosen to incorporate the federal minimum MLR requirements in their rate review process, thereby applying the federal standard on a prospective basis. It should be noted that a retrospective credibility adjustment should not be applied to a prospective loss ratio.

States that do not require ~~carriers~~issuers to price to the retrospective federal MLR may wish to have carriers state their intention to comply with the federal minimum MLR rebate requirements. States may also wish to request ~~carriers~~issuers provide an estimate of the federal MLR as further demonstration of anticipated compliance and to ensure that the range of potential rebates is reasonable.

i) The health insurance issuer's capital and surplus

Capital and surplus levels are already included in financial statements filed with the ~~s~~State~~,~~; therefore some ~~s~~States do not require ~~carriers~~issuers to include this in their rate filings.

j) Allowed case characteristics and community rating

The allowable case characteristics that are permitted in rate filings have varied historically state-by-state. Starting in 2014, all ~~s~~States will adopt modified community rating with the following set of allowable case characteristics:

- Geographic rating areas;
- Age;
- Family size/composition; and

- Tobacco use.

States will need to verify that the variation in rates created by each case characteristic complies with federally mandated ratios.

k) Risk Adjustment

As a result of guaranteed issue and community rating requirements, there will be increased adverse selection and ~~carriers~~issuers will have a decreased ability to vary premiums to appropriately reflect the specific risks they are insuring. In response to this, a risk adjustment mechanism will be implemented in 2014.

A risk adjustment mechanism will need to be calibrated so that it can financially compensate (or charge) carriers when the risk of their block of business is greater (or less) than the average risk in the market in a state. As a result, carriers will need to price their business based on the average risk pool of the state market rather than the average risk pool of their own block of business. It is not clear what tools or information will be given to ~~carriers~~issuers in order for them to be able to do this.

Further complicating the matter, any risk adjustment algorithm, not matter how good, will not perfectly compensate carriers for the risk of their member populations. As a result, ~~carriers~~issuers might add a degree of conservatism to their rates until they understand how the risk adjustment mechanism will affect their financial results.

State regulators will need to be aware that rate filings will include an adjustment for the ~~carriers'~~issuers' expected risk population compared to the expected average market risk, plus potential short-comings of the risk adjustment program.

It should be noted that the risk adjustment program, as envisioned by HHS, will be based on *relative*, not *absolute*, risk, so it will be virtually impossible for any ~~carrier~~issuer to assess its relative risk in the first year of operation of the risk adjustment program, and possibly longer given the timeframes for filing rates, timeframes for risk adjustment settlement, and data audit adjustments.

l) Temporary Risk Mitigation Programs

Starting in 2014 and lasting for three years, a reinsurance and risk corridor program will be in place to help stabilize the market.

i. Reinsurance

Reinsurance will affect pricing since a charge will be assessed against all market participants. Some might assume that overall the effect will be neutral since premiums should roughly equal claims. However, if reinsurance premiums collected are less than claims covered, then the reinsurance pool ~~won't~~will not be able to pay all reinsured claims. Because of this risk, it is possible that ~~carriers~~issuers will not treat reinsurance as revenue neutral, but will add an extra margin to their pricing to cover the added cost risk. This is due to the fact that the "premium" being paid into the reinsurance pools will be made by those in the small group, large group, self-insured and individual markets, while the "claims" will be reimbursed only in the individual market. The effective in each market is not neutral, even if the total premium equals total claims.

ii. Risk Corridor

The risk corridor likely ~~wouldn't~~ would not affect pricing or rate review of filings, at least initially.

m) Small Group – list bill vs. composite rating

As this relates to the manner of billing rather than rating or pricing one might reasonably expect that it would not affect the rate review.

5. Coordination of Regulatory Efforts with Exchange

a) Coordination of Frequency of Review

In an effort to minimize the regulatory burden on issuers and to promote efficient Exchange management, the Plan Management functions should generally be performed by the ~~s~~State's insurance department to the extent they have familiarity with and authority to perform the rate review function under Plan Management. ~~Many~~ In those ~~s~~States that require annual filings for rates, ~~and for those states we would recommend that~~ the QHP rate review should be coordinated with the issuer's annual rate filing. To the extent issuers submit rate filings less than annually, the Exchange, in coordination with the S~~s~~tate insurance department, should request premium renewal information from the issuer for purposes of evaluating patterns of rate increases.

b) QHP's

As required under ~~Per Section~~ §155.1020, an Exchange must receive justification for rate increase for a QHP prior to implementation. It is expected that Exchanges will leverage existing regulatory mechanisms to meet the Rate Review requirements under Plan Management.

c) Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act

Section 2794(b)(1)(B) of the PHSA requires the ~~s~~State's insurance commissioner to make recommendations, as appropriate, to the Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases. This provision explicitly involves the S~~s~~tate insurance commissioner; ~~and~~ therefore, ~~we recommend that~~ the S~~s~~tates should consider developing a process to review issuers' history of rate increases ~~and make~~for making recommendations to the Exchange. ~~We believe it is appropriate for s~~It is appropriate for State regulators to perform this analysis ~~to perform this analysis~~ and report to the Exchange on an annual basis unless the Exchange requests an interim review due to a recent pattern of rate increases.

6. Other Considerations

a) SERFF

The NAIC has established a project to build out the required Plan Management functions through SERFF, at the request of the members Proposed key functions to support rate review include navigation between rate/form filings and plans, managing plans within SERFF, communication and correction of issues by issuers, and state certification of plans according to state specific needs. A key component for rate review is the navigation function, which will permit SERFF users to leverage tie plan filings to existing or new forms and rates filed and approved with the state to satisfy the related components of the QHP review and certification process. The remaining components provide states and issuers with the necessary interface to manage and communicate issues, similar to the current SERFF functionality for rate and form filings.

The SERFF implementation team expects the release of the QHP management module to occur in December 2012, with the functionality for renewal and decertification to follow in the 2nd and 3rd quarter 2013. The Plan Management functions in SERFF are to support an ~~e~~Exchange regardless of whether it is a SBE, Partnership Exchange or FFE~~format (i.e., state-based, partnership or full federally facilitated)~~.

b) New vs. Existing Plans

The QHP certification process will be applied to all plans seeking QHP status on the Exchange effective January 1, 2014. This will include both the review of any rate increase as well as the evaluation of patterns of rate increases as required under Section 2794 of the PHSA. Once the Exchange has been established, new plans would be expected to follow the same process applied to plans seeking QHP status on January 1, 2014. Existing plans will have the same requirements but ~~s~~States can leverage prior evaluations of rate increase patterns to minimize the regulatory effort.

c) Grandfathered Plans

~~As~~Because grandfathered plans cannot be offered on ~~the~~an Exchange, it is expected the regulatory burden for grandfathered plans to be significantly less than non-grandfathered plans – for example, grandfathered plans are not subject to the federal rate review process. However, ~~s~~States should understand the size and composition of insureds remaining in grandfathered plans to understand the

© 2012 National Association of Insurance Commissioners

potential adverse selection effects on Exchange business. Also, ~~s~~States may apply the same rate review requirements on grandfathered plans.

Due to the numerous triggers resulting in the loss of grandfathered status, it is expected that the number of grandfathered plans will diminish significantly over time.

d) Catastrophic Plans

Section 1302(e) of the ACA allows issuers to offer catastrophic-type plans to individuals under the age of 30 that meet certain affordability or hardship standards. The plans will cover ~~essential health benefits~~EHBs, but will include deductibles equal to the amounts specified as out-of-pocket (OOP) limits for HSA-qualified high deductible health plans (HDHPs).

Since catastrophic plans are considered QHPs, the rate review requirements under QHP certification will apply equally to catastrophic and metal level plans.

e) Funding/Resources

Federal ~~R~~rate ~~R~~review ~~G~~grant funds have been made available to states for the purpose of upgrading rate review processes to meet the minimum federal standards for an effective rate review process. However, the continued availability of these funds is not guaranteed and, in fact, unlikely. As ~~s~~States consider enhancing rate review standards and processes the need for additional resources, and the sources of funds to cover those costs, need to be taken into consideration.

B. Federal Rate Review

1. Authority

Section ~~42 USC 300gg-94 of the ACA~~2794 of the PHSA requires the Secretary, in conjunction with the States to establish a process for the annual review of unreasonable rate increases in premiums for health insurance coverage. The ACA requires health insurance issuers to submit to the Secretary and the relevant S~~s~~tate insurance departments, a justification for a premium increase over the threshold amount prior to the implementation of the increase.

On May ~~19~~23, 2011, the ~~Center for Medicaid and Medicare Services (~~CMS~~)~~ ~~issued~~published in the *Federal Register* the final regulation on Rate Increase Disclosure and Review Requirements.[13] Pursuant to the regulation, CMS must determine if a ~~s~~State has effective rate review authority over health insurance. In 45 CFR 154.301, the criteria for determining whether or not a S~~s~~tate has an effective rate review program includes receipt of data and documentation sufficient to make the justification determinations required by federal law; timely and effective review of the reasonableness of assumptions; and effective review of the impact of changes to medical trend, utilization, cost-sharing, benefits, risk profiles, reserve needs, MLR and other information relating to administrative costs. In addition, the ~~s~~State's reasonableness determination must be made under a standard set forth in ~~s~~State law or regulation, and the ~~s~~State must provide public access to Preliminary Justifications.

If CMS determines that a ~~s~~State does not have "an effective rate review program," CMS will perform the review of rate increases equal to or greater than 10 % or any other "state-specific threshold" identified in later years. In 2011, CMS identified seven ~~s~~States that had ineffective rate review authority or no rate review authority, in whole or in part, over rates in the individual and small employer group non-grandfathered major medical health insurance market. CMS conducts the review of rate increases over 10% pursuant to 45 CFR Part 154 in those states.

When reviewing rate increases for an "ineffective" ~~s~~State, if CMS finds that a particular rate increase is "unjustified," "excessive," or "unfairly discriminatory," it will make a public announcement of that finding, post it on the CMS website, and require the health insurance issuer to post that finding on its website as well. CMS does not have the authority to "disapprove" a rate increase or prohibit an issuer from using the rate that it found to be unjustified. [45 CFR 154.205; 45 CFR 154.225]

[13] http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf

An issuer may choose to reduce its rate increase below the 10% and avoid the publicity. If the issuer lowers its rate increase, but not below the threshold, it must submit a new Preliminary Justification and CMS will review it again. If a health insurance issuer implements a rate increase determined by CMS to be "unreasonable," the issuer must submit a "Final Justification" to CMS that responds to the unreasonable rate increase determination and the health issuer must post the finding on its website. The information in the final justification must be consistent with the information filed in the Preliminary Justification. [45 CFR 154.230]

2. Federal Reporting Requirements

Beginning September 1, 2011, all non-grandfathered small employer group and individual market health insurance rate increases that are 10% or more (state specific thresholds may change in subsequent years), must be reported to the Secretary and the ~~s~~State insurance department, if that department has an effective rate review program. CMS will defer to the State's determination of reasonableness in states that CMS has determined to have an effective rate review program. [45 CFR 154.210] In states that do not have effective rate review, all rate increase information required to be reviewed under the regulation is filed with the Secretary through HIOS. CMS has actuaries on staff and under contract who review those rate increases. CMS will share information and discuss its review with the "ineffective" states, if the ~~s~~State insurance commissioner requests that information.

Health insurance issuers must submit to the Secretary a "Preliminary Justification" for each product affected by the increase on a form prescribed by the Secretary that contains the following information: the rate increase summary (Part I), a written justification of the rate increase (Part II) and rate filing documentation (Part III). An "ineffective" ~~s~~State can require that Parts I and II also be filed with its State insurance department. However, Part III is sent to CMS only. A single, combined Preliminary Justification can be sent for multiple products, if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same for all those products. The detailed content of Parts I, II and III is described in 45 CFR 154.215.

3. Consumer Disclosure

CMS posts Parts I and II of all Preliminary Justifications on its website. State i~~I~~nsurance ~~D~~ddepartments must also post this information on their websites.

The Preliminary Justification contains a rate increase summary (Part I) and the written description justifying the rate increase (Part II). The rate increase summary must include historical and projected claims experience, trend projections related to utilization, any assumptions related to benefit changes, allocation of premium increase to claims and non-claims cost, per enrollee per month allocation of current and projected premiums, and a three year history of rate increases for the product. The written description justifying the rate increase must include a simple and brief narrative describing the data assumptions used, including an explanation of the most significant factors causing the rate increase and a brief description of the overall experience of the policy, historical and projected. Part III of the Preliminary Justification contains documentation supporting the rate increase. Part III information will be posted only to the extent that it does not contain trade secrets or is otherwise confidential. CMS enables the public to comment on the Preliminary Justifications. [45 CFR 154.215]

CMS posts its determination and a brief explanation of its findings on its website. State insurance departments may also post the information. The health insurance issuer is legally required to prominently post on its website the information relating to CMS's determination of "unreasonable," if the issuer chooses to implement a rate increase determined to be unreasonable by the state or CMS. The issuer must also include its "Final Justification" for implementing the increase despite the unreasonable determination. The health insurance issuer must keep this information on its website for at least three years. [45 CFR 154.230]

4. Coordination with and Role of the States

CMS will coordinate its review with ~~s~~State insurance departments that have been determined to be "ineffective," if that ~~s~~State has some authority to review or investigate health insurance rates and is interested in being involved with the federal effort to implement and enforce the Health Insurance Issuer Rate Increases: Disclosure and Review Requirements regulations. State ~~I~~insurance d~~D~~epartment involvement may benefit consumers and assist with public disclosure.

VI. Exchange QHP Review

A. State Based Exchange

1. Authority

The ACA authorizes each ~~s~~State to establish an ~~American Health Benefit Exchange (~~Exchange~~)~~ by no later than January 1, 2014 for the purpose of facilitating the purchase of "QHPs."[14] The Exchange is only authorized to offer health plans which are certified as QHPs.[15]

2. Rate Review

a) QHP Certification

The ACA requires the Secretary ~~of HHS~~ to promulgate regulations to "establish criteria for the certification of QHPs."[16] It also authorizes an Exchange to certify health plans as QHPs ~~(QHPs)~~ if they meet certain requirements, including those specifically established by the Secretary through regulation.[17] A health plan may be certified as a QHP if the health insurance issuer demonstrates compliance with the minimum certification requirements stated in the regulations.[18]

Health plans seeking certification as QHPs must (1) "submit a justification [to the Exchange] for any premium increase prior to implementation of the increase" and prominently post the justification on their websites[19] and (2) agree to charge the same premium rate for each QHP it offers, regardless of whether the plan is offered through an Exchange or in the outside market.[20] Exchanges are specifically required to take the justification information submitted by health plans, along with information and recommendations provided by a State related to patterns of excessive or unjustified rate increases, into consideration when determining whether a particular health insurance issuer's plan(s) should be offered through the Exchange.[21] The Exchange is also required to consider information reported by a State regarding "any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange."[22]

b) Degree of overlap or independence with State DOI

As stated above, Exchanges are specifically required to take information and recommendations provided by a State's insurance regulator when determining whether a health plan should be available on the Exchange. HHS encourages Exchanges to minimize the potential burden on QHP issuers by leveraging the existing State rate review processes, including adopting the format currently being used by health issuers for the submission of rate justifications to the States,[23] but does not specifically prohibit Exchanges from conducting additional review of rate increases.[24] However, it is noted that an Exchange's consideration of rate increases is limited to determining whether a QHP should be offered on the Exchange.[25] It is also important to note that the requirement for a QHP to post a rate increase justification on its Web site is required regardless of whether the increase is considered an "unreasonable increase" and subject to review by a State.[26]

c) Comparison of rates and growth of rates inside and outside the exchange.

[14] ACA § 1311(b), 42 USC § 18031(b)
[15] 45 CFR §155.1000
[16] ACA § 1311(c), 42 USC § 18031(c)
[17] ACA § 1311(e), 42 USC § 18031(e)
[18] 45 CFR § 155.1000
[19] ACA § 1311(e), 42 USC § 18031(e); 45 CFR § 155.1020
[20] ACA § 1301(a), 42 USC § 18021(a)
[21] ACA § 2794(b), 42 USC § 300gg-94(b); 45 CFR § 155.1020
[22] ACA § 1311(e), 42 USC § 18031(e); 45 CFR § 155.1020
[23] ACA § 2794(a), 42 USC § 300gg-94(a)
[24] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,407 (March 27, 2012).
[25] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).
[26] 45 CFR § 156.210; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).

© 2012 National Association of Insurance Commissioners

As stated above, an Exchange is also required to consider information regarding excess premium growth outside the Exchange as compared to the rate of such growth inside the Exchange when considering the rate increase justifications submitted by QHPs. HHS notes that information about rates and rate increases for similar health plans being sold outside of the Exchange may be helpful in this process.[27]

d) SERFF[28]

In the fall of 2011 NAIC staff began discussions with HHS officials regarding the potential use of the existing SERFF system as a tool for the States to use when performing rate review functions associated with the certification of QHPs. The NAIC created a SERFF Plan Management Technical Study Group (TSG) to define the business requirements for the SERFF Plan Management project, with a focus on the capabilities that will be needed in early 2013 when issuers begin to submit their plans for QHP certification. These critical capabilities include: 1) creation and submission of plans by issuers; 2) review functions for approval and certification by the ~~s~~States and Exchanges; and 3) the ability to share plan data among Exchange-related software applications. Work to implement these functions will continue throughout 2012 and will be available to the States for use in 2013.

While the SERFF development team has been working on modifications to support Plan Management functionality related to Exchanges, SERFF will separate the code for the Plan Management portion of SERFF to greatly reduce the possibility of impacts to non-Plan Management SERFF customers. Users will sign in to SERFF with the same user ID and password they have today with the intent of presenting a look and feel consistent with the current SERFF user interface as the additional QHP-specific screens are developed. As with other aspects of SERFF, only the users who need to see and work with the additional Plan Management features will see the associated options in SERFF.

3. Coordination with State DOI

a) Effective Rate Review States vs. States Without Effective Rate Review Status

Although the regulations issued by HHS to date do not provide clear guidance regarding the role of the States that do not have an "effective rate review program" as it relates to Exchanges, these States may still have an obligation to assist Exchanges in meeting their QHP rate justification requirements. HHS has stated that CMS will determine whether rate increases subject to review under ~~Sec.~~section 2794 of the ~~ACA~~PHSA are "unreasonable" unless a State has an effective rate review program.[29] However, ~~Sec.~~section 2794 of the PHSA also requires the States that have been awarded Premium Review grants to make recommendations to Exchanges regarding whether particular health insurance issuers should be permitted to offer plans on the Exchange based on a "pattern or practice of excessive or unjustified premium increases" and information regarding premium growth rates inside and outside of the Exchange. Exchanges are required to take such recommendations into consideration.[30]

b) Coordination of Frequency of Review

Health insurance issuers offering QHPs in an Exchange must: (1) submit information on rates at least annually in a manner and form specified by HHS; (2) set rates for an entire benefit year or SHOP plan year; and (3) submit justification for any rate increase prior to the implementation of the increase.[31]

During the comment period for the Exchange regulation some commenters expressed concerns about the requirement to set rates for an entire benefit or plan year because of the possible need to establish new rates, quarterly or annually, to accommodate Federal or State regulatory changes. HHS declined to make an exception to the "entire year" rule because it determined that such regulatory changes are

[27] 45 CFR § 155.1020; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).
[28] NAIC HIX Bulletin, Issue 4, April 30, 2012
[29] 45 CFR § 154.210
[30] ~~ACA~~PHSA §-2794(b), 42 USC § 300gg-94(b); ACA § 1311(e), 42 USC § 18031(e).
[31] 45 CFR § 155.1020; 45 CFR § 156.210

© 2012 National Association of Insurance Commissioners

generally known to issuers well in advance and it believes the number of changes that would take effect in the middle of a benefit or plan year would be limited.[32]

c) Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act

See comments above.

4. Federal Reporting Requirements

a) HIOS

As addressed in other sections of this White Paper, the ACA requires States that receive Premium Review grants to provide quarterly reports to HHS, through ~~the Health Insurance Oversight System (~~HIOS~~)~~, regarding the number of rate filings received and reviewed, number requesting an increase, and number approved, denied or deferred.[33] States must also provide specific information about each filing, including the identity of each insurance company submitting a filing and the type and amount of the requested rate change. In addition, States that have an effective rate review program are also required to provide CMS with a final determination of whether a requested rate increase is unreasonable, which must include a brief description of its analysis of the rate filing and how it arrived at its determination.[34]

b) Other Reporting Requirements

In addition to the general rate review requirements, as stated above, States have specific reporting obligations related to Exchanges, including information related to "patterns or practices of excessive or unjustified premium increases" and information about the growth rate of premiums both inside and outside the Exchange.[35]

5. Consumer Disclosure

As stated above, all QHP issuers are required to submit to the Exchange a justification for all rate increases prior to their implementation and to prominently post these justifications on their ~~Web sites~~websites.[36]

6. Funding

Exchange Establishment Grant funds are available ~~for~~ to the ~~s~~States through 2015. These funds may be used to cover costs of establishing a ~~State-Based Exchange~~SBE, including upgrading systems and processes for rate review. However, funding for the on-going operation of the Exchange is a responsibility of the states. DOIs that will be performing additional functions for the Exchange will need to ensure additional costs are covered.

B. Partnership Exchange[37]

1. State Partnership with Federally Facilitated Exchange

In guidance issued in May 2012, HHS provided some insight into how a federal/~~s~~State partnership may work.[38] In such an arrangement, HHS would retain full authority and responsibility for the Exchange as a ~~Federally Facilitated Exchange~~FFE, but the ~~s~~States could choose to fulfill the Plan Management and/or Consumer Assistance functions of the Exchange.

[32] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).
[33] ACA § 2794(b), 42 USC § 300gg-94(b).
[34] 45 CFR § 154.210.
[35] ACA § 2794(b), 42 USC § 300gg-94(b).
[36] ACA § 2794(b), 42 USC § 300gg-94(b); 45 CFR § 156.210
[37] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18325-18,326 (March 27, 2012).
[38] http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf

In the May 2012 guidance, the various functions are broken down as follows:

Plan Management	**Consumer Assistance**
QHP certification, recertification, and decertification	Support, administer, and oversee Navigators
QHP certification review: • Licensure in good standing • Service area • Network adequacy • Essential Community Providers • Marketing Oversight • Accreditation • Essential Health Benefits • Actuarial Value • Discriminatory benefit design • Benefits of meaningful difference • Rates (new and increases)	Provide in-person assistance to consumers: • Filing an application • Receiving an eligibility determination • Renewing coverage • Comparing and selecting a coverage option • Enrolling in a QHP
QHP issuer account management	
QHP oversight and monitoring, including marketing	
Collect data	
Verify accreditation status and collect data for Exchange	
Collect and display quality data	
Coordinate with HHS on quality rating and enrollee survey	

A ~~s~~State choosing to partner with the ~~Federally Facilitated Exchange~~FFE must agree to fulfill all of the functions under Plan Management and/or Consumer Assistance in order to be a partner. States are eligible to receive federal Exchange Establishment grant funds, as a partner, to pay for additional expenses to prepare for fulfilling the partnership functions. It is still unclear how operational costs will be covered, or how the roles and responsibilities of the federal and ~~s~~State partners will be finalized, though likely through a Memorandum of Understanding.

The enhanced SERFF Plan Management functionality that will be available to the States with ~~state-based exchanges~~SBEs will also be available for use by States that chose to perform Plan Management as a part of a Partnership Exchange.

Further details on what will be expected of ~~s~~State partners are currently not available. States interested in partnering with the ~~Federally Facilitated Exchange~~FFE should begin discussions with their regional contact to ensure the ~~s~~State processes will meet the needs of the federal Exchange.

States must submit an application by November 16, 2012, expressing their intent to partner~~s~~ with the federal government and outlining their plan for fulfilling the functions by October 1, 2013.

2. Funding

States may receive funds from Exchange Establishment Grants for the cost of updating systems and processes to perform the plan management functions and/or consumer assistance functions required as part of the partnership agreement. These funds are available through 2015. The grant funds may also be used by the ~~s~~States to transition from a Partnership Exchange to a ~~State-Based Exchange~~SBE.

However, how ongoing operation costs will be covered is yet unclear. Will the ~~s~~State be responsible for raising the funds to cover operational costs? Will the ~~s~~State~~s~~ be reimbursed by the ~~Federally Facilitated Exchange~~FFE? Additional guidance and discussion is needed on this issue.

© 2012 National Association of Insurance Commissioners

C. Federally Facilitated Exchange

1. Authority

If a State fails or elects not to establish a ~~State-based Exchange~~SBE, HHS is authorized to establish and operate an Exchange within the State.[39] HHS has stated that ~~Sect.~~section 1321 of the ACA "does not contemplate divided authority over an Exchange" and HHS "retain[s] ultimate responsibility and authority over operations and all inherently governmental functions" of a ~~Federally-facilitated Exchange~~FFE.[40]

In guidance published in May 2012, HHS indicated that under a ~~Federally Facilitated Exchange~~FFE all QHP certification functions, including the review and approval of QHP premium rates, would be performed by HHS. However, States would also retain all existing statutory authority related to the review and/or approval of premium rates consistent with the procedures described in other sections of this White Paper, including those rates used by issuers for QHPs sold through the ~~Federally-facilitated Exchange~~FFE operating within the state. HHS has acknowledged that certification of a QHP rate filing by the Exchange would be contingent upon a State's approval of the submitted rate, if appropriate. In addition, as stated above, States that received Premium Review grants would presumably continue to fulfill their obligations to provide the Exchange with information about rate practices and trends both within and outside of the Exchange.

2. SERFF

The enhanced SERFF Plan Management functionality that will be available to the States with state-based and ~~p~~Partnership ~~e~~Exchanges will also be available for use by those States that utilize the full ~~federally facilitated exchange~~FFE model in order to enable ~~s~~States to affirm plans are approved for use within ~~the~~a ~~s~~State, where the ~~s~~State has the regulatory authority to approve or disapprove.

[39] ACA § 1321(c), 42 USC § 18041(c); 45 CFR § 155.105.

[40] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,326 (March 27, 2012).

© 2012 National Association of Insurance Commissioners

Draft: 7/18/12

Limited Medical Benefit Plan (B/D) Working Group
Conference Call
June 8, 2012

The Limited Medical Benefit Plan (B/D) Working Group of the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee met via conference call June 8, 2012. The following Working Group members participated: Stephen W. Robertson, Chair (IN); Ted Nickel, Vice Chair (WI); Peg Brown (CO); Barbara Spear (CT); Trey Sivley (GA); James Morris (IL); Ted Clark (KS); David Blair (KY); Paul Boudreaux (LA); Bob Wake (ME); Therese M. Goldsmith (MD); Michael Draminski (MI); John Hornback (MS); Angela Nelson (MO); Michael Winsor (MT); Holly Blanchard (NE); Bob Lisson (NC); Gayle Woods (OR); Randy Moses (SD); Chlora Lindley-Myers (TN); Tanji Northrup (UT); Christina Rouleau (VT); and Gayle Pasero (WA).

1. Discuss Working Group's Charges

Commissioner Robertson began by thanking the consumer representatives for submitting a letter on the issue of expanding the Working Group's charges. The letter asked the Working Group to add "excepted benefit plans" and "mini-med plans" to their consideration of what is an appropriate limited medical benefit product. The letter expressed concern that the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) contains a broad description of a limited medical benefit plan.

Commissioner Robertson stated that he discussed the issue with the chair of the Health Insurance and Managed Care (B) Committee, and the consensus was that the Committee should review the charges of the Working Group at their next meeting. Commissioner Robertson asked the members of the Working Group and interested parties for comment.

Barbara Yondorf (Colorado Consumer Health Initiative) stated that the consumer representatives appreciated the discussion and reiterated the position that they did not believe that addressing excepted benefits was an expansion of the charges. Timothy Jost (Washington and Lee University School of Law) added that the definition of "limited medical benefit plan" and the regulation of those plans would be necessary, regardless of how the U.S. Supreme Court rules on the constitutionality of the federal Patient Protection and Affordable Care Act (ACA).

Commissioner Robertson stated that he appreciated the consumer representatives' position. He said that the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee would proceed with addressing the Working Group's charges at the Summer National Meeting.

Having no further business, the Limited Medical Benefit Plan (B/D) Working Group adjourned.

W:\National Meetings\2012\Summer \Cmte\B\Limited MedicalWG\6-8-12 ConfCall Minutes.docx

© 2012 National Association of Insurance Commissioners

Draft: 8/22/12

Limited Medical Benefit Plan (B/D) Working Group
Conference Call
May 9, 2012

The Limited Medical Benefit Plan (B/D) Working Group of the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee met via conference call May 9, 2012. The following Working Group members participated: Stephen W. Robertson, Chair (IN); Ted Nickel, Vice Chair (WI); Peg Brown (CO); Barbara Spear (CT); Ted Clark (KS); David Blair (KY); Paul Boudreaux (LA); Bob Wake (ME); Therese M. Goldsmith (MD); Michael Draminski (MI); John Hornback (MS); Angela Nelson (MO); Michael Winsor (MT); Holly Blanchard (NE); Bob Lisson (NC); Gayle Woods (OR); Randy Moses (SD); Chlora Lindley-Myers (TN); and Christina Rouleau (VT).

1. Discuss 2012 Charges and Priorities

Commissioner Robertson began by asking the consumer representatives to discuss their letter on the issue of expanding the Working Group's charges. The letter asked the Working Group to add excepted benefits to their considerations of what is an appropriate limited medical benefit product. The *Accident and Sickness Insurance Minimum Standards Model Regulation* (#171) contains a broad description of "limited medical benefit plan." Commissioner Robertson said that including excepted benefits in the charge and amending the NAIC models would require clarification from the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee. The consumer representatives stated that they believed that reviewing the issues surrounding the utility of these plans post-2014 was included in the current charge. Commissioner Robertson said that it was premature to recommend changes to the models prior to the U.S. Supreme Court issuing its opinion on the constitutionality of the federal Patient Protection and Affordable Care Act (PPACA). Bonnie Burns (California Health Advocates) stated that, regardless of the ruling, these products will continue to exist in some form and the issues will remain. Commissioner Robertson said that he would speak with the chairs of the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee and request clarification on where the Working Group should focus its efforts.

2. Any Other Matters

Commissioner Robertson asked NAIC staff for a description of the NAIC's Special Activities Database (SAD). Mr. Draminski stated that the database only covers licensed individuals. Mr. Blair said that the SAD was envisioned to be an early warning and avoid problems associated with the Freedom of Information Act. Commissioner Robertson asked if any state actually used the database. Ms. Spear and Ms. Nelson said their licensing and fraud units use it. Mr. Blair said the NAIC's Regulatory Information Retrieval System (RIRS) database covers more state action items, while SAD includes broader information including non-actions.

Having no further business, the Limited Medical Benefit Plan (B/D) Working Group adjourned.

W:\National Meetings\2012\Summer \Cmte\B\LimitedMedicalWG\5-9-12 ConfCall Minutes.docx

© 2012 National Association of Insurance Commissioners

Draft: 8/14/12

Health Care Reform Regulatory Alternatives (B) Working Group
Atlanta, GA
August 13, 2012

The Health Care Reform Regulatory Alternatives (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Atlanta, GA, Aug. 13, 2012. The following Working Group members participated: Michael F. Consedine, Chair (PA); Ted Nickel, Vice Chair (WI); Bret S. Kolb (AK); Kevin M. McCarty (FL); Sandy Praeger (KS); Tom Record (ME); Monica J. Lindeen (MT); Louis Belo (NC); Christy Neighbors (NE); Adam Hamm (ND); Barbara Richardson (NH); Glenn Shippey (NV); Chlora Lindley-Myers (TN); Cassie Brown (TX); Neal T. Gooch (UT); Mike Kreidler (WA); and Tom C. Hirsig (WY).

1. Welcome and Opening Remarks

Commissioner Consedine began the meeting by discussing the need for a working group to address the needs of those states and territories that will not be operating a state-based health insurance exchange (SBE). Jurisdictions that will have a federally facilitated exchange (FFE), or that will be participating in a Partnership exchange will face a number of questions regarding their authority outside of the exchange and within it. He noted that this new Working Group will help answer these questions, as well as help regulators make informed choices about what type of exchange would operate in their jurisdiction and other implementation choices. He also noted that the Working Group is not intended as a forum for criticism of the federal Affordable Care Act (ACA), but for discussion of important issues regarding state authority and preemption issues.

2. Review of Working Group's Charges

Commissioner Consedine reviewed the Working Group's charges (Attachment Five-A), noting that they had been carefully crafted to include the territories and to address their specific situation under the ACA. The Working Group will be focusing on Partnership exchanges and FFEs, examining the impact of these types of exchange models on state regulatory authority. The Working Group also will be compiling and getting answers to a running list of questions to which the states and territories need answers in order to make informed decisions about non-SBE options. Additionally, many of the states and territories have questions about the preemption of a number of NAIC model laws and state laws, such as those addressing producer licensing. Finally, Commissioner Consedine said that the Working Group will provide an opportunity for the states and territories to explore new solutions to some of the problems facing health insurance markets that were not addressed by the ACA.

Commissioner Nickel added that, as the Working Group identifies potential innovations and regulatory ideas, it could share them with the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) and the U.S. Department of Health and Human Services (HHS). Commissioner Kreidler suggested that the Working Group also identify opportunities that the states and territories might forego by allowing an FFE to be established. Commissioner Hamm agreed that identifying these opportunities would be useful, but said that the most important thing would be for the Working Group to identify the options that the states and territories have and the regulatory consequences of those options.

3. Discuss List of Questions for the Working Group to Address

Commissioner Consedine also noted the work that the Health Insurance and Managed Care (B) Committee had done, such as the plan management white papers and the list of state decisions related to the different exchange options. He asked the Working Group to inform NAIC staff about their preferences for prioritizing the Working Group's charges and potential options that it should explore. The Working Group would then begin to expand upon the list of options that had been compiled by NAIC staff and focus on the implications of each option. Commissioner Kreidler also suggested considering the impact of decisions regarding Medicaid expansion and the impact those decisions would have on health insurance premiums inside and outside of the exchanges. Commissioner Consedine agreed that the decisions regarding Medicaid expansion would have an impact on coverage in the exchanges and said that if information about that impact was readily available, it would be helpful to the Working Group, but that time constraints would force the Working Group to concentrate on health insurance issues.

© 2012 National Association of Insurance Commissioners

4. Timetable and Next Steps

Commissioner Consedine said that the Working Group would hold a series of calls to begin vetting issues identified by the states and territories once the Working Group's membership had been identified, probably by the end of September. Commissioner Hamm agreed and said that the issues should be categorized and the Working Group should hold a call to develop a work plan. Timothy Jost (Washington and Lee University School of Law) told the Working Group that he strongly approved of its creation and the tasks before it and reiterated the importance for consumers of having well thought-out cooperation between the state insurance departments and the exchanges. Candy Gallaher (America's Health Insurance Plans) also expressed support for the Working Group and its charges. Mr. Belo noted that deadlines were quickly approaching, including the Nov. 16 deadline for submission of state exchange blueprints to HHS, and that the Working Group will need to begin holding calls well before the end of September. Commissioner Consedine agreed and said that the Working Group would move forward quickly.

Having no further business, the Health Care Reform Regulatory Alternatives (B) Working Group adjourned.

W:\National Meetings\2012\Summer\Cmte\B\HCRRAWG\08-HCRRAWGmin.docx

© 2012 National Association of Insurance Commissioners

Additional Charge to B Committee

Appoint a **Health Care Reform Regulatory Alternatives (B) Working Group** to:

1. Provide a forum for discussion of and guidance on the alternatives to implementing a PPACA compliant state-based exchange and the implications of such alternatives on NAIC Member regulatory authority.

2. Identify and assist Members in resolving open issues that need to be addressed with regard to non-state exchange PPACA alternatives.

3. Analyze impact of PPACA on existing Member regulatory authority both inside and outside of a federal exchange as well as the impact on NAIC Model Laws (Unfair Insurance Practices Act, Producer Licensing Model Act, Model Law on Examinations, etc.)

4. Identify opportunities for Members to continue to innovate and regulate outside of a federal exchange.

W:\National Meetings\2012\Summer\Cmte\B\HCRRAWG\Working Group Charge.docx

© 2012 National Association of Insurance Commissioners