



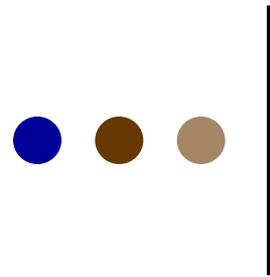
Qualified Health Plan (QHP) Requirements

Presentation by:

Pam Silberman, JD, DrPH

October 26, 2011





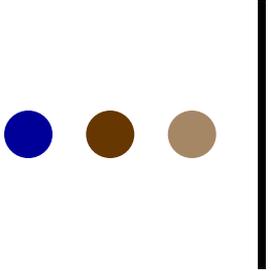
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- Statutory provisions
- Regulatory provisions



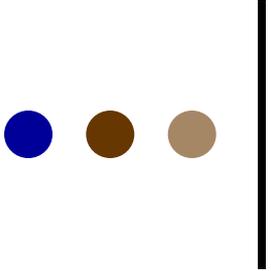
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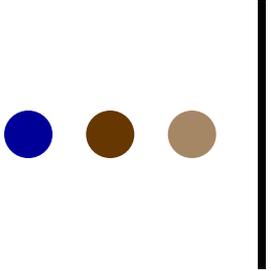
Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
 - Meet marketing requirements
 - Ensure sufficient choice of providers and provide information about in-network and out-of-network providers
 - Include essential community providers in the network
 - Be accredited on clinical quality measures and implement a quality improvement strategy
 - Utilize a uniform enrollment form
 - Provide standardized health plan information
 - Report pediatric quality reporting measures
 - Submit a justification for any premium rate increase prior to the increase



Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
 - Provide essential benefits package
 - Be licensed under state law
 - Offer at least one qualified health plan in silver and gold levels in the HBE
 - Agree to charge the same premium rate for each qualified health plan, whether or not offered through the HBE
 - Operate a single risk pool for the individual market (whether or not offered through the HBE), and a single risk pool for small employers
 - Be accredited, report on clinical quality measures, and implement activities to reduce health disparities (including language services)



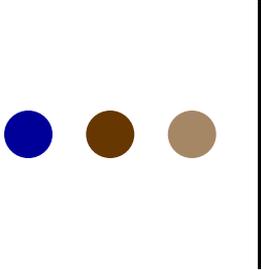
Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
 - Provide specific plan-related information to enrollees, in plain language, including information on finances, enrollment and disenrollment, denied claims, out-of-network costs, claims payment policies and practices.
 - Provide timely information about the amount of cost-sharing (deductibles, copayments and coinsurance), and make this information available through the Internet



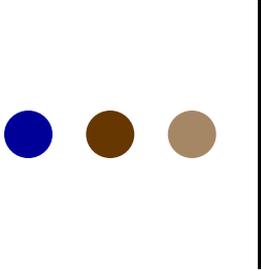
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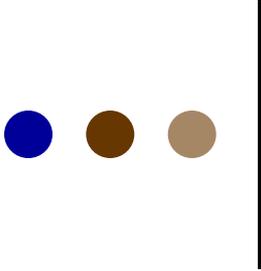
Minimum Certification Requirements (45 CFR 156.200)

- To participate in HBE, QHP must:
 - Be certified by the HBE.
 - Comply with all HBE exchange processes, procedure and requirements
 - Comply with the benefit design standards
 - Be licensed and in good standing in the state in which the issuer offers insurance
 - Implement and report on quality improvement strategies and health care quality
 - Pay applicable user fees
 - Comply with risk adjustment program.



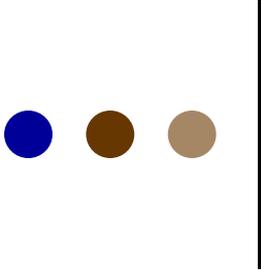
Minimum Certification Requirements (45 CFR 156.200)

- To participate in HBE, QHP must:
 - Offer at least one QHP in silver and gold coverage levels
 - Offer a child-only plan at same coverage levels to children who have not yet attained the age of 21.
 - Adhere to additional requirements of the HBE or the state.
- An QHP may not discriminate on basis of race, color, disability, age, sex, gender identity, or sexual orientation.



Transparency in Coverage (156.220, 155.1040)

- QHP must provide information to the HBE, the State Insurance Commissioner, and US DHHS including:
 - Claims payment policies and practices; periodic financial disclosures; data on enrollment, disenrollment, and number of claims that are denied; data on rating practices; information on cost-sharing and payments for out-of-network coverage; and information on enrollee rights.
 - Information must be provided in “plain language.”
 - Plain language defined as: “language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing.” (45 CFR 155.20)

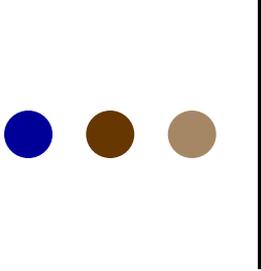


Transparency in Coverage

- The QHP must make the amount of enrollee cost sharing for a specific item or service available to the enrollee in a timely manner.
 - At a minimum, the information must be made available through the Internet and other means for individuals without access to the Internet.

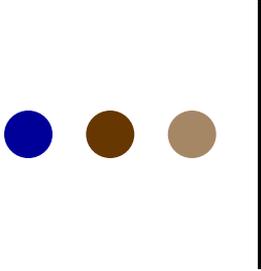
Marketing QHPs (45 156.225)

- The QHP issuer, officials, employees, agents and representatives must:
 - Comply with state laws governing marketing
 - Not employ marketing practices that discourage the enrollment of people with significant health needs



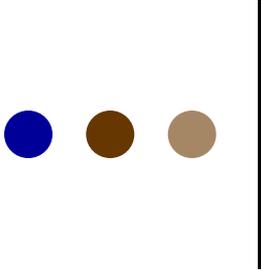
Network Adequacy (45 156.230)

- The QHP issuer must ensure that the provider network meets the following standards:
 - Includes essential community providers (see later slide)
 - Complies with network adequacy standards established by the HBE
 - Is consistent with network adequacy provisions of Section 2702(c) of the Public Health Service Act
- QHP must make its provider directory available to the HBE for online publication, and must identify providers who are not accepting new patients.



Essential Community Providers (45 CFR 156.235)

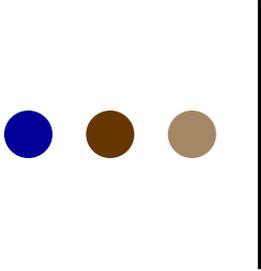
- QHP must include in the provider network *a sufficient number* of essential community providers that serve predominantly low-income, medically underserved individuals.
 - Essential community providers include 340B eligible health care providers, and other similar organizations (eg, FQHCs, public or nonprofit hospitals).
 - QHP not required to contract with all essential community providers.
- Nothing in the law requires health plans to provide coverage for any specific medical procedure provided by the essential community provider.



Primary Care Medical Homes

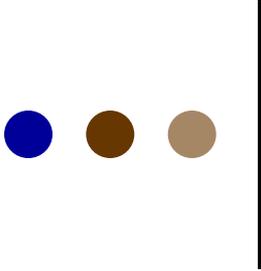
(45 CFR 156.245)

- QHP may provide coverage through direct primary care medical home, as long as other requirements met.
 - Direct primary care medical home is an arrangement where a fee is paid by or on behalf of an individual directly to a medical home for primary care services.



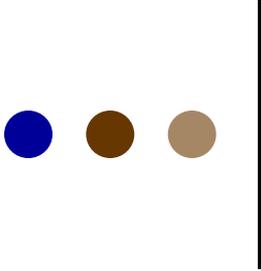
Application and Notices (45 CFR 156.250)

- QHPs must provide all applications and notices in accordance with the standards required in 45 CFR 155.230(b).
 - The applications, forms and notices must be written in plain language
 - The QHPs must provide meaningful access to people with limited English proficiency
 - The QHPs must ensure effective communication for people with disabilities



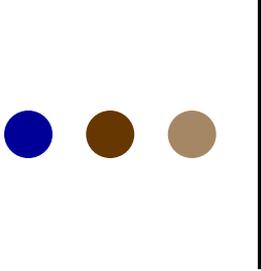
QHP Rate and Benefit Information (45 CFR 156.210, 156.255)

- QHP issuer must set rates for an entire benefit year, or for SHOP, a plan year.
 - The QHP issuer must submit rate and benefit information to the HBE, and must obtain justification for the rate increase before implementation of the increase.
- QHP may vary premiums by geographic rating areas established by the state; but must charge the same premium rate whether the plan is offered through the HBE, directly from the issuer, or through an agent.
- QHPs must cover all the following groups, using some combination of: 1) Individuals, 2) two-adult families, 3) one-adult family with a child or children; and 4) all other families.



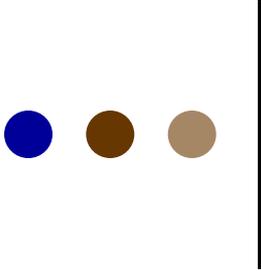
QHP Rate and Benefit Information (156.210, 155.1020)

- HBEs must receive information, at least annually from the QHP, including rates, covered benefits and cost-sharing requirements.
 - HBE must consider rate increases, including the justification for the rate increase prior to implementation of the increase, recommendations from the state Dept. of Insurance, and any excess of rate growth outside the HBE as compared to the rate increase inside the HBE.
- QHP/HBE must make information on enrollee cost sharing for participating provider to enrollee in timely manner.



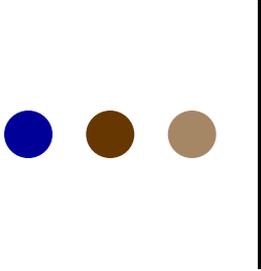
Enrollment Process (45 CFR 156.260, 156.265)

- QHPs must enroll qualified individual during the initial and annual open enrollment periods and abide by effective dates of coverage.
 - QHPs must also make available special enrollment periods.
 - QHP must notify the qualified individual of his or her effective date of coverage.
- If the applicant initiates enrollment directly with the plan, the issuer must:
 - Obtain enrollment information using the single application.
 - Transmit the information to the HBE.
 - Enroll the individual only after receiving confirmation that the eligibility process is complete and the individual is eligible for to enroll.



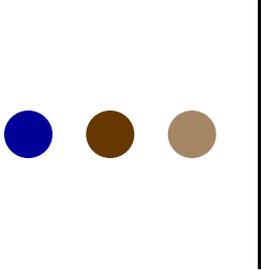
Enrollment Process (45 CFR 156.260, 156.265)

- The QHP must accept enrollment in an electronic format from the HBE.
- The QHP must follow the premium payment process established by the HBE (45 CFR 155.240).
- Must provide the following information to enrollees:
 - Enrollment information package.
 - Summary of benefits and coverage.
- QHP must reconcile enrollment files with the HBE no less than once/month.
 - Must acknowledge receipt of enrollment information from HBE.



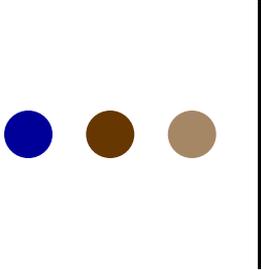
Termination of Coverage for Qualified Individuals (45 CFR 156.270)

- QHP/HBE may terminate coverage pursuant to 155.430(b):
 - Individual no longer eligible for coverage through the HBE.
 - Enrollee becomes covered with other minimum essential coverage.
 - Payments cease (after 3 consecutive month allowable grace period for people receiving advance payment of tax credits).
 - Coverage is rescinded.
 - QHP is terminated or decertified.
 - Enrollee changes QHP during open or special enrollment period.
- QHP must provide HBE and enrollee with a notice of termination.



Termination of Coverage for Qualified Individuals (45 CFR 156.270)

- QHP must establish a standard policy for termination due to nonpayment of the premium.
 - Must include the grace period for enrollees receiving the tax credit.
 - Grace period must be at least three months if the enrollee receiving the advance payment of the premium tax credit has previously paid at least one month's premium.
 - Must be applied uniformly to all enrollees in similar circumstances.
 - The QHP must provide notice to the enrollee on the payment delinquency.
 - If the enrollee fails to pay, the QHP may terminate coverage at the end of the grace period.
 - QHP must abide by the terminate effective dates specified in 155.430(d).

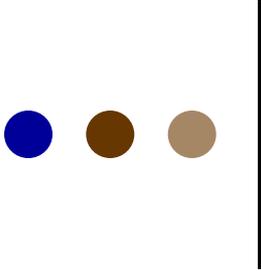


Accreditation (45 CFR 156.275)

- QHPs must be accredited by agency recognized by US DHHS.
 - QHPs must be accredited on performance in: clinical quality measures, patient experience, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information.
 - QHP must authorize the accrediting agency to release this information to the HBE and HHS.
- HBE must establish uniform standards for health plans to obtain accreditation, if not already accredited.

Segregation of Funds for Abortion Services (156.280)

- QHPs must comply with state laws, if state prohibits abortion coverage in QHP
 - Nothing in the ACA requires a QHP issuer to provide abortion coverage as part of its essential health benefits.
- If state allows, and QHP provides abortion coverage, the QHP may not use any of the premium tax credit or cost sharing reduction towards the cost of abortion coverage
 - Must collect payment from enrollees for the actuarial value of the abortion coverage separately from other payments and keep it in a separate allocation account.
 - In determining actuarial amount, must take into account additional costs, but may not take into account cost reductions.
 - QHP may not discriminate against providers who refuse to provide or refer for abortion services.

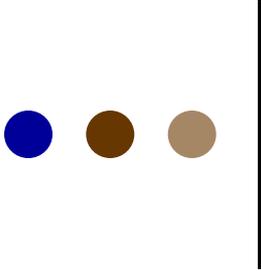


Special Rules for QHPs in SHOP_(45 CFR 156.285)

- QHP must meet requirements, including:
 - Accepting payment from SHOP on behalf of employers.
 - Adhere to SHOP timeline for rate setting, and charge the same rate for a plan year.
 - Provide for annual and special enrollment periods.
 - Provide enrollees with applicable materials (eg, enrollment information, summary of benefits).
 - Reconcile enrollment information at least monthly.
 - Follow applicable termination rules and send appropriate notices.
 - If employer terminates coverage in QHP, must send notices to all covered employees.

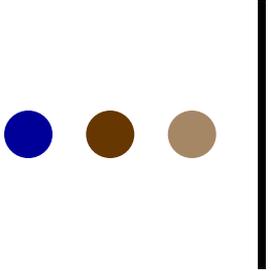
Non-renewal and Decertification Process (45 CFR 156.290)

- QHPs that choose *not* to seek recertification must:
 - Notife the HBE of its decision prior to the beginning of the recertification process.
 - Cover benefits for each enrollee through the plan year.
 - Provide notices to enrollees, and terminate coverage in accordance with 45 CFR 156.270.
- A QHP will only be decertified if:
 - It provides notice to the HBE, and provide opportunities to enrollees to enroll in other coverage.



Prescription Drug Reporting (45 CFR 156.295)

- QHPs must provide information to HHS on:
 - Percentage of all prescriptions provided under contract through retail pharmacies vs. mail order, and percentage of prescriptions for which generic drug was available and dispensed compared to all drugs dispensed by pharmacy type.
 - Aggregate amount of drugs, type of rebates (or other price concessions) that are passed through to the plan sponsor.
 - Aggregate amount of the difference between the amount the QHP issuer pays the pharmacy benefit manager and the amount the PBM pays retail pharmacies, mail order pharmacies, and total number of prescriptions dispensed.
 - Confidentiality protections for the use of the information.
 - Penalties for failing to provide required information.



Overview

- Proposed regulations issued: July 15, 2011
- Proposed regulations available at:
<http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>.
- Comments due to CMS no later than September 28, 2011.



Questions

