Connecticut Health Insurance Exchange

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Access Health CT (AHCT)

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

Plan Year 2022

Release Date: April 23, 2021

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I. General Information and Background

The Connecticut Health Insurance Exchange dba Access Health CT (AHCT) is soliciting applications from health insurance Issuers ("Issuers") to market and sell Qualified Health Plans ("QHPs") through the AHCT marketplace for the 2022 plan year. The Solicitation defines the requirements an Issuer must comply with to participate in the AHCT Individual and/or the Small Business Health Options Program (SHOP) marketplaces. All requirements listed herein pertain to both the Individual and SHOP marketplaces, unless otherwise expressly noted.

This Solicitation may be amended by addenda as necessary to assure compliance with state and federal laws. AHCT will post any amendments to this Solicitation on its website.

Issuers participating in the AHCT Individual marketplace must agree to offer QHPs to any eligible consumer seeking to purchase such coverage for a term of twelve (12) months for coverage beginning on January 1st of a given plan year, or a term that shall last for the remainder of the plan year when coverage starts on February 1st or later in a given plan year. The open enrollment period for the 2022 plan year will begin on November 1, 2021 and end on December 15, 2021. AHCT reserves the right to modify the dates of this open enrollment period. The Issuer will also agree to offer its QHPs during special enrollment periods to eligible consumers or enrollees, and their eligible co-beneficiaries, where applicable, who may experience a valid change in circumstances as defined in 45 C.F.R. §155.420.

Issuers participating in the SHOP marketplace must permit a qualified employer to begin to offer coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage (45 C.F.R. §155.726(b)) and last for the following 12 months after the effective date. Issuers offering QHPs through the SHOP marketplace must also charge the same contract rate for each month of the applicable small employer's policy year in accordance with 45 C.F.R. §156.286(a)(3).

AHCT offers Issuers a statewide marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance. Only health plans certified as a QHP by AHCT can be sold through the AHCT marketplace.

AHCT is the only distribution channel in Connecticut through which individuals and small employers are able to purchase coverage that may provide for certain insurance affordability programs, including:

- Premium tax credits and/or reduced cost-sharing plan variants for individuals and families purchasing health insurance through the individual marketplace whose household income makes them eligible for this financial assistance;
- An Alaska Native/American Indian (as defined in 45 C.F.R. §155.300) plan and a limited cost sharing plan variant for each plan offered by a QHP through the Individual marketplace in accordance with 45 C.F.R. §155.350; and

- Small Business tax credits available to eligible employers offering coverage in the SHOP marketplace.

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

The QHP certification process and requirements for the 2022 plan year maintain many aspects of the processes and requirements carried out for previous plan years, including close coordination and collaboration with the Connecticut Insurance Department (CID).

In setting the certification requirements outlined in this Solicitation, AHCT was guided by its mission to increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

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

A. Regulatory Filings

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

Any determinations by AHCT to certify a health plan as "qualified" will be conditional upon the CID approving rate and form filings.

B. Separate Billing and Segregation of Funds for Abortion Services

In accordance with 45 C.F.R. §156.280, an Issuer offering coverage for non-excepted abortion services should, as a condition of participating in the AHCT marketplace, submit a plan to the State Insurance Commissioner that details its process and methodology for complying with the segregation of funds requirements. For additional information, please refer to the CID Bulletin No. MC-21.

C. Solicitation Process and Timetable

The following schedule includes key dates and deliverables pertinent to PY2022 Issuer and QHP Certification. Please note these target dates are subject to change.

Plan Year 2022 Key Deliverable/Milestone	**Target Dates** *(Dates are subject to change)*
AHCT Board of Directors Meeting to Approve Recommended AHCT Standardized Plan Designs and Certification Requirements Changes	April 15, 2021
Release AHCT QHP Issuer Solicitation Package and Non-Binding Notice of Intent	April 23, 2021
Issuer Completed QHP Non-Binding Notice of Intent Due to AHCT	May 5, 2021
Release AHCT QHP Issuer Application Package	May 12, 2021
Issuer Rate and Form Filings Due to Connecticut Insurance Department	July 2, 2021
Issuer Completed QHP Application, Plan and Rate Template Data, Supporting Documentation Due to AHCT	July 2, 2021
AHCT Review of QHP Issuer Data Submissions/Resubmissions	July 6 – September 15, 2021
AHCT/Issuer Discussions to Address/Resolve QHP Data Submission Issues	July 6 – September 15, 2021
Issuer Preview/Approval of Individual & SHOP PLAN Data in AHCT Plan Management Portal (PMP) Staging System	September 7 – September 10, 2021
Issuer Preview/Approval of Individual & SHOP RATE Data in AHCT Plan Management Portal (PMP) Staging System	September 21 – September 23, 2021
AHCT Certifies Individual and SHOP Plan Data/Release to CMS	October 14, 2021
AHCT Activates Certified/Approved AHCT QHP Plan Data	October 14, 2021
AHCT Publishes QHP Plan Data in AHCT Consumer Portals	November 1, 2021
Commence Plan Year Open Enrollment Period	November 1 – December 15, 2021

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

All Issuers seeking participation in the Individual marketplace and/or the SHOP marketplace must submit *the '**Non-Binding Notice of Intent (NBNOI) to Submit Qualified Health Plans'.*** An Issuer cannot apply without first submitting the NBNOI, unless pre-approved by AHCT. Only those Issuers acknowledging interest in this Solicitation by submitting the NBNOI will continue to receive Solicitation related correspondence, including the 2022 AHCT QHP Application.

Submission Instructions and Deadlines for NBNOI:

1. Please complete the form titled "**Non-Binding Notice of Intent (NBNOI) to Submit Qualified Health Plan"**. The NBNOI is available at: https://agency.accesshealthct.com/healthplaninformation#one
2. Issuers should submit this form via email to the AHCT person of contact identified in Section E no later than **May 5, 2021**.
3. Please make sure the email subject line reflects: "Non-Binding Notice of Intent to Submit Qualified Health Plans".
4. The Issuer will receive a response confirming receipt of the submission.
5. Any subsequent updates to this Solicitation will be communicated directly to the authorized representative identified in the Issuer Non-Binding Notice of Intent

E. Authorized AHCT Contact for Solicitation

AHCT authorized Contact for all matters concerning this Solicitation:

Name: **AHCT Plan Management**

E-Mail: CTHIX-Issuers@ct.gov

All questions to, and requests for information from AHCT concerning this Solicitation by a prospective Issuer or a representative or agent of a prospective Issuer, should be directed to the Authorized Contact. Please include "Access Health CT 2022 QHP Solicitation" in all correspondence. Questions should be in writing and submitted via the e-mail address noted above. All answers to questions, and any Addenda to this Solicitation, will be made available to all prospective Issuers.

F. Eligibility and Enrollment

a. Individual Marketplace

AHCT is responsible for the enrollment process and all eligibility determinations of individuals and families. Licensed certified brokers, as defined in 45 C.F.R. §155.20, may assist individuals and/or their authorized designees with QHP selection and AHCT may provide enrollment assistance.

In addition, all eligibility changes must be made through AHCT.

AHCT will perform primary verifications through the Federal Data Services Hub (FDSH).

Please refer to Chapter 45, Section 155, the US Code of Federal Regulations for eligibility requirements. All eligibility determinations, re-determinations and changes will be made in accordance with federal and state law and in accordance with the terms of the Issuer Agreement and any related transactions between the Issuer and AHCT, which serve to amend or clarify such documents or applications of law. AHCT will distribute an 834 Companion Guide to all participating Issuers, which will include the specifics with regard to transactions and the coding of transactions.

b. Small Business Health Options Program (SHOP) Marketplace

Licensed certified brokers, as defined in 45 C.F.R. §155.20, may assist small employers, and the employees of those groups, with QHP selection and AHCT may provide enrollment assistance.

AHCT's SHOP vendor transfers data electronically between the SHOP vendor and Issuers. The SHOP vendor produces a single premium invoice to the small employer for the total premium dollars due. The small employer remits the premium due (both employee and employer contributions) to the SHOP vendor. The SHOP vendor processes the small employer premium payments by disbursing the applicable amount to the appropriate Issuer. The SHOP vendor is also responsible for sending an aggregated broker commission payment to the individual brokers for all enrollees the broker has assisted.

G. Qualifying Events and Special Enrollment Periods

AHCT grants a special enrollment period (SEP) for qualifying life events (QLE) that occur outside of Open Enrollment in accordance with 45 C.F.R. §155.420 for the Individual marketplace and 45 C.F.R. §155.726(c) for the SHOP marketplace.

Per federal regulation, Special Enrollment Periods (SEP) of sixty (60) days begin on the date of the qualifying life event (QLE) or, in the case of a future loss of coverage, the SEP begins sixty (60) days prior to the end date of coverage. Effective dates of coverage are assigned according to federal regulation and are based on the date an individual attests to having experienced a QLE and enrolls in a plan unless in the case of a future loss of coverage for which the coverage effective date is the first day of the month following the end date of the coverage.

H. Grace Periods

a. Individual Marketplace

i. Enrollees Receiving Advance Premium Tax Credit

Issuers must adhere to the requirements in 45 C.F.R. §156.270 in determining grace period and termination procedures due to non-payment of the premium for enrollees receiving an Advanced Premium Tax Credit (APTC). Currently, the grace period for those receiving APTCs is as follows:

1) During the first month where premium is in arrears, coverage shall remain as if the account was not in arrears;

2) During the second and third months, the Issuer may pend claim payments on any claims received but may not limit an enrollee's access to coverage. Issuers may notify a requesting provider of the status of an enrollee's account;

3) The account may be cancelled at the end of the ninety (90) day grace period back to the end of the first month of the current grace period if the consumer fails to make all payments due by the end of the ninety (90) days. The APTC payments received by the Issuer may be kept for the

first month only and the Issuer may seek payment of any remaining premium due through any lawful collection action. The Issuer shall remit back to the federal government, upon cancellation, any APTCs received by the Issuer on behalf of the enrollee for the second and third months of the grace period wherein coverage for the second and third months has been deemed not effective.

ii. Enrollees Not Receiving Advance Premium Tax Credit

AHCT will require Issuers to comply with a 30-day grace period for the enrollees not receiving APTCs.

iii. Guaranteed Availability of Coverage and Premium Collection Methods

Participating Issuers may require payment of past due premiums before effectuating coverage for a new coverage year but cannot do so without advance notification to AHCT and enrollees*.

** Outlined in the 'Guaranteed Availability of Coverage' section (§ 147.104) of the preamble to the 2017 Market Stabilization Rule (82 FR 18346) as finalized April 18, 2017.*

b. SHOP Marketplace

AHCT has established a 30-day grace period for small employers that do not pay the premium on time. To account for months with less than 30 days, the grace period extends to the end of the month.

I. Office of Personnel Management (OPM) Certification of Multi-State Plan (MSP) Options

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

AHCT requires MSP Issuers to comply with all of the standards and requirements set forth in AHCT's Issuer QHP Application for Participation and all applicable Federal and Connecticut State laws that may apply to either health insurance, in total, or Exchanges. Additionally, Issuers offering an MSP Option on the AHCT marketplace must be distinguished from any other Issuer participating on the AHCT marketplace by Issuer HIOS Plan ID number(s) and plan marketing name(s).

J. Amendment(s) to Solicitation

AHCT reserves the right to amend this Solicitation as may be necessary to assure compliance with state and federal laws. AHCT will post any amendment(s) to this Solicitation on its website, https://agency.accesshealthct.com/healthplaninformation#one.

II. QHP Application Components and Certification Requirements

This section outlines the various components that AHCT will require for Plan Year 2022 QHP certification. The forthcoming QHP Application and any associated guidance related to its submission, including any supporting documentation, will be provided to the Issuer primary point of contact identified in the NBNOI.

The QHP Application will collect Issuer information, as well as benefit information and rate data, largely through standardized Federal QHP data templates, and supporting documentation. Additionally, Issuers will be required to attest to adherence to the regulations set forth in 45 C.F.R. parts 155 and 156 and AHCT requirements. AHCT has also adopted the requirements set forth in 45 C.F.R. § 156.340 whereby Issuers maintain responsibility for the compliance of their delegated and downstream entities.

AHCT will grant Issuer and QHP certification for one year, providing Issuer meets all requirements. Issuers interested in offering QHPs through AHCT marketplace in subsequent plan years must seek recertification on an annual basis.

A. Issuer General Information

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

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

B. Issuer Compliance and Performance Oversight

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

- Designation of a compliance officer and compliance committee
- Written policies and procedures and documentation of proven adherence
- Effective communication among all levels of the company ensuring a shared responsibility to compliance
- A record retention policy, not less than 10 years for any information related to CSR or APTC

- Compliance education and an effective training program
- Compliance metrics as part of an employee performance appraisal process and compliance standards enforced through well-publicized disciplinary guidelines
- An internal audit process and the monitoring of such
- Corrective action plan initiatives to monitor and respond to detected offenses
- A statement of corporate philosophy and codes of conduct

Further, the Issuer will be required to attest that its compliance plan adheres to all applicable laws, regulations, and guidance and that the compliance plan is implemented or ready to be implemented.

AHCT intends to monitor and evaluate an Issuer's performance using information received by AHCT from sources such as but not limited to, the CID, Office of Healthcare Advocate, consumers, and providers. AHCT will utilize complaint data, Issuer self-reported problems, information related to consumer service and satisfaction, health care quality and outcomes, Issuer operations, and network adequacy in its assessment of Issuer's performance in the marketplace.

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

C. Licensure and Financial Condition

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

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

Issuers applying for QHP certification must be able to demonstrate State licensure and good standing prior to the beginning of the annual open enrollment period. AHCT will obtain information regarding licensure and good standing directly from the CID.

D. Market Participation

An Issuer may elect to participate in either the Individual marketplace or SHOP marketplace, or both.

- If participating in the SHOP, the Issuer must agree to fully participate in each of the AHCT's purchasing options. The three options are Issuer Bundle, Metal Tier Bundle, and Single Plan option. Each choice model is defined below:
    - **Issuer Bundle (Vertical Choice)**: Allows an eligible employer to offer their eligible employees plan options from all available "metal tiers" from any one selected Issuer (i.e. any 'Issuer A' plan in any metal tier);
    - **Metal Tier Bundle (Horizontal Choice)**: Allows an eligible employer to offer their eligible employees plan options from all participating Issuers, across any one selected "metal tier" (e.g. any Silver plan from any of the Issuers);
    - **Single Plan**: Allows an eligible employer to offer their eligible employees one plan design in any one metal tier from any one Issuer for group offering.
- AHCT will only calculate and display premiums based on the total of the individual premiums of covered participants and beneficiaries as described in 45 C.F.R. § 147.102(c)(1).

E. Marketing Guidelines

All marketing materials for any QHP offered through AHCT must be reviewed and approved in advance by AHCT. Issuers must allow up to fifteen (15) business days for AHCT's review and approval prior to the materials being published and/or released.

Issuers may display or make reference, verbally or otherwise, to an Issuer calculator for the purpose of estimating a consumer's eligibility for APTCs or other affordability programs, but only if the Issuer informs AHCT of this intended reference and includes required AHCT Subsidy Calculator Disclaimer language any time an Issuer's calculator is referenced and/or displayed, which is as follows:

> *"The information from the (Carrier name) calculator is an **estimate** of your eligibility for a federal subsidy. Only Access Health CT can determine your eligibility to receive federal subsidies, and the amount of your subsidy. The (Carrier name) calculator may give you a different amount or eligibility result because it does not contain all of the information that Access Health CT uses to determine your **official** subsidy."*

Affordability program eligibility assessment and enrollment is the sole responsibility of AHCT.

Currently AHCT does not permit co-branding of an Issuer's brand or logos with those of AHCT without AHCT's express written prior approval. Specifically, Issuers are not permitted to use AHCT's name or logo in any of their marketing materials. In addition, Issuers' marketing material cannot include a reference to the "Exchange" "Marketplace" or "Connecticut Exchange" or any other word or sequence of words used with the intent to express a connection with AHCT or which may lead a consumer to reasonably assume a connection between AHCT and the issuer exists without express prior approval from AHCT.

AHCT requires the Issuer's Plan Marketing Names to be consumer friendly and in plain language; specifically, AHCT prohibits inclusion of an Issuer's internal coding, numeric values, and/or special characters (e.g., "%", "#", "$", etc.) in the Plan Marketing Names. Issuers must include appropriate commonly known product abbreviations in the plan name, e.g., "PPO", "HMO", "POS", "HSA", the metal level, e.g., Platinum, Gold, Silver, Bronze*, as well as, the term "Standard" for those plans required by AHCT. AHCT's Plan Marketing Name character limit is 75 characters.

NOTE: Zero and limited cost-sharing variant plans offered through the Individual Exchange do not meet federal requirements to be HSA-eligible. Therefore, plan documents should not include a reference to "HSA" for these plans.

**Note: Plans that fall within the 'Expanded Bronze' Actuarial Value range should indicate 'Bronze' as the metal level within that plan's marketing name.*

F. Consumer Information

a. Enrollee Material

Issuers will be required to submit the following draft Individual and SHOP documents to AHCT in English:

- Evidence of Coverage (EOC): the draft document(s) for each QHP product the Issuer intends to offer on the Exchange for sale (PPO, HMO, POS).
    - Plans that exclude elective abortion coverage must include text such as the following within the covered services section of the Evidence of Coverage document:
        - "Abortions in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which Federal funding is allowed)."
    - Plans that exclude elective abortion coverage must also include text such as the following within the exclusions section of the Evidence of Coverage document:
        - "We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which Federal funding is not allowed. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed."

- Schedule of Benefits (SOB): the draft documents for each unique offering that depicts the cost-sharing for each metal tier.

  Issuers must submit Final Individual QHP SOB and EOC documents to AHCT in both English and in Spanish upon approval by the CID. Issuers must submit Final SHOP QHP SOB and EOC documents to AHCT in English upon approval by the CID. Each final, approved EOC and SOB should be combined in a portable document format (PDF) and submitted through the System for Electronic Rate and Form Filing ("SERFF") within the Plan Management tab. The SOB should appear as the first document in the combined PDF. The purpose for this

formatted approach is to enhance a consumer's shopping experience by permitting the consumer to easily review the cost sharing and contract by company and plan design. Additional submission instructions, such as file naming conventions, will be provided in the forthcoming AHCT QHP Application.

- Summary of Benefits and Coverage (SBC): Issuers are also required to prepare an SBC for each plan design and plan variation, including each of the coverage examples defined by HHS for each QHP offered through the AHCT marketplace. AHCT expects to provide consumer access to this information via SBC URLs submitted by the Issuer. Issuers will be required to submit SBC URLs to AHCT in a format specified by AHCT (e.g., Microsoft Excel workbook). AHCT reserves the right to review Issuer SBC documents to ensure accuracy and regulatory compliance.

  In accordance with 45 C.F.R. §147.200 and 45 C.F.R. §147.136(e) Issuers must prepare the SBC in a culturally and linguistically appropriate manner. In addition, the Issuer must conform with 45 C.F.R. §155.205(c)(2)(i)(A) which requires all issuers to provide telephonic interpreter services in at least 150 unique languages.

b. Company Logo

Issuers will be required to provide an electronic image of the Issuer's logo. Size and format specifications will be outlined in the AHCT QHP Application.

c. Provider Directory

Pursuant to 45 C.F.R. § 156.230, AHCT will require Issuers to make available provider directories to AHCT by providing the URL to the Issuer's network directory in a format specified by AHCT (e.g., Microsoft Excel workbook).

The URL provided must link directly to the online provider directory, so that consumers do not have to log on, enter a policy number, or otherwise navigate the Issuer's website before locating the directory. If an Issuer maintains multiple provider networks, the consumer must be able to easily discern which providers participate in which plans and which provider networks apply to which QHP(s) at the point when a consumer could access the AHCT shopping portal to review plan design options for a plan year. AHCT will not certify any QHP unless the URL is a direct link to the provider directory search tool for the specific QHP. The directory must include location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. AHCT also requires Issuers to include an option for consumers to search the directories by filtering those providers that are accepting new patients versus those that are not. Additionally, the provider directory must include an indicator for each provider, regardless of provider's specialty, that clearly states whether the provider is accepting new patients or not. Such information must be kept up to date. The Issuer is expected to update its provider network directory at least once a month.

AHCT QHP Issuers must also make provider information available to AHCT in a uniform data file format and submit current provider data at minimum on a monthly basis and in a manner specified by AHCT.

AHCT may also require Issuers to submit up-to-date, accurate, and complete in-network provider directories for each QHP in a searchable PDF or in an unprotected excel format upon request.

AHCT QHP Issuers are responsible for complying with the culturally and linguistically appropriate standards outlined at 45 C.F.R. § 155.205(c) regarding oral interpretation, written translations, taglines, and website translations. AHCT encourages Issuers to include languages spoken, provider credentials, and whether the provider is an Indian Health Service provider. Directory information for Indian Health Service providers should describe the population served by each provider.

d. Prescription Drug Formulary

Issuers must publish, in a document with a searchable format and with a direct URL, an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, AHCT, HHS, the U.S. Office of Personnel Management, and the general public pursuant to 45 C.F.R. § 156.122(d).

Issuers must also include accurate information on restrictions in which an enrollee can obtain the drug, including prior authorization, step therapy, quantity limits, and any access limitations related to obtaining the drug from a physical retail pharmacy location.

The URL provided as part of the QHP Application should link directly to the formulary, so that consumers do not have to log on, enter a policy number or otherwise navigate the Issuer's website before locating the drug list. If an Issuer has multiple formularies, it should be clear to consumers which formulary applies for the specific QHP under which the consumer has elected to search. Issuers will submit URLs to AHCT in a format specified by AHCT (e.g., Microsoft Excel workbook).

AHCT reserves the right to require Issuers to provide formulary information in a format specified by AHCT and at any time if deemed necessary.

G. QHP Requirements

- Each QHP must comply with the benefit standards required by the ACA, including:
  - Cost sharing limits
  - Actuarial value ("AV") requirements
  - Federally approved State-specific essential health benefits (EHB)
    - In the standardized plan designs Issuers are required to embed pediatric dental benefits
    - In the Non-standardized plan designs, inclusion of pediatric dental benefits is at the option of the Issuer when a stand-alone dental plan (SADP) is offered through AHCT.

- The Issuer must set premium rates for its QHPs for the entire plan year.
- An Issuer must submit a justification for a rate increase prior to the implementation of the increase. An Issuer must prominently post the justification on its website. AHCT will request a URL to the Issuer's website where the rate increase justification has been posted prominently. To ensure consumer transparency, AHCT will provide access to such justification on the AHCT marketplace website.
- Except for cost sharing reduction variants, each plan in a metal tier must meet the specified Actuarial Value (AV) requirements based on the cost-sharing features of the plan:
    - Bronze plan – AV of 60 percent
    - Silver plan – AV of 70 percent
    - Gold plan – AV of 80 percent
    - Platinum plan – AV of 90 percent

    A de minimis variation of – 4/+2 percentage points in AV is allowable for any Platinum, Gold, or Silver QHP offered. A de minimis variation of +/- 1 percentage point in AV is allowable for the silver plan cost-sharing reduction variants available in the Individual marketplace.

    In accordance with 45 C.F.R. § 156.140(c), the de minimis range for bronze plans may have an allowable expanded variation in AV for such plans of -4/+5 percentage points depending on the structure of the plan and covered services.

- AHCT will require Issuers to submit, as part of the QHP Application, information that supports the rating submission, such as the Actuarial Memorandum Part III, which is a narrative describing and supporting information submitted on the Unified Rate Review Template (URRT). CMS guidance outlines the minimum information that should be contained in this document, including requirements related to current enrollment. Information related to rating factors for age, area, plan relativity and in the case of Small Group, quarterly trend adjustments, should be incorporated. CMS guidance on completing this Actuarial Memorandum Part III is available at: https://www.qhpcertification.cms.gov/s/Unified%20Rate%20Review

- All QHPs offered, inside and outside of the exchange, Individual and small employer group markets, must include the Connecticut specific EHBs. No substitution of actuarially equivalent benefits will be allowed. To view these benefits, please refer to the Connecticut exhibits found at the following CMS URL https://www.cms.gov/cciio/resources/data-resources/ehb.html#Connecticut .
- Issuers must comply with the non-discrimination requirements outlined in 45 C.F.R. § 156.
- Within the Individual marketplace, AHCT requires Issuers to submit three cost-sharing reduction (CSR) plan variations for each silver level QHP as well as the zero and limited cost-sharing plan variations for all QHPs, except for catastrophic plans, in accordance with 45 C.F.R. § 156.420. The AHCT standardized plan designs are not "gatekeeper" plans and were designed to provide enrollees with direct access to specialists. Accordingly, AHCT will not

certify the standardized plan designs offered by an Issuer at any coverage level if the Issuer requires a referral from a Primary Care Provider (PCP) in order for an enrollee to be able to access a specialist. Should an Issuer impose the "gatekeeper" requirement in its non-standardized plans, AHCT will require an Issuer to identify this requirement in the Schedule of Benefits and/or the Issuer's Plan Marketing Name(s). Additionally, such requirement must be described explicitly and prominently in the Issuer's Evidence of Coverage.

- Issuers may offer tiered networks in their non-standard plans only. A tiered network:
    - Has distinct contracting differentials among provider tiers, e.g. preferred vs. non-preferred;
    - Enrollee cost sharing is not based solely on type of facility where service is obtained, i.e., site of service;
    - Includes other typical industry strategies to demonstrate the network differential, e.g., incentivizing members to obtain services from preferred providers that result in lower out-of-pocket costs.

    Within the Actuarial Value calculator, the response to the question "Tiered Network Plan?" designation must be checked by Issuers and expected utilization must be included in all appropriate fields.

- Should an Issuer offer a non-standard plan that includes tiered networks, AHCT will require an Issuer to clearly explain and prominently display any tiered cost shares on their Summary of Benefits and Evidence of Coverage documents. Issuers will also be required to clearly identify preferred vs. non-preferred providers and display these provider designations within their Provider Network Directories and online search tools.
- In order to ensure AHCT understands the network distinctions for different plan offerings, Issuers will be required to submit a narrative outlining the high-level differences of the networks, including composition, tiering and out-of-service area coverage. The narrative should apply to the plans for the applicable market segment (i.e., Individual or Small Group).
- Issuers must follow CID guidance pertaining to network adequacy and drug formulary requirements and submissions.

H. Plan Options

An Issuer may elect to participate in either the Individual marketplace or SHOP marketplace, or both. The requirements regarding plan options for each marketplace are outlined below.

a. Individual Marketplace

Standardized plan designs promote transparency, ease, and simplicity for comparison shopping by consumers. AHCT has developed for the Individual market standardized plan design for gold, silver, and bronze metal tiers which define deductible, co-payment and/or co-insurance cost sharing on an in-network and out-of-network basis. These 2022 Individual standardized plan designs can be found on AHCT's website at the following URL:

https://agency.accesshealthct.com/healthplaninformation#one.To participate in the AHCT Individual marketplace the following criteria must be met:

- An Issuer **must** submit at least one (1) standardized Gold plan, one (1) standardized Silver plan, and two (2) standardized Bronze plans (one standardized Bronze plan and one standardized HSA compatible Bronze plan).
- An Issuer **must** submit three cost-sharing reduction (CSR) variants for the one standardized Silver Plan offered by the Issuer to households with attested income between 100% and 250% of Federal Poverty Level (FPL) applicable at the start of the plan year. The CSR variants are
    - a 73% AV CSR silver plan variant which must be separated from the silver 'standard' design on which it is based by a minimum AV difference of 2%,
    - an 87% CSR silver plan variant, and
    - a 94% CSR silver plan variant.
- The variants must conform to the requirements of 45 C.F.R. §156.420 and any other applicable federal guidance or regulations.
    - An Issuer **must** submit two cost-sharing alternatives for each QHP in accordance with 45 C.F.R. §156.420 which shall be made available to members of federally recognized American Indian tribes or Alaskan-Natives. There must be:
        1. one alternative that offers zero cost-sharing for American Indians/Alaskan Natives under 300% of the FPL applicable at the start of the plan year; and
        2. one alternative that offers limited cost-sharing for American Indians/Alaskan Natives, regardless of income, for any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.

        NOTE: Zero and limited cost-sharing variant plans offered through the Individual Exchange do not meet federal requirements to be HSA-eligible. AHCT will include an indicator to this effect within the consumer shopping experience.

- An Issuer **must** offer a child-only QHP option at the same level of coverage(s) as any QHP offered through the AHCT marketplace in accordance with 45 C.F.R. §156.200(c). A consumer seeking child-only coverage may obtain that coverage through the purchase of a single QHP with applicable rating for child-only coverage. In other words, any QHP can be sold as a child-only plan.

Issuers are also encouraged to offer any of the following:

- The Issuer may opt to offer a catastrophic coverage plan. Any Issuer offering the catastrophic coverage plan option must comply with Federal law including Section 1302 (e) of the ACA and 45 C.F.R. §156.155, and any applicable State law.
- Two non-standardized Platinum plans
- Up to three non-standardized Gold plans
- Up to three non-standardized Bronze plans

b. SHOP Marketplace

To participate in the SHOP marketplace, an Issuer must offer the following combination of plans:

- At least one (1) **Gold** plan must be offered; with the option to offer five (5) additional Gold plans
- At least two (2) **Silver** plans must be offered, of which, one must be HSA compatible and one that is not; with the option to offer up to four (4) additional Silver plans
- At least two (2) **Bronze** plans must be offered, of which, one must be HSA compatible and one that is not; with the option to offer up to two (2) additional Bronze plans

Issuers are also encouraged to offer Platinum plans up to a maximum of (4) four.

Additionally, each of the minimum number of required plans must comply with the following requirements:

- Include Out-of-Network (OON) coverage
- Include Pediatric Dental EHB coverage
- Not require a 'gatekeeper'

I. Federal Data Templates

The Federal QHP data templates must be completed and submitted within the Plan Management tab of the System for Electronic Rate and Form Filing (SERFF). The templates listed below contain Issuer and plan information required to effectively evaluate Issuer QHP submissions necessary for an Issuer to obtain QHP Certification for each plan design intended for sale on the AHCT marketplace

Federal Data templates and related information can be found at the following CMS URL: https://www.qhpcertification.cms.gov/s/Application%20Materials.

AHCT intends to extract information from these templates to optimize the consumer shopping experience screens.

AHCT will require Issuers to provide the following Federal QHP templates as part of QHP Application:

Template	Purpose
Plans & Benefits	Collects plan, benefit, and cost-sharing information for each plan to be offered via the marketplace.
Prescription Drug Formulary	Collects prescription drug benefit and formulary information.
Network ID	Collects the provider network ID for each provider network.
Service Area	Collects information on the Service Areas available for each plan to be offered via the marketplace.
Rates Table	Collects rate data by plan, by rating area, for each age band to be offered via the marketplace.
Business Rules	Collects certain enrollee eligibility information.
Uniform Rate Review	Collects data for market-wide rate review. This template includes Issuer information to support rating development

AHCT will require Issuers to provide the following additional data templates as part of QHP Application:

Template	Purpose
Administrative Data	Collects issuer administrative information, including name, address, and contacts (CMS 2016 version)
Essential Community Provider (ECP)	Collects information on the ECPs included in the issuer's provider network, and is used to assess compliance with AHCT contracting standards (AHCT specific template)
URL Submission Template	Collects provider network, formulary, and summary of benefits and coverage (SBC) URLs for display to a consumer within the shopping portal (AHCT specific template)

AHCT will also require Issuers to provide additional information via supporting documentation that will be outlined in the AHCT QHP Application.

J. Rating Factors

Issuers should refer to CID guidance for information regarding rating factors in Individual and SHOP markets.

- *Single Risk Pool*. An Issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by the Issuer both inside and outside of the AHCT marketplace to be members of a single risk pool encompassing either the Individual market or Small Group market.

- *Tobacco Use*. Issuers are prohibited from using tobacco use as a rating factor in the Small Group market in accordance with CGS §38a -567. AHCT will not permit tobacco rating in the Individual market.

- *Family Composition*. Federal regulations require Issuers to add up the premium rate of each family member to arrive at a family rate. However, the rates applicable to no more than the three oldest child dependents that are under the age of 21 will be used in computing the family premium.

- *Age.* Federal regulations require a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market. The federal government's age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive, subject to the following:

    - Children: A single age band for children 0 through 14 years of age where all premium rates are the same; and one-year age bands for individuals age 15 through 20.
    - Adults: one-year age bands starting at age 21 through age 63 and;
    - Older adults: a single age band for individuals age 64 and older, where all premium rates are the same
    - Rates for adults age 21 and older may vary within a ratio of 3:1

K. Wellness Incentives

AHCT may require Issuers intending to offer a wellness program(s) to provide a detailed proposal of such programs in order to assess potential discrimination based on health status. AHCT reserves the right to decide whether a wellness program(s) as described by an Issuer should be offered in the SHOP.

L. Accreditation

AHCT follows the standard regarding accreditation that is in place for the FFMs. Issuers will be asked to provide information about their accreditation status to determine if the standard in 45 C.F.R. §155.1045(b) is met.

The Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC have been recognized by CMS as accrediting entities for the purpose of QHP certification.

If an Issuer is entering its initial year of QHP certification, it must schedule, or plan to schedule, a review with one of the recognized accrediting entities, (i.e., AAAHC, NCQA, or URAC). An Issuer is not required to be accredited in its initial year of QHP certification.

Prior to a QHP Issuer's second year and third year of QHP certification (for example, in 2014 for the 2015 coverage year and in 2015 for the 2016 coverage year), a QHP Issuer must be accredited by a

recognized accrediting entity on the policies and procedures that are applicable to their Exchange products. Alternatively, if an Issuer has not yet received accreditation certification, the Issuer must have commercial health plan accreditation, granted by a recognized accrediting entity for the same State in which the Issuer is offering Exchange coverage. Furthermore, the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP.

If an Issuer is entering its fourth consecutive year of QHP participation or beyond, it must be accredited in the Exchange market and with one of the following recognized statuses:

- AAAHC: Accredited
- NCQA: Excellent, Commendable, Accredited, or Provisional
- URAC: Full or Conditional

An Issuer will not be considered accredited if the accreditation review is scheduled or in process.

Any information provided on accredited products must be for the same legal entity in the same state that submits the QHP Application.

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

Issuers will be required to provide AHCT with documentation of renewed certification if an Issuer's current accreditation status will expire mid-plan year for which the Issuer is seeking QHP certification.

M. Reporting Requirements

a. Quality Rating System (QRS)

Issuers are required to comply with standards and requirements related to data collection of quality rating information pursuant to 45 C.F.R. § 156.1120, and the QHP Enrollee Survey pursuant to 45 C.F.R. § 156.1125. Issuers must collect and report validated data annually, on a timeline and in a standard form and manner specified by HHS, to support the calculation of the QRS scores and ratings for each QHP that has been offered in a marketplace for at least one year.

Issuers are also required to contract with and authorize an HHS-approved vendor to annually collect and submit QHP Enrollee Survey data on their behalf for each QHP. Issuers that had more than 500 enrollees in QHPs in the previous plan year are required to submit this data. Issuers are expected to follow the specific requirements related to data collection, validation, and submission, as well as minimum enrollment criteria, for the QRS and QHP Enrollee Survey as detailed in technical guidance issued by CMS.

Consistent with 45 C.F.R. § 156.200(b)(5), in order to demonstrate compliance with the quality reporting standards as part of the certification process for the 2022 coverage year, Issuers will be required to attest that they comply with the specific quality reporting and implementation requirements related to the QRS and QHP Enrollee Survey.

b. Quality Improvement Strategy (QIS)

As required by the ACA, QHP Issuers must implement a QIS, which is a payment structure providing increased reimbursement or other incentives that will improve enrollee health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities and/or reduce health and health care disparities.

For the 2022 plan year, AHCT will follow CMS guidance pertaining to QIS requirements, including Issuer completion and submission of various forms, depending on the Issuer's QIS status. Information outlining the minimum enrollment threshold for QIS submissions is included in CMS QIS Technical Guidance. Eligible Issuers will submit a 'QIS Implementation Plan' form, and those Issuers submitting a QIS for Plan Year 2020 will submit both a 'QIS Implementation Plan' and a 'Progress Report' form.

The Technical Guidance and report forms will be available on the Marketplace Quality Initiatives (MQI) website located at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page

c. Transparency in Coverage

Transparency in Coverage requirements are outlined in federal regulations at 45 C.F.R. 155.1040(a) and 156.220. Currently, the reporting collection requirements do not apply to issuers of QHPs in state-based exchanges. Per CMS-10572, 'Transparency in Coverage Reporting by Qualified Health Plan Issuers', submitted to the federal Office of Management and Budget in February 2019, the reporting requirements are expected to be phased in for state-based exchanges with the next Paperwork Reduction Act package in three years.

d. Other Reporting Requirements

Additionally, Issuers will be required to attest to:

- Disclosing information on health care quality and outcomes as described in Section 399JJ of the Public Health Service Act.
- Providing to HHS and the Exchange at least annually, the pediatric quality reporting measures described in Section 1139A of the Social Security Act

N. Patient Safety Standards

As outlined in 45 C.F.R § 156.1110(a)(2), QHP Issuers must demonstrate compliance with the patient safety standards for coverage beginning on or after January 1, 2017. QHP Issuers who contract with a hospital with more than 50 beds must verify that the hospital utilizes a patient safety evaluation system as defined in 42 C.F.R. 3.20 and has implemented a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient.

As part of AHCT certification, QHP Issuers are required to demonstrate compliance with the patient safety standards as outlined in Federal regulations. AHCT will require an attestation that the Issuer has collected and is maintaining required documentation from their network hospitals.

O. Network Adequacy

a. General Requirements

Pursuant to 45 C.F.R. §156.230(a)(2), an Issuer of a QHP that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

Issuers will be required to adhere to the CID guidance pertaining to Network Adequacy.

AHCT reserves the right to require Issuers to submit information on consumer complaints pertaining to access to network providers in a format and at a frequency specified by AHCT.

b. Essential Community Provider (ECP) Network Contracting Standards

Issuers are also required to meet specific standards for the inclusion of Essential Community Providers (ECPs) within their QHP provider networks. The definition of an ECP is included in 45 C.F.R. §156.235. The ECP must provide services that are considered covered health services under the currently adopted definition of Essential Health Benefits to individuals at disparate risk for inadequate access to healthcare.

AHCT ECP Network Adequacy standards as approved by the AHCT Board of Directors follow:

- Issuers must contract with 50% of the Federally Qualified Health Centers (FQHCs) in Connecticut.
- Issuers must contract with 50% of the non-FQHC providers on the AHCT ECP list. This list is subject to periodic updates by CMS and AHCT.

To determine whether an Issuer is meeting the ECP standards, AHCT will require the Issuer to complete the AHCT "ECP List" on a semi-annual basis. AHCT will provide Issuers with due dates for ECP data submissions within the QHP Application. The AHCT ECP List will then be provided subsequent to the release of the QHP Application. If an Issuer does not meet the standard(s) at the time of semi-annual submission of ECP data to AHCT, the Issuer will be required to provide AHCT

with a narrative outlining demonstration of a good faith effort in meeting the AHCT contracting standards.

P. Attestations

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

- Issuers must complete the State-Based Marketplace (SBM) Issuer Attestations and the Connecticut Required Attestations as part of the QHP application submission.
- Attestation language will include the minimum certification standards required by CMS, the State, and/or AHCT.
- Attestations will cover Issuer's existing operations as well as any contractual commitments needed to meet AHCT requirements on an ongoing basis.
- Issuer will attest that it has in place an effective internal claims and appeals process and agrees to comply with all requirements for an external review process with respect to QHP enrollees, consistent with state and federal law (45 C.F.R. §147.136 and 45 C.F.R. §800.503 for Multi-State Plan options).
- Attestations will largely fall into the following general categories under which Issuers must comply:
    - General Issuer Attestations
    - Compliance Plan Attestations
    - Organizational Chart Attestations
    - Operational Attestations
    - Data Submission Attestations
    - EHB, Cost Sharing and Plan Attestations
    - Network Adequacy & Service Area Attestations
    - Rate Attestations
    - Enrollment Attestations
    - Financial Management Attestations
    - SHOP Attestations
    - Reporting Requirements Attestations
    - Accreditation Attestations

Q. User Fees/Market Assessment

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

R. Issuer Accountability

AHCT will require Issuers to attest that their business leaders have collectively performed a comprehensive preview of all required 2022 Federal QHP Data templates and supporting documents prior to submission via SERFF for the express purpose of confirming data accuracy and presenting required data to AHCT for Issuer and QHP certification.

Issuers will also be required to utilize specific QHP Application Review Tools developed by CMS and by AHCT, and to provide AHCT with resulting output of such tools to demonstrate that all errors have been corrected prior to each submission or resubmission of data to AHCT. AHCT may accept a written justification in limited circumstances when a warning is generated by a review tool and is not rectified in the Application submission. AHCT will provide copay thresholds for Issuers to use in the CMS Expanded Bronze Review Tool to assess whether a plan that offers certain covered 'major services' before the deductible will meet the reasonable cost requirements to ensure that the service is affordable and qualifies as an 'Expanded Bronze' plan.

S. Broker Commissions

AHCT will require participating Issuers to pay broker commissions as follows:

Commissions on the exchange must be "similar" to an Issuer's commission off exchange. Commissions will be deemed similar if the following conditions are met:

- A commission is payable on the exchange for a plan if the Issuer pays a commission for a comparable plan and service functions off exchange. A comparable plan is one at the same metal tier or a subset of that tier if commissions are limited to a specific type of offering such as a plan sold in conjunction with a tax qualified health spending account.
  If an Issuer does not offer plans off exchange, a commission shall be payable based upon a comparable plan of an affiliate. In the case where there is not an affiliate, a commission shall be payable based upon a comparable plan of other Issuers participating on the exchange.