United States

Office of

Personnel Management

The Federal Government's Human Resources Agency

Multi-State Plan Program Issuer Letter

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Subject: Multi-State Plan Program Call Letter

SUBMISSION OF PROPOSALS

This is our annual call for applications and recertification submissions from prospective and current Multi-State Plan (MSP) issuers for the contract term beginning January 1, 2015. We will provide a timeline as well as specific application and recertification instructions at a later date.

MSP PROGRAM BENEFITS AND INITIATIVES

I.   Introduction

The MSP Program was created to bring choice and competition to the Health Insurance Marketplace (also referred to as "Affordable Insurance Exchanges" or "Exchanges"). The Program's charge is to make available at least two quality, affordable MSP options in the Marketplace in every State and the District of Columbia.

In light of the breadth of its charge, the Affordable Care Act provides for the MSP Program to be phased in over several years. We built a strong foundation for the Program in the inaugural year, having certified more than 150 MSP options that are now available to consumers in 30 States and the District of Columbia. OPM also certified MSP options for the Small Business Health Options Program (SHOP) in four States and the District of Columbia. For 2015, our goal is to expand MSP coverage to at least five additional States, and to add one or more new MSP issuers or groups of issuers.

A. OPM's Application and Recertification Processes

As provided in the Affordable Care Act, OPM is implementing the MSP Program in a manner similar to the manner in which OPM administers the Federal Employees Health Benefits (FEHB) Program. Accordingly, we intend to follow a process modeled on the FEHB Program, but modified to take into account the special requirements of offering health insurance products on the Marketplace.

The process for initial certification of MSP options begins with the submission of an application by a health insurance issuer (or a group of issuers). Issuers already offering MSP coverage in 2014 will complete a streamlined recertification submission. All applications and recertification submissions will be completed through our convenient, secure, online web portal. We expect issuers to submit accurate, reliable, and timely information.

Issuers will submit to OPM many of the same templates that the Department of Health and Human Services (HHS) has developed for qualified health plans (QHPs). Issuers will also submit their policy forms and rate filings to both OPM and the appropriate regulators for the States where they propose to offer MSP coverage. OPM collaborates closely with State regulators on reviews of MSP options. Our team will be available to assist interested issuers in completing the MSP application process and in working through any applicable State and HHS processes and timelines.

MSP options, offered under a contract between OPM and an MSP issuer, are deemed certified by a Marketplace. We have developed a standard contract under which MSP options were certified for 2014, and we will be soliciting comments on that standard contract before certifying MSP options for 2015.

B. MSP Program Priorities for 2015

The MSP Program is committed to the goals of better care, affordable care, and healthier people and communities, as described in the National Quality Strategy.[1] In addition, we are committed to ensuring that MSP coverage takes into account the health care needs of diverse patient populations, and is available in all States and the District of Columbia by 2017. For 2015, we solicit applications and recertification submissions from issuers who share these commitments.

For 2015, we are interested in making progress on building a more robust MSP brand identity that will resonate with consumers in every State where MSP options are available. At the same time, we do not want to foreclose issuers from offering innovative MSP options to consumers

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[1] U.S. Department of Health and Human Services. Report to Congress: National Strategy for Quality Improvement in Health Care. March 2011. Available at http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf.

that may not be consistent across State lines, especially at this early stage in the program. Accordingly, we aim to balance consumers' desire for consistency among MSP options offered across the country with issuers' need for flexibility in designing those options to meet their business needs, which may vary from State to State.

We believe it is consistent with both interests, however, to ensure that consumers have clarity about the benefits and limitations of MSP options. For example, consumers should be able to determine how any one MSP option available to them differs from other MSP and QHP options offered by the same issuer in the same service area; the type of network coverage available under the MSP options and the providers participating in that network; and how the pharmacy benefit is structured.

These broader themes are reflected in the more specific guidance provided below for four key areas:[2] 1) benefit design; 2) wellness; 3) network standards; and 4) quality of care.

II.   Benefit Design

A. <u>MSP Coverage</u>

1. Family Coverage – Beginning in 2015, we expect MSP issuers to offer both family coverage and self-only coverage at the silver and gold metal levels.

2. Stand-alone Dental Coverage – OPM is not accepting applications for stand-alone dental plans for 2015, but we may consider accepting such applications in future years.

B. <u>Meaningful Difference</u>

A goal of the MSP Program is to encourage choice and competition in the Marketplace. To make an informed health plan selection, consumers must be able to distinguish between various health plan options. We recognize that some issuers may wish to offer multiple MSP options, as well as QHP options, to consumers in a given State. In that situation, we encourage MSP issuers to ensure that a typical consumer shopping for health insurance coverage can readily identify one or more meaningful differences between a given MSP option and the other options (both other MSP and QHP options) sold by the issuer in the Marketplace.

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[2] Consistent with the MSP Program final rule, MSP issuers must generally comply with State laws. The issues raised in this Call Letter do not have the effect of setting an MSP standard that would deem a State law inapplicable to an MSP issuer. OPM is committed to working closely with States to implement the MSP Program.

C. Mental Health Parity

On November 13, 2013, the Departments of the Treasury, HHS, and Labor released final regulations that implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.[3] The Departments also published FAQs discussing the timing of the requirements under the final regulations.[4] MSP issuers and applicants should review the requirements of the final regulations and ensure that their benefit designs are in compliance.

D. Essential Health Benefits

1. Non-discriminatory Benefit Designs – We expect MSP issuers to review plan benefits and design, in particular any limitations or exclusions related to age, and potentially discriminatory cost-sharing and prior authorization requirements to ensure that they are in compliance with all Federal and State laws barring discrimination,[5] including the standards set forth at 45 CFR 156.125 and 45 CFR 156.200(e), which bar discrimination based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

2. Habilitative Services – We recognize that coverage of habilitative services as an essential health benefit is evolving. Lacking a standard definition, many issuers have begun by offering habilitation in parity with rehabilitative services. However, the duration and scope of services an individual may need to acquire skills for the first time may differ from what a person may need to regain function after illness or injury. To accommodate such unique circumstances, we encourage MSP issuers to provide a reasonable "exceptions process" to consider requests for additional habilitative services when such services are medically necessary to achieve a therapeutic milestone or avoid significant deterioration in health status.

3. Prescription Drugs – To help consumers understand and evaluate pharmacy benefits, we encourage all MSP issuers to consider adopting a common pharmacy benefit structure with at least the following four suggested tier levels, where State law permits:

   ▪ Generics
   ▪ Preferred brands

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[3] Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 FR 68239 (November 13, 2013). Available at https://federalregister.gov/a/2013-27086.
[4] FAQs About Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation (January 9, 2014). Available at www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html.
[5] 45 C.F.R. § 800.101(i).

- Non-preferred brands
- Specialty drugs

We also expect that drugs in each formulary tier will conform to the tier's description (*e.g.*, all generic drugs should be placed on any tier labeled "Generics"), with limited exceptions. Ensuring consistency between tier descriptions and the drugs found on that tier will improve consumers' understanding of the MSP Program pharmacy benefit.

Further, we note that the Centers for Medicare and Medicaid Services (CMS) intends to propose through rulemaking that Marketplaces may require that issuers temporarily cover non-formulary drugs (including drugs that are on the issuer's formulary but require prior authorization or step therapy) as if they were on the issuer's formulary during the first 30 days of coverage, for coverage beginning on January 1 of each year, starting with the 2015 plan year. This proposed policy would also allow those newly enrolled in a QHP to receive coverage for a non-formulary drug during this time period without using the exceptions process. This would prevent disruptions in treatment for new enrollees while the issuer and/or the enrollee pursues prior authorization, step therapy, and/or drug exception processes and would only apply to enrollees who change QHPs or become newly enrolled in a QHP after having other non-QHP coverage. We encourage MSP issuers to accommodate the needs of new enrollees by covering a transitional fill of these drugs for new enrollees.

III.   Wellness

A. Preventive Care

The Affordable Care Act offers coverage to individuals who were previously uninsured or underinsured. This increases the importance of educating consumers about the value of preventive care, in particular the availability of those services that have no cost-sharing requirements. We strongly encourage MSP issuers to develop patient education programs that address the needs of individuals who are new to the health care system.

B. Weight Management

The United States Preventive Services Task Force recommends screening adults and children for obesity and providing referrals for behavioral change interventions where applicable, and issuers are required to cover these services without cost-sharing. We appreciate the efforts of issuers to ensure these services are available. Given the impact of obesity on individual and population health, we also encourage issuers to provide enrollees with access to a full range of weight reduction treatment interventions. Issuers that specifically exclude coverage for weight reduction and/or management interventions should review the clinical rationale for those exclusions and document how enrollees will receive appropriate care to achieve and sustain a healthy weight.

C. Coverage of Primary Care

CMS is considering whether to require through rulemaking that all plans, or at least one plan at each metal level per issuer, cover three primary care office visits prior to meeting any deductible. We encourage MSP issuers to cover three primary care office visits prior to meeting any deductible.

IV.   Network Standards

A. Network Adequacy

MSP issuers must provide adequate access to high-quality in-network care wherever they offer coverage. Consumers must be able to receive care from providers with the appropriate expertise to treat them without unreasonable delay. We expect MSP issuers to have sufficient numbers and types of providers in their networks to meet the needs of a diverse population, to monitor their networks continuously for quality and access, and to make prompt adjustments to networks as needed. We will pay special attention to areas where concerns have been raised about network adequacy. Every MSP issuer must ensure that each of its provider and pharmacy networks, as available to all enrollees, meets the following standards:

- Is sufficient in number and type of providers or pharmacies to ensure that all services are accessible without unreasonable delay;
- Is consistent with the network adequacy provisions of § 2702(c) of the Public Health Service Act; and
- Includes a sufficient number of essential community providers and retail pharmacies that serve predominantly low-income, medically-underserved individuals, in compliance with 45 C.F.R. § 156.235.

In addition, MSP issuers must have in place a process to provide timely exceptions to ensure that consumers who need care from out-of-network providers (because of rare or complex medical conditions or lack of in-network providers in a geographic area) can receive it with reasonable cost-sharing, applying enrollee costs to the in-network out-of-pocket maximum, and protection from balance billing. Finally, we expect MSP issuers to provide consumers with ready access to clear and accurate provider directories, both before and after they are enrolled.

B. Consistent and Continuous Coverage

We envision the MSP Program as providing consistent and continuous coverage throughout the United States. To advance this goal, we encourage MSP issuers to:

- Ensure that preferred provider organizations (PPOs) offer out-of-service-area coverage that is not limited to emergent and urgent care.
- Provide coverage throughout metropolitan areas that cross State boundaries.
- Facilitate the administrative transfer of coverage from one State to another State to assist consumers who move among States.

V.   Quality of Care

We believe MSP issuers can become quality leaders, distinguished by their performance regionally and nationally. As issuers gain sufficient numbers of enrollees, we intend to require specific quality and customer service measures reported at the product level.[6] In the interim, beginning the first year that an issuer offers an MSP option, any issuer that collects a Consumer Assessment of Healthcare Providers and Systems (CAHPS[7]) sample on any line of business must also report those results to OPM. The format and timeframe for these submissions will be provided by separate communication.

OPM may share CAHPS results to assist consumers in their choice among plans. OPM also intends to recognize plans demonstrating exceptional customer satisfaction. We invite issuer input on how best to accomplish this.

CONCLUSION

In addition to feedback on any of the specific initiatives described above, we welcome general recommendations to improve the MSP Program and meet consumers' needs. Specifically, we will entertain programs or pilots that enhance the ability of MSP options to distinguish themselves in the market and ideas to build performance incentives for MSP issuers. If you have any questions about this letter, please address them to mspp@opm.gov.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

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[6] 45 CFR § 800.112.
[7] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).