QHP CERTIFICATION REQUIREMENTS

1. Please check whether you think QHPs should be required to meet standards in addition to those specified in the federal law, or whether HBEs should have the authority to impose additional standards if "in the public interest." We welcome comments to explain your choices further. We also welcome any other ideas you may have about other potential QHP certification requirements. **(Includes comments from Rebecca Whitaker, Tracy Baker , Mike Matznick, Barbara Morales Burke, Fred Joyner, Michael Keough, Mary Bethel, Elizabeth Phillips)**

	HBE should require for all QHPs (eg, mandatory certif. requirement for all QHPs)	HBE should be allowed to require (eg, HBE flexibility to impose)	HBE should be able to incentivize QHPs to do this, but not require (eg, special recogni-tion?)	HBE should not be able to require	Comments

Limit number or types of plan variations	1	6		1	• In so far as the restrictions would promote meaningful choice
					• While an unlimited number of plan designs could be confusing for consumers, forcing very strict plan designs and/or a limited number of plan options would have an adverse impact to potential members in the following ways:
					  • Eliminating flexibility of plan designs may eliminate the introduction of new models of care (for example: ACO's).
					  • Reducing flexibility of plan design could cause significant system and IT changes for certain carriers and reduce the number of carriers that participate in the HBE.
					  • The HBE should be committed to consumer choice, innovation, and cost reduction for consumers. If plan design flexibility is eliminated, innovation will be eliminated as well.
					• I would be open to the HBE control over the number and types of plans with the hope that choices would be broad to allow the consumer access to a variety of plans that might

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					meet their needs. • The Exchange should organize information and provide tools to help people identify and compare their options, and select a plan appropriate to their needs and preferences. • I agree with the group in that the more choices that a person has the more difficult it may be to make a well informed decision. If limitations are put in place, then individuals may not feel as overwhelmed • I believe that limiting plans will limit competition within the exchange and also innovation as it pertains to plan design. I would advocate for the HBE to have a limited role.
Require health plans participating in HBE to offer all 4 precious metal plans	1	2	3	4	• Requiring health plans to serve in all 4 precious metal plan offerings may limit participation of insurers thus limiting the choices consumers have. • Requiring health plans to participate in all metal options could have the following impact: • Certain carriers may choose not to participate at all if forced to offer all metallic plan levels. Some carriers may not currently offer "platinum" level benefits due to utilization expectations and/or weaknesses in their provider contracts and may not wish to participate in these high-benefit plans. On the opposite side, a given health plan may not wish to participate in the lower cost plans because of MLR reform. Certain companies may not

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					be able to survive financially on their portion of a low premium plan with an 80% MLR mandate. • Mandating participation in all plans may lead carriers to place uncompetitive plans in the HBE in an effort to comply. Now the HBE ends up with extra plans with no participation. • All plans may not be in the best interest of all involved. • Encouraging carriers to offer all 4 precious metal plans would be fine, but not require. If some carriers did not feel that they wanted to offer all levels, for competitive reasons, I would not want to prohibit them from participation. That would not be of benefit for the consumer.
Require health plans participating in HBE to offer standardized plan designs either exclusively or in addition to non-standardized plans	1	1	1	4	See thoughts in prior responses. • To enhance consumer choice non-standard plans should be allowed • Reliance upon standardized benefit design may lead to other important determinants of plan value such as formulary, network providers and service being overlooked or undermined. ACA's essential health benefits coupled with metal tiers, other coverage provisions (eg, annual out of pocket max) and minimum MOLR requirements provide a basis for some comparison without overstating comparability. • To assure choice, innovation and competition, non-standard plans should be allowed • The key would be "in addition to"

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Additional quality standards beyond accreditation and implementing quality improvement strategies (including enrollee satisfaction, data reporting) (Note: these requirements will be defined further in regulations)	1	1	5	2	• We believe that the federal requirements regarding accreditation and the implementation of quality improvement strategies will largely ensure that HBE members have access to high quality health plans. In addition, the DOI will continue to have oversight of other critical functions of the Qualified Health Plans (example: financial stability). Moreover, the accreditation bodies (e.g., NCQA, URAC) will likely have significant backlogs in processing and reviewing applications from issuers from across the country. Any additional accreditation standards above and beyond the federal standards at this time would only lengthen the accreditation time line.
					  • We also believe that an open market will encourage new cost and quality innovations as QHP's encourage new members to choose their plan. To the extent that the state seeks to encourage carriers to exceed the quality standards, it should be done through market-based incentives rather than through requirements.
					  • Lastly, the HBE needs to carefully weigh all administrative requirements placed on the QHPs. Administrative expenses will ultimately be passed through in premium increases, and the HBE's will need to evaluate all mandates versus the associated increase in premium to the consumer.
					• Quality and consumer value standards may be worth discussing through the exchange. But I'm not sure that should

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					be the role of the Exchange. Federal and state agencies already have enough oversight in quality standards. Other Standards need to be carefully weighed in concert with Insurers to insure expense levels to not get out of hand for the carriers. • I am not sure this is the role of the HBE. Carriers should be looking for ways to improve and be competitive in the HBE. I would expect that the Federal requirements should be sufficient along with those of other accreditation organizations.
Additional requirements to foster broader NC state health policy goals (for example, support for patient-centered medical homes)	1	2	2		• This is hard to answer unless we understand the actual policy goal and the intended support for the goal. In the example provided, patient-centered medical homes, we would need to understand how the HBE would provide support before we can answer the question. • Not sure that this is the role of the HBE as it does not seem to fit into the functions of an insurance marketplace. • I'm also not sure this is the role of the HBE as the question is posed. The HBE is supposed to the clearinghouse to provide choice, simplicity and assistance to consumers. It should not be the health policy driver for the state of NC.
Other Ideas:					

2. **If the state has flexibility, should it allow for a phase-in of the accreditation requirements?**

   6 Yes (If Yes, how long should issuers have to achieve accreditation)?

   1 No

   ___ Other (Explain)

   Comments:

   - Perhaps a tiered system for new health insurance companies (eg, if a CO-Op were to form in the state).
   - Currently, over half of the carriers operating in NC today are not accredited by any agency. The HBE should not require accreditation before 2016, thus allowing all carriers an opportunity to become accredited. Please note that the requirements for accreditation are not currently defined. As noted above, we expect the accreditation bodies (e.g., NCQA, URAC) will increase in demand for their services, and we have concerns regarding whether the approved accrediting bodies will have the resources and capacity to handle the volume of new accreditation requests.
     We certainly understand the goal of ensuring that all QHPs achieve accreditation in a timely manner. However, we do not believe that short timelines would be prudent and could serve to discourage entry and competition by new market players. One option that the state should consider in tandem with postponing the accreditation requirements until 2016 would be to apply the delay if a health plan issuer was actively pursuing accreditation, similar to the flexibility that CMS afforded states by allowing "conditional" approval of their exchange plans even if outright approval cannot be achieved by January 1, 2013.
   - We need to provide as much flexibility in the early stages of the HBE development to allow carriers to meet accreditation requirements to enhance the competitive aspects of the HBE. The length of time should be established by the HBE based on market parameters.
   - Given the timeframes for accreditation, 12 months seems reasonable.
   - This question is bettered answered by participating carriers, but flexibility in the timeline is important to insure more participation by many carriers in achieving accreditation.
   - Generally yes, but some standards will require a phase-in—for example, employee satisfaction. If some are phased in, the time should not be longer than one-year.
   - 30-60 days, depending on the requirements.

3. **The proposed federal regulations give states the responsibility of setting network adequacy standards. Who should set these standards?**

1 HBE
7 _ NCDOI
___ NCGA

Comments (Suggestions about network adequacy standards):

- Insurers should be required to contract with any willing essential community provider (as defined in the federal law) that is recognized as a Level 1 Patient-Centered Medical Home (or some similar standardized quality measure). Such a requirement would help avoid a scenario in which insurers exclude FQHCs from networks in order to avoid paying the Medicaid PPS reimbursement level mandated in the federal law.
- Both the HBE and DOI.
- The carriers in NC currently file their networks with the NCDOI. This is an opportunity to eliminate duplication of effort.

4. Should network adequacy standards be the same inside and outside the Exchange?

4 Yes
3 No
___ Other (Explain)

Comments:

- I think that flexibility should be give to allow for development new innovative models and alternatives to assure the best choices for consumers .
- Unsure. Is there a possibility that more stringent network adequacy standards within the Exchange could disincentivize issuers from participating? Sensitive to being too prescriptive and limiting innovation.
- To ensure that everything is as equal as possible, standards should be the same.
- Generally, the network standards will be the same. However, the HBE needs to leave room for the possibility that new networks and new models of care will be formed, and that these new models may or may not be sold both inside and outside of the exchange.
- Since Healthcare Reform is a far reaching piece of legislation that effects the whole organization of medical delivery, I think it would be best to allow some flexibility for carriers and the health care delivery industry to develop alternatives outside of the exchange that might not be possible, if the standards were the same.

5. **Should quality standards be the same inside and outside the Exchange?**

4 Yes

2 No

___ Other (Explain)

Comments:

- Again, we need to leave room for innovation and understand that the products sold in the exchange may not be the same as the products sold outside the exchange. Also note that QHP's may only take one entity through accreditation (for example, an HMO) and not take other entities through accreditation (potentially a PPO).
- Not quite sure what we are referring to in this question, but would seem to think that this would likely be the same.
- A common theme for response to this and similar questions is to insure Carriers have the flexibility to develop innovative approaches and should not be restricted on how they must operate outside the exchanges.

6. **Should we limit the option to offer catastrophic plans to issuers who participate in the HBE?**

3 _ Yes

3_ No

___ Other (Explain)

Comments:

- Participation in catastrophic plans will likely be small and should not warrant the addition of other QHP's.
- I do think that some catastrophic plans should be available through the HBE. All consumers should have access to these plans, if they choose and should be able to benefit from the government subsidies to purchase a plan, if they qualify.
- I am unsure of the intent of this question. The ability of an issuer to offer catastrophic plans on or off the HBE should be linked to its participation in the HBE.
- I think to maximize innovation, competition and choice for the consumer, the offering of catastrophic plans should not be restricted to carriers participating in the exchange.
- To clarify, insurers should not be able to offer only catastrophic plans.

7. **What, if any, are the barriers that prevent state innovations to enhance value and reduce costs?**

Comments:

- Most consumers will define value as the best benefits for the lowest cost. Given MLR reform, the administrative portion of the cost has been regulated and the remaining portion of cost will be medical expenses. The medical expenses will only drop if any or all of the following happen: Member cost share increases (this is not likely given the high-level plans coupled with subsidies in the exchange), Utilization by providers and/or members decreases (based on historic data, there is no reason to believe that current utilization levels will decrease without significant changes to the current models of care in NC), Unit Costs decrease in NC (again, historic data suggests that providers in aggregate are increasing their reimbursements rates well above normal CPI), The population has a significant improvement in overall health and wellness (This is a difficult change without a fundamental change in the way health care is delivered). An inability to change the way health care is delivered today is the barrier to reducing cost. Without this fundamental change, consumers will simply find the same products at generally the same price both inside and outside the exchange.
- There are specific state laws that limit the ability for health plans to introduce innovations to enhance value and reduce costs. A couple of examples include the ability to offer incentives to encourage healthy behaviors, limits on benefit differentials for in and out of network services and more flexibility in sending electronic communications to members.
- The existence and use of Most Favored Nation Clauses (MFN) in carrier/provider contacts must be prohibited or the Exchange will again be dominated by one carrier as the market is currently. This would be in direct contrast to the purpose of the exchange which is to provide choice, competition and value.
- A barrier to enhancing value and reducing costs may be the lack of the HBE's ability to negotiate rates directly with the plans.

8. **Other comments or suggestions related to state QHP certification requirements**

Comments:

- The NC exchange will also need to ensure that QHP's and the people or entities that distribute the QHP's , are not creating any opportunities for adverse risk selection in the Exchange. This will require QHP's to price consistently inside and outside of the exchange and will potentially require commission reform both inside and outside of the exchange.