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AGENDA ITEM

[X] **For Possible Action**

[ ] **Information Only**

Date: January 10, 2013

Item Number: VIII

Title: Plan Certification, Recertification and Decertification

PURPOSE

The purpose of this report is to provide information to assist the Board in determining the proper procedures and methods for plan certification, recertification and decertification. This report includes component plan certification recommendations, now listed as Plan Certification and Management Recommendation 9. To see a list of policy decisions that have been approved by the Board, see: Advisory Committee Recommendations Approved by the Board.

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RELATED POLICIES PREVIOUSLY APPROVED BY THE BOARD

FREE MARKET FACILITATOR MODEL

One of the first major decisions of the Board was whether to pursue a free market facilitator model or an active purchaser model. A Free Market Facilitator model provides a general structure capable of facilitating market competition, establishes basic rules for buyers and sellers and serves as a source of reliable, impartial information about the available plans. An Active Purchaser exchange limits the number of plans by contracting directly with insurance providers, standardizing plan design parameters and directly negotiating rates with contracted plans. Advocates of an active purchaser model believe savings can be negotiated due to the ability of a carrier to capture a large portion of the market; that quality can be improved by contracting with the best plans as determined by the purchasing entity. Free market facilitator advocates believe carriers will offer the best pricing, quality and choice due to competition created by individuals naturally selecting the products with the best value. Anecdotal case studies can be offered that support either model.

The ACA will have an enormous impact on the health insurance market in 2014. Changes to rating and quality rules, the addition of taxes on insurers, providers, individuals and employers and the addition of a tax subsidy will create difficult to predict changes in consumer purchasing patterns. Consumers who have not purchased health insurance due to cost or pre-existing conditions will be able to do so for the first time. The additional consumers in the health insurance market, whose health care needs are unknown to insurers, will make it difficult for insurers to provide premiums that are competitive but do not create solvency issues for the insurer.

With the above market disruption in mind, on April 12, 2012, the Board approved the free market facilitator model as one of the key principles for the Plan Certification and Management Advisory Committee. It is expected that the Free Market Facilitator model will ensure the maximum participation by insurers and the widest choice for consumers.[1] The model will also give the Exchange some experience in the new ACA market prior to making decisions that will affect hundreds of thousands of enrollees.

[1] Advisory Committee Recommendations Approved by the Board, Plan Certification and Management Recommendation 1, Key Principles

DIVISION OF INSURANCE CONDUCT RATE REVIEW

Also during the April 12, 2012 Board meeting, the Board approved the recommendation that the Division of Insurance (DOI) conduct rate review on behalf of the Exchange.[2] The DOI, through its certified health actuaries and/or outside actuarial consulting firms, review rate change applications submitted by carriers to ensure that any proposed rate change is warranted. The accuracy of data included in the application is fully reviewed for historical and mathematical accuracy. During the review, the DOI may request more information from the insurer. An application is not considered complete until all information required has been submitted. Public comments are considered while reviewing the necessity of the proposed rate increase. The DOI will leverage its current process to complete the additional requirements of the ACA.

PLAN CERTIFICATION POLICY REVIEW

During various discussions at Board meetings throughout 2012, members expressed interest in reviewing the free market facilitator model on a regular basis to determine if or when the Exchange should transition to an active purchaser model. At the December 13, 2012 Board meeting the Board determined it would formally review all plan certification policies on a semiannual basis[3].

PLAN CERTIFICATION , RECERTIFICATION AND DECERTIFICATION

PLAN CERTIFICATION AND MANAGEMENT ADVISORY COMMITTEE RECOMMENDATIONS

On October 29, 2012, the Plan Certification and Management Advisory Committee reiterated the free market facilitator key principle (recommendation (a) below) and provided recommendations regarding plan certification, recertification and decertification (recommendations (b), (c) and (d) below):

a. Notwithstanding any requirement or limit to the contrary, any health plan that meets the requirements of the Exchange, the Division of Insurance and the Affordable Care Act and its regulations will be certified as a Qualified Health Plan (QHP) to be offered on the Exchange.
b. Allow the Division of Insurance, on behalf of the Exchange, to certify health plans as QHPs to be offered on the Exchange.
c. Allow the Division of Insurance, on behalf of the Exchange, to recertify health plans as QHPs to be offered on the Exchange on an annual basis.
d. The Exchange may decertify a QHP that ceases to meet the requirements of the Exchange, the Division of Insurance or the Affordable Care Act and its regulations by majority vote of the Board. The Exchange will set up a procedure for decertification of a QHP that will include an appeals process.

[2] Advisory Committee Recommendations Approved by the Board, Plan Certification and Management Recommendation 2, Division of Insurance Conduct Rate Review
[3] Advisory Committee Recommendations Approved by the Board, Plan Certification and Management Recommendation 6, Plan Certification Policy Review

On December 13, 2012, the Board discussed these recommendations, the amount of control the Exchange Board maintains and the effects that control would have on the Exchange market. Members recognized that the Exchange has been moving forward as a free market facilitator but some members were concerned that allowing the DOI to complete the entire certification, recertification and decertification process without any review of the plans ceded too much control to the DOI and may set a precedent that would be difficult to return to the Exchange Board. Some members recommended creating a process in which standards could be set in the future for carrier participation; that such standards would allow only the highest quality carriers to participate in the Exchange. Others preferred to weed out plans after they are certified citing concerns that there may not be enough QHPs available on the Exchange; that the Exchange would simply choose the best of the QHPs available in a given year. There was also concern about what standards the Board would set to determine whether to decertify a plan, whether the decision would appear to be arbitrary or capricious and the consequences of decertifying a plan in the middle of a plan year.

EXCHANGE RESPONSIBILITY TO CERTIFY, RECERTIFY AND DECERTIFY

The following excerpts from 45 CFR Part 155 are provided to help clarify federal requirements (emphasis added):

> "The *Exchange* may certify a health plan as a QHP in the Exchange if… the *Exchange* determines that making the health plan available is in the interest of the qualified individuals and qualified employers…"[4]
>
> "The *Exchange* must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements in § 155.1000(c)."[5]
>
> "The *Exchange* may at any time decertify a health plan if the *Exchange* determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in § 155.1000(c)."[6]

The Federal Rule is very clear that the *responsibility* to certify, recertify and decertify a health plan as a QHP lies with the Exchange. The Board, of course, is ultimately responsible for the success or failure of the Exchange. However, the Board is not required to certify, select or approve specific plans, but rather, to ensure the Exchange has adequate processes in place to certify the appropriate plans. The regulations do not limit the Exchange's ability to delegate the authority to certify plans.

QHP certification has limited application outside the Exchange. Carriers are required to charge the same premium rate for a QHP regardless of whether the plan is offered through the Exchange or directly to the individual (outside the Exchange).[7] Therefore, all QHPs offered on the Exchange will be available for purchase outside the Exchange. Carriers may benefit from

[4] 45 CFR § 155.1000(c)(2)
[5] 45 CFR § 155.1010(a)(2)
[6] 45 CFR § 155.1080(c)
[7] 42 USC § 18021(a)(1)(C)(iii)

marketing such QHPs outside the Exchange to those individuals who do not qualify for the advance premium tax credit. However, those who enroll in a QHP outside the exchange would not be required to disenroll from the QHP if it is decertified.

PLAN CERTIFICATION AND RECERTIFICATION FUNCTIONS

EXPERTISE

The question, then, is who has the expertise to perform the formal plan certification review. With whom should the Exchange partner to perform this function. The plan certification and recertification process includes (but is not limited to) a review of the following items:

1. Benefit design (45 CFR § 156.200(b)(3))
    a. Inclusion of all Essential Health Benefits
    b. Conformance with cost sharing limits
    c. Conformance with Actuarial Value metal tiers and silver plan variations
2. Confirmation of license in good standing (45 CFR § 156.200(b)(4))
3. Include quality improvement strategies; disclose, report on quality outcomes (45 CFR § 156.200(b)(5))
4. Comply with the requirements of the risk adjustment program (45 CFR § 156.200(b)(7))
5. Confirmation (45 CFR § 156.200(c)):
    a. Carrier offers at least one silver and one gold plan
    b. Plan includes a child only plan
6. Confirmation plan does not discriminate (45 CFR § 156.200(d))
7. Marketing and benefit design (45 CFR § 156.225)
8. Confirmation carrier holds a certificate of adequate network (45 CFR § 156.230)
9. Confirmation carrier holds a certificate of accreditation (45 CFR § 156.275)
10. Segregation of funds for abortion services (45 CFR § 156.280)
11. Number of QHPs from a licensed carrier in a given tier (limit 5)[8]
12. Conformance with other requirements of the Affordable Care Act (45 CFR § 156.200(b)(1))

The Plan Certification and Management Advisory Committee recognized the expertise of the DOI and sought to leverage the rate review process that the DOI already performs. While 45 CFR Part 155 clearly indicates plan certification and recertification are the responsibility of the Exchange, seeking a partnership with the DOI to perform these responsibilities does not remove it from the Exchange's purview. Additionally, such a partnership need not be permanent.

CONTRACT/MOU REQUIREMENTS AND TERMINATION PROVISIONS

On September 13, 2012, the Board reviewed the Memorandum of Understanding (MOU) between the Exchange, DOI and Department of Health and Human Services. The MOU was

[8] Advisory Committee Recommendations Approved by the Board, Plan Certification and Management Recommendation 5, Number of QHPs Offered by Each Carrier in a Given Tier

designed to be a living document that could be updated as appropriate. Paragraph 4 of the MOU states:

> "The terms of this MOU may be modified, in writing, upon the consent and signature agreement of all the Parties. The terms of this MOU shall be reconsidered and modified accordingly by the Parties upon material change of the ACA or relevant Nevada law."

The MOU provides a broad overview of the various functions of the Exchange and which entity would take the lead role for each function based on the best information available at the time. Paragraph 5 of the MOU states:

> "The Parties understand that the various duties, obligations, and responsibilities of the law are undetermined in scope and involvement as of the date of this MOU. The matrix below illustrates categories and duties that may be required of each Party, and identifies as "Lead" the Party that has the lead role for that responsibility. The matrix is not all-inclusive, and may be amended as provided in paragraph 4."

The matrix includes the following relating to plan certification:

Duties	Exchange	DOI	DHHS
Design of certification requirements for QHPs	Lead	X	
Certification of QHPs	X	Lead	
Monitoring of QHPs	X	Lead	
Recertification/decertification of QHPs	X	Lead	
Rate review and approval for QHPs in the Exchange	X	Lead	

This MOU will need to be updated to reflect the decisions of the Board regarding plan certification.

EXPECTED RATE REVIEW AND CERTIFICATION/RECERTIFICATION WORKFLOWS

In requesting the DOI conduct the certification and recertification processes for the Exchange, staff envisioned the following workflow based on recommendations provided by the National Association of Insurance Commissioners (NAIC).[9] This workflow assumes the Board has set specific measurable criteria, prior to plan submission, for carriers to target and for the DOI to follow in determining whether a plan will be certified or recertified.

1. Plan submission
    a. Insurer creates plan binder with templates (in SERFF- an electronic submission system administered by the NAIC)
    b. Insurer submits binder (in SERFF)
2. DOI Rate Review and Certification
    a. DOI receives binder (in SERFF)
    b. DOI reviews plan (in SERFF)

[9] This workflow is not final and is subject to the requirements of SERFF, the Division of Insurance, the Exchange web portal and the Exchange.

   i. If changes are needed, go to step 3
   ii. If no changes are needed, go to step 4
3. Plan resubmission (if changes are needed; rates rejected)
   a. Insurer receives request for change (in SERFF)
   b. Insurer creates update (in SERFF)
   c. Insurer submits update (in SERFF)
   d. Go back to step 2.b.
4. DOI Rate Review and Plan Certification Completion
   a. DOI completes rate review and certification (in SERFF)
   b. DOI records certification on behalf of Exchange
   c. DOI notes certification results in SERFF
5. SERFF Closeout[10]
   a. SERFF stores ratification results
   b. SERFF notifies insurers
   c. SERFF transmits data to Exchange web portal

BOARD INPUT WITHIN CERTIFICATION/RECERTIFICATION WORKFLOWS

The preamble to the exchange rule states, "At its discretion, an Exchange may establish additional recertification criteria or review processes, if the Exchange believes such criteria will improve the consumer experience."[11] As discussed, the workflows provided above assume the Board sets specific measurable criteria for the DOI to follow in determining whether a plan will be certified or recertified. These criteria can be altered each year as market conditions warrant. However, any changes to standards would be communicated prior to the first plan submittal for each plan year. Setting specific measurable criteria allows insurers to target a specific set of requirements to become certified. It will likely provide stability to the market, allow insurers to plan ahead and is likely to spur participation.

Based on the discussion of the Board on December 13, 2012, staff provides the following two options for the Board's consideration:

1. Carrier selection. The Board could, by majority vote, select only certain insurers to provide plans for certification or recertification prior to step 1 of the workflow.
   a. Pros:
      i. Gives the Board more control over which insurers will be allowed to participate.
      ii. More efficient than the plan selection option below; carrier selection would be completed by the Board prior to the beginning of the rate review

[10] The NAIC/SERFF workflow assumed the DOI would do rate review only and included an Exchange certification step between steps 4 and 5. However, the step is not necessary if the Exchange leverages the DOI's rate review process to conduct plan certification and recertification.

[11] Preamble, Final Rule CMS-9989-F, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Federal Register, Vol. 77, No. 59, Tuesday, March 27, 2012, Rules and Regulations, p. 18412.

and plan certification process; the DOI would only certify plans from selected insurers.

b. Cons:
   i. Without specific metrics to determine which insurers are allowed to participate:
      1. The decision of the Board may seem arbitrary and capricious.
      2. The Board could weed out good quality carriers or carriers that are more likely to participate.
      3. Carriers may be dissuaded from investing in the infrastructure necessary to participate in the Exchange if the criteria to select the carriers are unknown or inconsistent.
   ii. If the Exchange has specific metrics or criteria to determine which insurers should be selected, the determination could be made by the DOI during step 2.

2. Plan selection. The Board could, by majority vote, allow only certain plans to become certified during step 4 of the workflow.
   a. Pros:
      i. Gives the Board more control over which plans will be offered on the Exchange; could give the Board the ability to weed out poor performing plans.
      ii. Should provide more options to choose from than the carrier selection option above.
   b. Cons:
      i. Without specific metrics to determine which plans should be certified:
         1. The decision of the Board may seem arbitrary and capricious.
         2. The Board could weed out good plans with the poor performing plans.
         3. Carriers may be dissuaded from investing in the infrastructure necessary to participate in the Exchange if the criteria to select the plans are unknown or inconsistent.
      ii. Selection of plans may be time consuming. The average plan application is expected to consist of hundreds of pages of documentation. Assuming each application is only 100 pages, the Exchange eliminates 3 plans from certification and certifies 12 plans in the Individual Exchange as stated in the Exchange Strategic Plan, the Board would need to review 1,500 pages of documentation to come to a comprehensive conclusion regarding which plans are best for the Exchange.
      iii. Due to open meeting law and quorum requirements, this review by the Board could create delays in the plan certification process and may not allow enough time for user acceptance testing of plan documents and rates in the web portal.
      iv. If the Exchange has specific metrics or criteria to determine which plans should be selected, the determination could be made by the DOI during steps 2 and 4.

In pursuing these options, the Board should consider under what circumstances it might reject the DOI's recommendation to certify or recertify a plan. If those circumstances are based on specific criteria, how might the Exchange market benefit if those criteria are communicated in advance of plan submission? If the Board does not expect to override the DOI's recommendation, is the formal approval of the recommendation necessary?

DECERTIFICATION

DEFINITION

45 CFR § 155.1080(a) defines decertification as "the termination by the Exchange of the certification status and offering of a QHP." Therefore, we interpret "decertification" to include a situation in which a previously certified QHP is not recertified. Additionally, "the Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in § 155.1000(c)."[12]

CONSEQUENCES

It is important to ensure carriers meet the standards of the Exchange. However, it is equally important to understand the consequences of decertification. If a plan is decertified (or not recertified), all enrollees of the plan must select a new plan. Deductibles would be reset in the new plan which would mean that anyone who paid any portion of their deductible under the decertified plan would not receive any credit for that payment. A mid-year decertification may cost participants a lot of money and cause extreme dissatisfaction with the Exchange.

MID-YEAR DECERTIFICATION

Because of the disruption that is likely to occur due to a mid-year decertification, staff assumes that it is not the intent of the Board to decertify a plan in the middle of a plan year. To clarify this point, staff provides the following example.

Assume an insurer holds a certificate of accreditation and provides certified QHPs on the Exchange. Assume that same insurer, is going through a review of its accreditation and loses its accreditation. Technically, it no longer meets the certification standards provided in 45 CFR § 156.275. However, the incremental drop in quality that moved the insurer from a satisfactory accreditation to no accreditation should not warrant requiring thousands of enrollees to immediately select a new plan. It may warrant a probation period or decertification at the end of the plan year.

The federal rule allows for multiple enforcement options:

> "QHPs with persistent or significant compliance issues should be decertified and removed from the Exchange; however, we recognize that Exchanges may, for example, wish to pursue intermediate sanctions for minor violations of certification standards that do not adversely impact consumers, so

[12] 45 CFR § 155.1080(c)

> long as such actions are consistent with applicable law. While it is our expectation that an Exchange would decertify a QHP that is not compliant with certification standards or where the health and safety of an enrollee may be at-risk, this final rule permits Exchanges to explore a variety of oversight and enforcement strategies, up to and including decertification."[13]

On the other hand, an insurer could have an egregious violation or financial solvency issue that would warrant decertification in the middle of the plan year. The DOI is committed to protecting the rights of Nevada insurance consumers. Those rights include participating in a high quality plan that do not have egregious violations and participating in a stable plan for an entire year in which the participant can enjoy the full protections from financial risk. The DOI has a multitude of legal tools to use to assist the carriers to correct an issue. If the issue cannot be corrected, an insurer's license to provide health insurance may be revoked. An issuer cannot participate in the Exchange if they are not licensed and in good standing to offer health insurance coverage.[14]

Staff recommends that the Exchange proceed with a mid-year decertification only as a result of a revocation by the DOI of a license to provide health insurance. A decertification for revocation of a license would not be appealable. The Exchange would work closely with the DOI in these cases.

RECOMMENDATION(S)

Based on the recommendations of the Plan Certification and Advisory Committee and the discussion of the Board, staff recommends:

a. Any health plan that meets the requirements and standards of the Exchange, the Division of Insurance and the Affordable Care Act and its regulations will be certified as a Qualified Health Plan (QHP) to be offered on the Exchange. The requirements and standards of the Exchange may be changed by the Exchange for any future plan year. Any change to the requirements and standards of the Exchange will be communicated to the Division of Insurance, carriers and the public prior to the start of the plan certification process.
b. Request the Division of Insurance, on behalf of the Exchange, certify or recertify health plans as QHPs to be offered on the Exchange on an annual basis.
c. The Exchange will proceed with a mid-year decertification only as a result of a revocation by the DOI of a license to provide health insurance. A decertification for revocation of a license would not be appealable. The Exchange would work closely with the DOI in these cases.
d. The Exchange will set up a procedure for decertification of a QHP that will include an appeals process.
e. Pursuant to 45 CFR § 155.1000, ultimate responsibility for certification lies with the Exchange. The Exchange may, for any year after 2014, change any plan certification policy, strengthen the insurer participation standards and QHP standards or elect to

[13] Preamble, Final Rule CMS-9989-F, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Federal Register, Vol. 77, No. 59, Tuesday, March 27, 2012, Rules and Regulations, p. 18413.
[14] 45 CFR § 156.200(b)(4)

switch to an active purchaser model. Such changes will be made in consultation with the Commissioner of Insurance and communicated to the Division of Insurance, carriers and the public prior to the start of the plan certification process.