



BP 3.14 PCIP TRANSITION PLAN

In accordance with section 155.345(i) of the Exchange Final Rule, the Exchange must follow procedures established in accordance with 45 CFR 152.45 related to the Pre-Existing Condition Insurance Plan (PCIP) transition.

The WV OIC attests to the fact that HHS will handle the transition of individuals on the PCIP as HHS operates the PCIP plan in West Virginia; however, the State intends to comply with future guidance.



West Virginia Offices of the Insurance Commissioner

Blueprint Section 4 - Plan Management

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4.0 PLAN MANAGEMENT

BP 4.1 AUTHORITY TO CERTIFY AND OVERSEE QHPs

THE EXCHANGE HAS THE APPROPRIATE AUTHORITY TO PERFORM THE CERTIFICATION OF QHPs AND TO OVERSEE QHP ISSUERS CONSISTENT WITH 45 CFR 155.1010(A)

As expressed in former West Virginia Governor Joe Manchin’s letter to HHS Secretary Kathleen Sebelius dated September 20, 2010 (see supporting document titled “Governor’s Letter_ACA Enforcement_9_20-10”), the WV OIC will use the tools currently available under State law to enforce the provisions of the ACA. Specifically, the primary authority for WV to review and recommend Qualified Health Plans (QHPs) for certification lies in the requirement that all insurance policy forms and rates for individual and small group health plans be filed with and approved by the WV Insurance Commissioner prior to such plans being marketed to WV consumers (W. Va. Code §§33-6-8, 33-15-1b & 33-16B-1). WV Code 33-6-9(e) requires the Insurance Commissioner to disapprove a form “if the coverages provided therein are not sufficiently broad to be in the public interest.”

Following certification of a QHP and the sale of such plans in WV, the Insurance Commissioner will be able to monitor and enforce insurer compliance with the terms of the policy and the filed rates in the same manner as with other plans, using all the available tools such as the authority to: Examine any issuer's "financial condition and methods of doing business" at any time (W. Va. Code §33-2-9); enjoin and penalize any person found to be "transacting insurance in an illegal, improper or unjust manner (WV Code 33-2-10 & -11); revoke a license of or to impose a penalty of up to \$10,000, seek a receiver and/or injunction or any “further orders as may be necessary ...” with respect to any issuer found to be "transacting insurance in an illegal manner" (33-3-11); and to issue cease and desist orders under the Unfair Trade Practices Act with respect to undefined acts that are “unfair or deceptive” (33-11-7). In addition, in light of the Commissioner's duty to oversee insurer solvency includes a duty to act if it appears that an issuer may be in a “hazardous condition”, the potential for large HHS-imposed fines occasioned by ACA-noncompliance could trigger regulatory action such as placing the issuer under administrative supervision (33-34-1 et seq.).

West Virginia will continue to evaluate whether the State’s enforcement capabilities could be enhanced with the passage of additional legislation.

Per submission of the Declaration Letter, the WV OIC expresses an intent to carry out the functions of a yet to be developed agreement with the Federal government. Pursuant agreement on the terms of this agreement, the WV OIC will carry out the listed state functions of the Federal-State Partnership.

BP 4.2 QHP CERTIFICATION PROCESS

THE EXCHANGE HAS A PROCESS IN PLACE TO CERTIFY QHPS PURSUANT TO 45 CFR 155.1000(C) AND QHP CERTIFICATION REQUIREMENTS CONTAINED IN 45 CFR 156

CAPACITY TO CERTIFY QHPS (BP 4.2A)

THE EXCHANGE HAS THE CAPACITY TO CERTIFY QHPS IN ADVANCE OF THE ANNUAL OPEN ENROLLMENT PERIOD PURSUANT TO 45 CFR 155.1010(A) (1)

In January 2013, the OIC Health Policy Division performed a staffing analysis with other OIC Divisions expected to be involved either directly (e.g., Rates and Forms) or indirectly (e.g., IT) in the QHP initial certification and ongoing monitoring process. The analysis indicated that in the first year, approximately 4.2 FTE's across seven Divisions will be required to perform Plan Management responsibilities, only two of which are new FTE's to the OIC.

As a natural extension of existing responsibilities approving insurance rates and forms for use in WV, the OIC's Rates and Forms Division will serve as the central coordinator for the evaluation of QHPs seeking certification, using SERFF to collect information from the issuer and gather evaluation results from other OIC Divisions and communicate with the issuer regarding the application status. The expectation is that the existing Rates and Forms team will be capable of managing surges in activity around initial certification and annual open enrollment from QHP issuers as they are accustomed to increased filings resulting from new state, federal or other requirements and other annual submissions; additionally, the number of QHP filings is expected to be relatively low (see Section 4.3 for details on expected QHP quantity).

Two existing Rates and Forms staff members are being cross-trained to assist the two Rates and Forms Analysts who currently review Life and Health filings, and, consistent with existing processes, actuarial subcontractors may be leveraged as needed to perform actuarial review of rate filings and plan actuarial value. The Rates and Forms Division Director will also provide support for planning and implementation activities.

This expectation will continue to be evaluated as the OIC learns additional information about review requirements and the number of expected QHP submissions.

CAPACITY TO ENSURE COMPLIANCE WITH QHP CERTIFICATION STANDARDS (BP 4.2B)

ENSURING QHP COMPLIANCE WITH THE QHP CERTIFICATION STANDARDS CONTAINED IN 45 CFR 156, INCLUDING BUT NOT LIMITED TO STANDARDS RELATING TO LICENSURE, SOLVENCY, SERVICE AREA, NETWORK ADEQUACY, ESSENTIAL COMMUNITY PROVIDERS, MARKETING AND

Overview

The OIC will ensure that policies, operating procedures and systems are in place for the certification of QHPs. Multiple OIC Divisions –such as Health Policy, Rates and Forms, Market Conduct, Consumer Services, Financial Conditions, and Legal- are collaborating in the development of the certification approach. In addition, the OIC has engaged in extensive stakeholder outreach to insurance issuers, consumer advocates, providers and producers to gather their input into policy and process development, and the OIC has partnered with the National Association of Insurance Commissioners (NAIC) in areas such as the development of white papers and enhancements to SERFF.

West Virginia will build off of existing processes currently performed by the OIC to complete a review of issuer and plan compliance with QHP certification requirements. The OIC has established a certification “checklist” or set of standards against which the QHP application will be evaluated, and the review of the QHP application will be performed by Rates and Forms , who will reach out to other Divisions within the OIC, e.g. Market Conduct, Rates and Forms, Consumer Services, and Financial Conditions, as necessary. SERFF will be the primary IT system used to manage all steps in these business processes, including communications (via the “Correspondence” tools) between the OIC and issuers during initial evaluation of and revisions to the plan.

Revision of the QHP application will largely mirror and leverage existing OIC processes for revising issuer filings since the QHP application will be submitted via SERFF and evaluated in large part by Rates and Forms. This process may be performed at different points during the QHP certification process to allow the issuer to resubmit portions of its QHP application or to submit supplemental data if issues with the application are discovered during review.

A decision to recommend *non-certification* of a QHP to HHS will be determined by Rates and Forms based upon whether or not the plan meets the certification criteria (or certification “checklist”) as established by Federal statute and rule. Trigger events for non-certification may also include failure to submit plan information within the established QHP application window; however, Rates and Forms has the discretion to allow for a grace period if it is deemed in the best interest of consumers (e.g. to provide for more QHP selection in the Exchange). The OIC does not intend to perform appeals of non-certification and decertification decisions since it is only making QHP certification and decertification recommendations to HHS, which has ultimate decision-making through the ratification process.

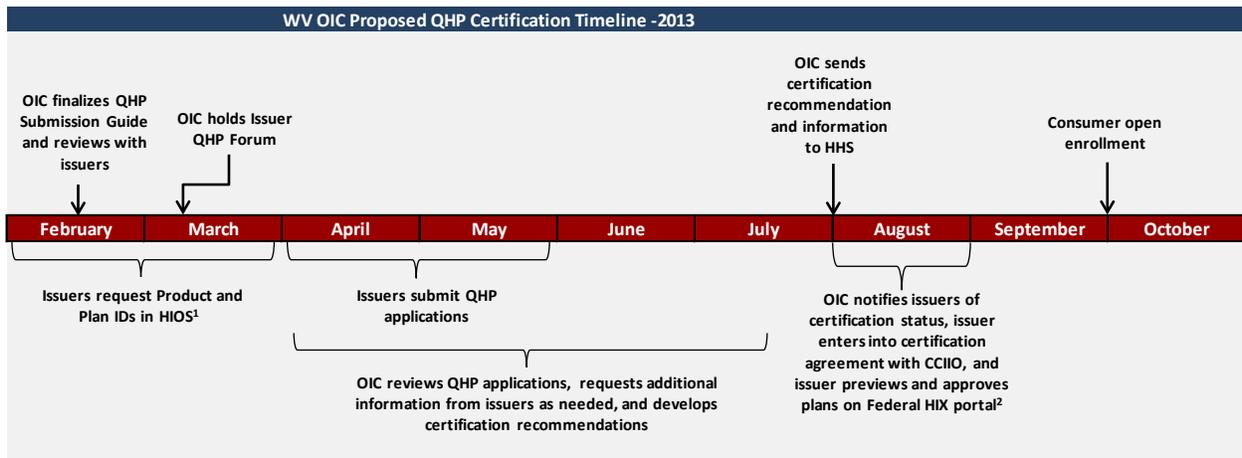
Contingent upon the release date of SERFF v6.0 on March 28, 2013, the OIC is prepared to review and recommend certification of QHPs to CCIIO by the deadline of July 31, 2013.

These processes are described in this narrative and further supported by the West Virginia-specific process flows, which are being submitted as a supporting document. West Virginia is also submitting a “WV OIC QHP Certification Checklist” supporting document with this narrative; please reference the

document for a table of QHP certification requirements, OIC standards, and reviewing entities. The issuer “QHP Submission Guide” also provides details on the standards, submission, and review processes the OIC will employ in support of QHP certification.

Timeline

Based on currently available information, the OIC has proposed the following QHP certification timeline. The proposed timelines were adjusted based on the delay in the SERFF v6.0 release to March 28, 2013, and would need to be adjusted should the release be delayed again.



¹Estimated dates only as dependant upon CCIO

²Dependent on timing of HHS ratification of OIC decisions and processing of data sent from the State

Prior to notification of the delay in the SERFF release, WV considered allowing stand-alone dental plans to be submitted in advance of other QHP’s to allow issuers submitting major medical QHP’s to make decisions about how to structure the plans, e.g. whether or not to include the pediatric dental benefit or not. The State has reconsidered this approach as HHS has indicated they will confirm the presence of stand-alone dental plans in the marketplace prior to the opening of the application window for QHP’s offering major medical coverage.

The timeline is based on the following feedback and assumptions:

- Release of SERFF v6.0 delayed until March 28, 2013, however the system will be prepared to begin accepting QHP applications on that date
- HHS will grant Partnership states until July 31, 2013, to review QHP applications and submit certification recommendations and data to the Exchange
- Carriers desire a minimum 60-day application window, with a preference for 90 days
- Existing WV filing and review processes, which provide the OIC with 60 days after submittal to review and approve a filing and 10 days for the issuer to respond to OIC requests for revisions or additional information (with the ability to request an extension) will be truncated due to compressed review timelines

The OIC is concerned about the ability of issuers to submit QHPs within the required timeline considering their comments regarding the delay in developing plans as they await important final information related to product design and pricing (e.g. EHB's, rating rules) . Similarly, the OIC is concerned about the ability to review the QHPs and make certification recommendations to HHS by the deadline established by HHS. The OIC has developed the following mitigation strategies to address this concern:

- Provide extensive support and training to carriers in advance of and during application submission to simplify and facilitate the QHP application process ;
- Move forward with the actuarial vendor on developing rating factors to the degree possible with the information available and conform to what the market is currently doing as appropriate to minimize disruption and allow issuers to develop QHPs;
- Request additional time from HHS for review of plans if needed;
- Reduce application time for carriers (from preference of 90 days to 60) and OIC review time (from 90 to 60 days);
- Leverage existing review and approval prioritization processes to manage Rates and Forms workflow.

The OIC will continue to work through these concerns with HHS and carriers and refine the proposed QHP submission and review dates as needed should additional changes be required.

Co-Op Plans

Should a CO-OP be formed in WV, reviews will be conducted on the same basis and in the same manner as for other regulated issuers. The OIC will review all plans and provide recommendations to HHS on whether a CO-OP plan meets standards for a QHP to assist HHS in its decision to deem a CO-OP as certified to participate in the FFE Partnership according to 42 CFR 156.520 (e).

Stand-Alone Dental Plans

Aligned with existing processes, issuers will submit stand-alone dental plan applications for review by the Rates and Forms Division using SERFF. The OIC had originally proposed accepting and reviewing SADP's prior to QHPs providing major medical coverage in order to inform issuers whether or not an SADP is expected to be sold within the Exchange so their plans may be developed accordingly (i.e. they can opt not to provide the pediatric dental EHB), however early submission may no longer be possible or required given compressed timelines from the SERFF delay and HHS' plan to confirm with national dental representatives that plans will be offered in the state.

The OIC is awaiting additional guidance from HHS related to other aspects of stand-alone dental plans prior to making decisions and developing policies and procedures related to their inclusion in the Exchange. The State has, however, entered into an MOU with the WV Oral Health Program to develop an oral health strategy for the Exchange. Areas covered include: 1) methods to maximize the number of Exchange consumers procuring dental coverage; 2) an assessment of the availability of dentist and dental hygienist practices in state carrier networks; and 3) recommendations for how dental plans

should be made available and presented on the Exchange in terms of standardization, comparison, and coverage.

SHOP Plans

West Virginia has not identified any major review process differences between the QHP certification processes for plans in the individual and small group (SHOP) markets. Reviews of SHOP plans will be conducted through the same process, timelines and criteria as for individual plans, although SHOP QHPs will be required to comply with the SHOP-specific criteria as outlined in § 156.285 of the final Federal rule. SERFF will be used to manage SHOP plans and will have the functionality required to maintain data elements related to SHOP. The OIC will continue to consider SHOP-specific requirements in its Plan Management planning and implementation efforts.

Initiate QHP Application Process

Prior to the commencement of the QHP certification process, the OIC will communicate the process and timeline for issuer submission of plan filings. This communication will include a general announcement about the QHP application and certification process and instructions for submission, deadlines for filing QHP applications, and contact information if issuers have questions or need assistance during the submission process. The OIC also anticipates that this information may be made available to issuers in SERFF on the QHP-Specific General Filing Instructions page and via SERFF's State-Generated Messages.

To date, the OIC has developed a QHP Submission Guide to provide guidance to health insurance issuers regarding the certification standards for individual and/or SHOP Qualified Health Plans (QHPs) offered through the Exchange. An overview of the Guide and the QHP certification requirements will be reviewed with issuers at a stakeholder meeting on February 12, 2013. Additionally, the OIC is planning a day-long issuer forum for March 5th with the following objectives¹:

- Provide issuers with an overview of the State and Federal oversight responsibilities in a Federally Facilitated Plan Management Partnership Exchange;
- Support and prepare issuers by providing information on the timeline and processes, standards, and IT systems and tools that will be used to support Qualified Health Plan (QHP) submission and certification in West Virginia;
- Provide information on rating factors and the approach to rate review in West Virginia; and
- Answer outstanding issuer questions related to QHP submission and certification.

Applications will be accepted via the System for Electronic Rate and Form Filings (SERFF) system. Although West Virginia continues to work with NAIC to define the specifics of how SERFF can and will be used to perform the QHP application intake and review processes, the expectation is that the majority of information and data required for QHP review will be able to be submitted to the OIC by issuers in

¹The QHP Submission Guide, stakeholder presentation from February 12th, and the meeting agenda for March 5th have been provided as supporting documents.

SERFF. Some information will be directly entered into fields in SERFF but other elements such as plan, product, and issuer information; benefits, cost-sharing, and rates; and the formulary will be uploaded using SERFF standard templates (developed in partnership with HHS). Using standard templates will ensure the necessary data are captured for HHS, maximize consistency and efficiency for carriers that have products in multiple states, and to take advantage of the instructions and data validation made available in SERFF. WV will consider the ability to use .pdf attachments in SERFF if additional state-specific information must be gathered. NAIC also indicated that the SERFF team is working with the Phase I accreditation entities (NCQA and URAC) to automate the collection and display of accreditation status (although the issuer must authorize sharing of such information).

Issuer-Level Review Criteria

Licensed, Solvent, and in Good Standing

In the QHP application process, West Virginia will continue to leverage the traditional role of the Financial Conditions Division of the OIC, which licenses carriers, stand-alone dental plans, and HMOs. The role of the OIC is to assure that these entities are financially solvent. To transact insurance in the State of West Virginia, entities that will provide QHPs in the market must have a valid license issued by the OIC.

A first step in the review of QHP applications will be to assure that the issuer filing the application is an admitted carrier in good standing. If this is not the case, the carrier will be required to complete the WV carrier licensing process, which is handled by the OIC's Financial Conditions Division. West Virginia is a NAIC Uniform Certificate of Authority Application (UCAA) participant state; therefore, West Virginia accepts the UCAA Primary and Expansion Applications. To obtain a license in West Virginia, insurers and stand-alone dental plans must follow the procedures outlined in the UCAA Primary and Expansion Applications.

The UCAA process is designed to allow insurers to file copies of the same application for admission in numerous states. Each state that accepts the UCAA is designated as a uniform state. While each uniform state still performs its own independent review of each application, the need to file different applications, in different formats, has been eliminated for all states that accept the uniform application.

The UCAA includes three applications. The Primary Application is for use by newly formed companies seeking a Certificate of Authority in their domicile state and by companies wishing to re-domesticate to a uniform state. The Expansion Application is for use by companies in good standing in their state of domicile that wish to expand their business into a uniform state. The Corporate Amendments Application is for use by an existing insurer for requesting amendments to its certificate of authority.

West Virginia has a goal of processing Primary Applications within 90 days of receipt and Expansion and Corporate Amendments Applications within 60 days of receipt. Resource constraints can lengthen this timeframe and in such case the applicant will be notified. To access the UCAA filing forms please go to http://www.naic.org/industry_ucaa.htm.

A Health Maintenance Organization (HMO) is a public or private organization which provides or otherwise makes available basic health care services to enrollees. Factors to consider in determining if an organization is an HMO include, but are not limited to, whether it: (1) receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis excluding copayments; (2) provides physician services through doctors who are either employees or partners of the organization and/or through arrangements with individual or group practice doctors; (3) assures the availability, accessibility, quality and effective utilization of the health care services which it provides; and (4) offers services through an organized delivery system in which a primary care physician is designated for each subscriber upon enrollment.

To operate in West Virginia, a foreign or domestic HMO must apply for and receive a Certificate of Authority from the Insurance Commissioner. Each application must set forth and be accompanied by the information and documentation requested. The Commissioner shall issue or deny a Certificate of Authority to any person filing an application within one hundred twenty days after receipt of the completed application.

An application will not be considered complete until all information and documentation requested have been submitted to the Commissioner, and the applicant has fully complied with all provisions or requirements of these guidelines or applicable laws. Prior to receiving a Certificate of Authority, an applicant will be contacted by the Insurance Commission to initiate the depositing of cash or government securities with the West Virginia Treasurer's Office in compliance with W. Va. Code §33-25A-4(2)(h). To view the licensure filing forms for HMOs please go to <http://www.wvinsurance.gov/company/Forms/HealthMaintenanceOrganization.aspx>.

Financial Conditions also performs financial analysis of health insurance companies, stand-alone dental issuers, and HMOs. The OIC utilizes the NAIC Level 1 checklist which gives an analyst a starting point to direct their analysis. The OIC relies heavily on the NAIC's Financial Analysis Handbook (Handbook), which was developed and released by the Financial Analysis Handbook Working Group (FAHWG) of the Examination Oversight (E) Task Force in 2004. The purpose of the Handbook is to provide a uniform risk-focused analysis approach for insurance departments to more accurately identify health entity's and/or holding company systems experiencing financial problems or to identify prospective risks that pose the greatest potential for developing financial problems. The Handbook includes both quantitative and qualitative procedures. The overall goal of the Handbook is to assist regulators to evaluate and understand health entity's risks; thus, potentially decreasing the frequency and severity of health entity insolvencies.

In addition, Financial Conditions uses the Financial Condition Examiners Handbook to assist in financial examinations on health insurance carriers, stand-alone dental issuers, and HMOs. The Annual Statement Instructions and §33-25A-9 of the West Virginia Code requires the submission of certain financial information pertaining to the officers and directors of West Virginia health issuers and HMOs. Quarterly and monthly financial statements must be filed on per NAIC Statement Blanks. For the past several years the OIC has been utilizing the Risk Focus approach. This approach focuses on

identifying risks that face a company and requires the company to address what is being done to minimize or mitigate those risks. These risks are then separated into Non-Financial and Financial risks.

Network Adequacy, including Service Area, Essential Community Providers, and Mental Health and Substance Abuse Providers

The OIC's Financial Conditions Division, which currently reviews and monitors HMO network adequacy in West Virginia, will also have responsibility for the review of QHP network adequacy. To create consistency and a level playing field across plans, the OIC will align standards for HMO's and QHP's.

General Network Adequacy

To fulfill the general network adequacy requirement, an issuer will need to be accredited with respect to network adequacy by an HHS-recognized accrediting entity and attest to complying with the following standards to demonstrate it has an adequate range of providers for the intended service areas:

1. Issuer will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2);
2. Issuer's network meets applicable WV network adequacy requirements as defined in West Virginia Informational Letter No. 112; and,
3. Issuer's network reflects executed contracts for the year in which the issuer is applying.

If the issuer is not accredited or is accredited but cannot respond affirmatively to each of the attestations, a network access plan must be submitted. In general, the access plan may include, but is not limited to, the following types of information based on the NAIC Model Act #47 requirements:

1. Standards for network composition
2. Referral policy
3. Needs of special populations
4. Health needs assessment
5. Communication with members.
6. Coordination activities
7. Continuity of care

Essential Community Providers

To fulfill the Essential Community Provider (ECP) requirement, issuers must denote the ECP's with which they have contracts for each network in which they plan to provide coverage. This must be provided for each service area to which the applicant is applying for QHP certification. Issuers will be required to use the CCIIO Excel data template to submit the ECP's in their network.

Based on an HHS-developed ECP list, the OIC will verify one of the following²:

²ECP standards outlined in this document are transitional policies to accommodate first year timeframes.

- Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers;
- Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission; or
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.

Justifications submitted by issuers that fail to achieve either standard will undergo stricter review by the OIC.

Issuers that provide a majority of covered services through employed physicians or a single contracted medical group must comply with the alternate standard established by the Exchange (45 CFR 156.235(b)), as follows:

- Issuer has at least the same number of providers located in designated low-income areas;
- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission; or
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.

Mental Health and Substance

Issuers must establish a standard to assure the QHP network complies with the Federal standard. A copy of this standard must be included in the QHP application, and the issuer must certify that the provider network for this QHP meets this standard.

Service Area

QHP service areas will be set by county in WV; partial county submissions will not be allowed. Data elements will be collected using the standard CCIIO Excel data template.

Marketing, Applications, and Notices

Consistent with existing practices, Rates and Forms will perform the evaluation of marketing/advertising standards when an issuer initially files a QHP. The OIC believes existing standards related to advertising and marketing (WV Legislative Rules Title 114 Series 10), which are based off of the NAIC Model Act for Advertisement of Accident and Sickness Insurance, provide adequate protections to consumers while maintaining the same standards inside and outside of the Exchange ensures a level playing field. Issuers will be asked to attest to compliance with the ACA requirements related to non-discrimination in marketing practices. Issuers must also submit a copy of all marketing materials, application, and notices for approval and provide a Certificate of Readability per WV 33-29-5.

Accreditation

Accreditation status will be confirmed by Rates and Forms via SERFF. West Virginia will require issuers comply with HHS standards, i.e., in the first year of certification, QHP issuers without existing

accreditation must schedule accreditation and be accredited on QHP policies and procedures by the second year of certification; and by the fourth year of certification, all QHP issuers must be accredited on the QHP product type. Issuers with existing Commercial, Medicaid accreditation for the state will need to attest that accredited policies and procedures are comparable to the Exchange (they do not all need to be the same) in Years 1-3.

Complaints and Compliance

The OIC's Market Conduct Division will perform a Market Analysis of past complaints and compliance for existing issuers (even if previously licensed in other states only) as the OIC feels this additional layer of review is in the best interest of WV consumers. When the QHP application is received by Rates and Forms, the analyst will notify Market Conduct that an application has been received; Market Conduct will have 30 days to perform the analysis and notify Rates and Forms of the results. As part of this analysis, complaint data is reviewed as follows:

- Market Conduct sends an e-mail to the Director of the Consumer Services Division;
- A complaint report is generated and reviewed within Consumer Services; and
- Consumer Services forwards comments or concerns to Market Conduct to be incorporated into the analysis.

Depending on the results of the Analysis, it may be necessary to proceed to a Level 2 Analysis, or further investigation may be needed, resulting in the need for longer than 30 days for review.

Plan-Level Review Criteria

Benefit Standards and Actuarial Value, Including Discriminatory Benefit Design

Essential Health Benefits

The OIC's Rates and Forms Division will assure that a QHP complies with the benefit design standards specified in the ACA and subsequent rules (45 CFR §156.200(3)), including³:

- Federally approved State-specific essential health benefits (EHB);
- Cost-sharing limits;
- Actuarial value (AV) requirements;
- Non-discriminatory benefit design; and
- Mental health parity.

In its review of the EHB's, the OIC will confirm the following:

- Issuer offers coverage that is substantially equal to the benchmark plan;
- Issuer has demonstrated actuarial equivalence of substituted benefits if the issuer is substituting benefits; and
- Issuer provides required number of drugs per category and class.

³Standards are contained in proposed Federal rules expected to be final in early 2013.

EHB substitutions will require an actuarial certification to support that the substitutions are compliant and actuarially equivalent substitutions (45 CFR 156.115(b)(2)).

Cost-sharing Limitations

The OIC will review plan data for compliance with ACA cost-sharing limitations, including out-of-pocket limits and deductibles for employer-sponsored plans, using the standard CCIO Excel data templates to collect data.

Actuarial Value

QHPs will be reviewed by Rates and Forms to assure compliance with the metal tier levels (or catastrophic plan requirements). With exceptions for unique plan designs, issuers will be required to use the HHS actuarial value calculator within the SERFF application to produce computations of a QHP's metallic level based upon benefit design features. For unique plan designs for which the calculator does not provide an accurate summary of plan generosity, an actuarial certification will be required from the issuer indicating compliance with one of the calculation methods described in 45 CFR 156.135(b)(2). Issuers will also be asked to attest to complying with the requirements for offering of catastrophic plans, such as eligible individuals, only being offered in the SHOP, and other specific requirements for benefits.

Per proposed rule 45 CFR 156.150, standalone dental plans will not be allowed to use the HHS-developed AV calculator. Instead, any stand-alone dental plan certified to meet a 75 percent AV, with a de minimis range of +/- 2 percentage points, will be considered a "low" plan and anything with an AV of 85 percent, with a de minimis range of +/- 2 percentage points, be considered a "high" plan.

Non-Discrimination

An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125). In addition, QHPs must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation (45 CFR 156.200(e)) and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

Issuers will be required to attest to non-discrimination on these factors. In addition, State standards for evaluation of compliance with non-discriminatory benefit design are still under development, however the OIC may conduct outlier tests to identify potentially discriminatory benefit designs when a Federal analytic tool becomes available.

Mental Health Parity and Addiction Equity Act

The OIC Rates and Forms Division will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Rate Information

Existing Rates and Forms processes using SERFF and existing staff resources will be leveraged for analysis of QHP rate and benefit data in WV for initial QHP certification. Issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014 will be required limit variation in plan premiums to age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography (45 CFR 147.102; 45 CFR 156.255). The Federal rule prohibits the use of other rating factors such as health status, medical history, gender, and industry of employment to set premium rates. Review and analysis of WV-specific factors is underway by an actuarial vendor and will be defined within 30 days of the publication of the final Federal rules.

Issuers will also attest that they will set rates for an entire benefit year, or for the SHOP, plan year; charge the same premium rate without regard to whether the plan is offered through the FFE or directly from the issuer through an agent and is sold inside or outside of the Exchange; submit rate information to the Exchange at least annually; submit a justification for a rate increase prior to the implementation of the increase; and prominently post the justification on its Web site (45 CFR 156.210).

Additionally, Rates and Forms will review the justification of a rate increase prior to the implementation of the increase, assure that increase is posted on the issuer website, and consider any excess rate growth outside the Exchange as compared to the rate of growth inside the Exchange. Rate increases for QHPs are subject to the reporting and review requirements in 45 CFR 154.215 related to the submission of a Rate Filing Justification, inclusive of:

- An HHS standardized Unified Rate Review data template;
- A Consumer Narrative Justification (for increases subject to the review threshold); and
- An actuarial memorandum providing the reasoning and assumptions that support the data submitted in the data template and an actuarial attestation.

Rates and Forms will perform a review of Rate Filing Justifications, including actuarial memorandums.

Please see section 4.2e of this document and Business Processes titled BP-PM-03, BP-PM-10, and BP-PM-11 in the separate document for additional information.

The OIC is awaiting additional guidance on determination of “meaningful differences” among plans offered by the same issuer. West Virginia will work with the NAIC and HHS to identify criteria and determine responsibility within the OIC for evaluation of this standard.

Quality/Quality Improvement

Standards related to quality measures and quality improvement strategies—including OIC Division. In the interim, for accredited issuers, quality improvement policies and procedures and quality measures will be reviewed by the NCQA and URAC as a part of accreditation process. In addition, issuers, regardless of accreditation status, must provide attestations including acknowledgment that prior to 2016 CAHPS® data may be used on the Exchange Internet web site.

OIC Division responsibility for review of quality standards will be determined for future benefit years in accordance with forthcoming Federal guidance.

Transparency in Coverage

The OIC is awaiting additional guidance from HHS on standards for QHP collection and ongoing reporting of transparency data that must be made available by plans in the individual and small group market including: (1) Claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment; (4) data on disenrollment; (5) data on the number of claims that are denied; (6) data on rating practices; (7) information on cost-sharing and payments with respect to any out-of-network coverage; and (8) information on enrollee rights under title I of the ACA. The Market Conduct Division is interested in how and what data will be collected and the ability to access the data to further improve the review of health plans on a national as well as a State level.

Segregation of Funds for Abortion

Each QHP issuer that participates in the Exchange and offers coverage for abortion services will submit a plan to the Insurance Commissioner detailing its process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) related to the segregation of funds for abortion services. The segregation plan must be developed in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget and guidance on accounting of the Government Accountability Office. It will describe the health plan's financial accounting systems, including appropriate accounting documentation and internal controls, which would ensure the segregation of funds required by the ACA. The plan should address items including the following.

- The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services, which may be supported by Federal premium tax credits and cost-sharing reduction payments;
- The financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for non-excepted abortion services are reimbursed from the appropriate account; and
- An explanation of how the health plan's systems, accounting documentation, and controls meet the requirements for segregation accounts under the law.

Issuers will be asked to annually attest that they will comply with Federal requirements related to segregation of funds for abortion services, as well as provide a segregation plan. The OIC will perform periodic financial audits of each QHP to assure compliance with Section 1303 of the ACA.

Additional Certification Criteria

Rates and Forms will review applications to assure that issuers upload and sign-off on the list of HHS attestations (as delivered in proposed form as part of the PRA), as well as any WV-specific requirements, such as those related to network adequacy⁴.

Rates and Forms will perform a review of applications to assure that issuers comply with the following requirements:

- Provision of at least **one silver and one gold plan** (§ 156.200);
- Inclusion of identical plan as a **child-only health plan** for each non-catastrophic health plan offered (§ 156.200); and
- Submission of **three variations to each silver plan** reflecting reduced cost-sharing on the essential health benefits (§ 156.420(a)).

COST-SHARING REDUCTIONS (BP 4.2c)

The OIC will collect, analyze, and if required, submit to the Federal government for review QHPs' plan variations for cost-sharing reductions and advance payment estimates for such reductions using the SERFF/HIOS interface. This information may include the reduced maximum out-of-pocket limits and variations in co-pays, co-insurance, and deductibles. The OIC will also require issuers to comply with requirements related to benefits including that silver plan variations must have same benefits and provider network as silver plan and cost-sharing must not increase for a particular benefit or provider across higher AV silver plan variations.

The OIC's understanding is that SERFF will support submission of the information outlined above (e.g. AV, cost-sharing information, benefit information) and will support streamlined submission of plan variations for issuers and automated review by the OIC using the standard CCIIO Excel data template. The SERFF team has also indicated that a field will be available to support issuer submission of the estimated expected advanced payment from HHS.

ACTUARIAL VALUE AND ESSENTIAL HEALTH BENEFITS (BP 4.2d)

The OIC Rates and Forms Division will maintain responsibility for assuring that QHPs meet all benefit design standards including providing the essential health benefits package, limiting cost-sharing in accordance with ACA Section 1302(c), and meeting actuarial value standards (e.g. platinum, gold, silver, bronze, and silver plan variations). Aligned with existing processes, Rates and Forms will evaluate rate filing information and will utilize a third party actuary to verify rates and actuarial value as needed. In addition, the NAIC has indicated they intend⁴ to enhance SERFF so that plan actuarial value and metal

⁴ Please see Section 3.1 of the QHP Submission Guide for a detailed list of attestations.

level can be automatically determined using the Federal Actuarial Value calculator and the data submitted by carriers.

Please see Section BP 4.2b above for more information on how plan actuarial value will be reviewed by the OIC.

MARKET REFORM RULES (4.2e)

The OIC Rates and Forms Division currently evaluates plans for compliance with market reform rules and will continue this function to ensure QHP compliance with all applicable state and federal regulations and guidance, including ACA market reforms. Measures the OIC has already implemented to assure compliance include requiring issuers to submit the NAIC's PPACA Uniform Compliance Summary and using other tools as "checklists" when reviewing filings for ACA updates/language/limits, etc. The Rates and Forms Analysts also regularly participate in NAIC, Federal, and other meetings and calls related to healthcare reform and federal and state legislative updates, and the department meets weekly to discuss these filing issues. As needed, they also leverage the expertise of the OIC's legal team and contracted actuaries to ensure the Rates and Forms reviews are accurate, consistent and meet current mandate and reforms.

DESCRIPTION OF THE ENTITIES RESPONSIBLE FOR QHP CERTIFICATION, INCLUDING A DESCRIPTION OF ROLES AND RESPONSIBILITIES OF EACH ENTITY AS THEY RELATE TO EACH OF THE QHP CERTIFICATION STANDARDS

- The OIC's **Rates and Forms Division** will serve as the central coordinator for review and certification of QHPs and will be responsible for confirming plans meet all of the certification requirements using a "QHP Certification Checklist". Consistent with existing practices, the Division will review and approve or disapprove QHP rate filings to determine the consistency with statutory requirements that they not be excessive, unjust, or unfairly discriminatory. They will also review and approve or disapprove the QHP policies and related forms consistent with State and Federal statute and regulations and will assure QHP issuers comply with other Exchange-specific requirements.
- The **Financial Conditions Division** is responsible for the licensing, financial monitoring, and financial examination of the insurance companies admitted to do business in West Virginia. The Financial Conditions Division is also responsible for the administration of the state insurance tax laws. Related to QHP certification, they will assure issuers are licensed, solvent, and in good standing and perform reviews of network adequacy.
- The **Consumer Services Division (CSD)** provides assistance to West Virginia citizens who have questions or problems involving insurance; it is the consumer assistance and investigative arm of the OIC. The CSD will provide information on past complaints to Rates and Forms as part of QHP review and certification.
- **Market Conduct** proactively protects West Virginia consumers by identifying non-compliant business practices of regulated entities through examinations and data analysis. The Division will

perform analyses of issuers submitting QHP applications to review and identify compliance, complaint, or other regulatory issues.

- The **Legal Division** will provide ad hoc legal support to other OIC Divisions noted herein on an as needed basis.
- The **Health Policy Division** will be available as a resource to assist other OIC Divisions in communications with the Federal government, interpretation of Federal statute and regulations, QHP review and certification decisions throughout the process.
- **Third-Party Actuarial Services** may be used to assist in the analysis of rates and rate increase requests.
- The **Fraud Unit** is statutorily empowered to “initiate inquiries and conduct investigations” into any suspected criminal violations of the code related to the business of insurance and to cooperate with other law enforcement and regulatory agencies in the investigation and prosecution of suspected fraud and other criminal violations related to the business of insurance.

DESCRIPTION OF THE INTEGRATION BETWEEN THE EXCHANGE AND THE STATE DEPARTMENT OF INSURANCE

The WV OIC will leverage existing business processes and communication mechanisms to conduct QHP certification activities. Rates and Forms staff will review the QHP for certification based on criteria indicated on the checklist, and integration of efforts across OIC Divisions will occur by Rates and Forms staff notifying other Divisions when and if their input is needed (e.g. Market Conduct to perform a Market Analysis); each respective Division will then perform its review and communicate findings to Rates and Forms, who will enter whether or not the QHP meets the standards or not into SERFF. If additional discussion is needed regarding the results of the evaluation findings for specific criteria, aligned with existing processes pertinent OIC Divisions will meet to review, discuss, and make decisions accordingly. Although it will not be performing any specific review functions, the Health Policy Division will be available to serve as a resource to other Divisions on ACA and Exchange-related QHP certification requirements.

The OIC awaits guidance from HHS related to integration of efforts with the State, including certification/non-certification recommendations, HHS ratification of those decisions, and communication of decisions to issuers.

BP 4.3 PLAN MANAGEMENT SYSTEM(S) OR PROCESSES THAT SUPPORT THE COLLECTION OF QHP ISSUER AND PLAN DATA

THE EXCHANGE USES A PLAN MANAGEMENT SYSTEM(S) OR PROCESSES THAT SUPPORT THE COLLECTION OF QHP ISSUER AND PLAN DATA; FACILITATES THE QHP CERTIFICATION PROCESS;

MANAGES QHP ISSUERS AND PLANS; AND INTEGRATES WITH OTHER EXCHANGE BUSINESS AREAS, INCLUDING THE EXCHANGE INTERNET WEB SITE, CALL CENTER, QUALITY, ELIGIBILITY AND ENROLLMENT, AND PREMIUM PROCESSING

DESCRIPTION OF THE ANTICIPATED NUMBER OF HEALTH PLANS EXPECTED TO PARTICIPATE IN THE STATE

Based on the number of licensed issuers in the individual and small group market in WV, the requirement that issuers offer both a silver and a gold plan, and OIC experience and analysis, the OIC expects that approximately 40-60 individual and 70-75 small group plans will submit applications for QHP certification (not including multi-state plans offered through the OPM).

DATA COLLECTION METHOD AND APPLICABLE SYSTEMS THAT WILL BE USED TO SUPPORT THE BUSINESS OPERATIONS OF PLAN MANAGEMENT

The OIC has required issuers to submit filings in the NAIC's SERFF since January 2009, and it intends to use the enhanced version of SERFF to collect the majority of data and information from issuers required to evaluate and comply with QHP certification standards. In addition, communications related to filings will be logged and retained in SERFF (as is the case today) using Correspondence Services.

Exchange of Data with HHS

Integration with other business areas in the FFE Partnership is expected to primarily occur via HIOS. According to a meeting between the NAIC's SERFF team and the OIC on 9/5/12, the NAIC and HHS have been collaborating to allow SERFF to be leveraged for information-sharing related to benefit, rate, and other data collection between the State and the Federal government. The OIC intends to use all of the standard CCIIO Excel data templates and does not intend to make WV-specific edits to them, facilitating the validation and submission of data to the OIC and CCIIO. Specifically, the NAIC has indicated the following process will be used:

- Issuers will complete and finalize the Excel data templates;
- SERFF will convert the data files to XML format;
- XML files will be uploaded to the Federal Exchange where they are validated and converted back to Excel;
- Excel and XML files will be attached to the template in SERFF; and
- The State will perform reviews and submit the data and information to CCIIO using an "easy button" in SERFF when completed and ready to recommend a plan for certification.

The OIC is awaiting additional information related to the sharing and integration of complaints data with a Federal Exchange, however based on recent discussions with the NAIC, it seems likely that SBS may be leveraged to fulfill this requirements as the OIC's Consumer Services Division currently uses this application and has added a QHP-specific field in it to improve complaint tracking at a QHP-level. Other integration needs have not been identified at this time.

BP 4.4 ENSURE ONGOING QHP COMPLIANCE

THE EXCHANGE HAS THE CAPACITY TO ENSURE QHPS' ONGOING COMPLIANCE WITH QHP CERTIFICATION REQUIREMENTS PURSUANT TO 45 CFR 155.1010(A)(2), INCLUDING A PROCESS FOR MONITORING QHP PERFORMANCE AND COLLECTING, ANALYZING, AND RESOLVING ENROLLEE COMPLAINTS

DESCRIPTION OF GENERAL APPROACH TO ENSURING QHP COMPLIANCE AND MONITORING QHP PERFORMANCE

Monitoring compliance with QHP certification criteria falls within the purview of OIC Divisions. For example, Consumer Services acts as the primary conduit for adverse events/complaints (which may trigger further investigation from Divisions such as Market Conduct, e.g. if the number of complaints filed in a certain timeframe exceeds a minimum threshold or a complaint is apt to cause harm to the consumer), Market Conduct performs proactive periodic analysis and reactive/targeted analysis on various compliance issues, Financial Conditions monitors solvency, and Rates and Forms regularly performs carrier-initiated reviews (e.g. new filings for rates and benefits, marketing materials, or notices). Existing processes for coordination and integration of efforts across Divisions will be leveraged. For example, issues with benefit design may be identified as a result of a complaint filed with Consumer Services, as part of an analysis performed by Market Conduct, or as part of a review by Rates and Forms as a result of an issuer filing. Regardless of which Division identifies a potential compliance issue, the Divisions will collaborate and meet to review the issue and discuss required actions as needed. OIC Divisions included in the discussions and meetings will depend on the nature of the compliance issue; if intermediate sanctions fail to resolve the issue a decision made be made to recommend decertification to HHS.

Processes and responsibility for monitoring compliance with network adequacy standards will be determined when the OIC receives additional guidance from HHS.

A summary of compliance monitoring is provided in the table below.

Type of Monitoring	Function	OIC Division
Annual Compliance Monitoring	Attestation of compliance with segregation plan for funds for abortion services	Rates and Forms
	Review of annual QHP submission of rate, benefit and cost-sharing information	Rates and Forms
	Accreditation status for plans not yet accredited at time of certification (Year 2 – check for accreditation on QHP policies and procedures, Year 4 –check for accreditation on QHP product type	Rates and Forms
Periodic Compliance Monitoring	Quality data review	TBD
	Network adequacy review (frequency TBD)	TBD

Type of Monitoring	Function	OIC Division
	Cyclical Examination of domestic issues	Market Conduct
	Conduct Examinations and non-examination interventions based on market analysis or referrals from other divisions within the WVOIC (can include data requests, interrogatories)	Market Conduct
	Financial Examination using Risk Focus approach	Financial Conditions
Ongoing Compliance Monitoring	Consumer complaints received, tracked, investigated and responded to as appropriate	Consumer Services Division
	Marketing/advertising materials	Rates and Forms
	Proactively conduct annual Market Analysis on domiciled issuers	Market Conduct
	Conduct additional Market Analysis on non-domiciled licensed issuers based indicators available to include complaints, data housed in in NAIC systems, and referrals from other departments	Market Conduct

Please see the supporting document titled “DRAFT_WVOIC Plan Management BP PM 07-11_13_12” for additional information on the OIC’s approach to monitoring ongoing issuer and plan certification compliance. The same continuum of regulatory enforcement options will be applied to QHPs as with any other regulated entity.

DESCRIPTION OF THE INTEGRATION BETWEEN THE APPROPRIATE STATE ENTITY AND OTHER STATE ENTITIES WITH RESPECT TO QHP ISSUER OVERSIGHT AND RESOLUTION OF ENROLLEE COMPLAINTS

The Consumer Services Division has a robust system in place to collect, analyze, and resolve enrollee complaints, processes which will also be used for QHPs. Complaints are received by mail, fax, e-mail and phone calls. If a complaint is filed via phone, the CSD sends a Complaint Form or provides the person filing the complaint with information on how to obtain the form from the OIC’s website. The same process is followed for written complaints that are received and do not contain the Complaint Form. (By signing the form, the consumer gives the CSD authority to contact the company/agent on their behalf in compliance with HIPAA Privacy Rules.) Complaints are date stamped by Clerical Staff, general information is entered into SBS to obtain a file number, and the complaint is then scanned into IVUE. In addition, Consumer Services requested and received an additional field in SBS allowing complaints to be tracked at a QHP level. Complaints related to Medicaid are forwarded to WV Department of Health and Human Resources (DHHR).

After being assigned to a Complaint Specialist by the CSD Supervisor, the complaints are reviewed and the appropriate letter is sent to the company/agent and also to the consumer acknowledging receipt of the complaint. Companies/agents have 15 working days to respond to the letter. Upon receipt of the

requested information, the Specialist takes appropriate action. A letter is sent to the Consumer advising of the disposition of the file and then it is returned to the Supervisor, who reviews for completeness, and, if completed, enters the appropriate codes into SBS and closes the file. In some instances the responses provided by the company/agent are not sufficient and additional contact is needed, or there may be a Legal issue and the file is then referred to the OIC's Legal Division.

The OIC's Consumer Services Division will continue to perform its Consumer Assistance functionality and will accept complaints from consumers regarding plans, In-Person Assistors, and Navigators. Navigator complaints will be funneled to CMS for appropriate action. The State requests that complaints that are submitted to CMS regarding the Navigator program also be shared with the State; this will establish a 2-way communication strategy between CMS and the OIC to ensure the consumers of WV are most sufficiently being served. Complaints that are received regarding the IPA program will also be shared with CMS in the form of monthly or quarterly reports to demonstrate the evaluation process the State plans to have in place in providing oversight of its IPA program.

In addition to the internal processes described above, staff members from several OIC Divisions have been participating in an informal complaint workgroup comprised of members from the NAIC, HHS, and five other states in order to identify processes for individual consumer complaint resolution and overall complaint data sharing between the States and HHS in a Partnership Model. The States have proposed areas in which they would like to retain authority to resolve complaints, as well as areas that should fall under HHS' domain (e.g. operational or structural processes related to the Exchange). The States and HHS have indicated a desire to be kept informed as to the nature of all complaints -regardless of which entity is ultimately responsible for resolving them- and other reported measures demonstrating overall volume of complaints by category.

The next steps for the workgroup are focused on establishing interoperability processes and systems for States and HHS to share data. WV will continue to support and be actively involved in the development and implementation of complaint resolution integration processes between the State and HHS.

Please see the supporting documentation titled "WVOIC Complaint Resolution Process_11_7_12" for a diagram of the proposed interactions between the OIC and other entities related to complaint resolution.

BP 4.5 CAPACITY TO PROVIDE TECHNICAL ASSISTANCE AND SUPPORT TO QHP ISSUERS

THE EXCHANGE HAS THE CAPACITY TO SUPPORT ISSUERS AND PROVIDES TECHNICAL ASSISTANCE TO ENSURE ONGOING COMPLIANCE WITH QHP ISSUER OPERATIONAL STANDARDS.

DESCRIPTION OF ISSUER TECHNICAL ASSISTANCE AND SUPPORT ACTIVITIES TO BE PROVIDED BY THE EXCHANGE AND EXAMPLES WHERE APPLICABLE

Issuer support and technical assistance related to QHPs will leverage existing processes for the non-QHP market; because the number of QHPs is expected to be relatively low and relationships have already been established between the OIC and issuers, the OIC anticipates that existing staff will be able to adequately provide the necessary support. Assistance to issuers is currently made available by various OIC Division staff depending on the nature of the issue, e.g. Rates and Forms may provide plan submission support to issuers during the filing process; Market Conduct may assist with questions related to ongoing operational compliance with areas such as rating, network adequacy, and benefits after certification when the guidance is provided by HHS; Financial Conditions may provide support for questions related to licensing; and Consumer Services may provide assistance in the resolution of enrollee complaints. As referenced in Section 4.3, communications related to filings will be logged and retained in SERFF (as is the case today) using Correspondence Services. From a technical perspective, the NAIC provides support for the SERFF application from 8 am to 5 pm Central, Monday through Friday. The SERFF Help Desk can be reached by calling 816-783-8990 or e-mailing serffhelp@naic.org. If issuers require additional support, questions may either be handled through the OIC's Rates and Forms Division or be directed to the OIC's IT Division as appropriate.

Additionally, the OIC has proactively shared information, solicited feedback, and addressed technical and operational issues with carrier representatives at monthly stakeholder meetings throughout the Exchange planning process and will continue to do so throughout Plan Management implementation. Based on positive feedback received from the carriers in one of these meetings, the OIC is also considering using the SERFF State-Generated Messages function to augment its other existing communication mechanisms.

The OIC is awaiting additional guidance related to the Federal Issuer Account Manager role and will partner with HHS to coordinate issuer account management efforts as additional information is learned.

BP 4.6 RECERTIFICATION, DECERTIFICATION, APPEAL, AND TRANSITION OF ENROLLEES

THE EXCHANGE HAS A PROCESS FOR QHP ISSUER RECERTIFICATION, DECERTIFICATION, AND APPEAL OF DECERTIFICATION DETERMINATIONS PURSUANT TO 45 CFR 155.1075 AND 155.1080

Recertification processes will mirror the previously described certification processes and will be completed on or before September 15 of the applicable calendar year.

When compliance issues have been identified via the ongoing monitoring process, the OIC's Regulatory Compliance Division will communicate compliance issues to the issuer via mail; issuers will have 15 business days to respond to a compliance issue. The decision to take action against a QHP, including decertification, will follow existing processes, e.g. OIC Divisions, including Regulatory Compliance, may meet to review the issue and the issuer's response and discuss required actions. OIC Divisions included in the discussions will depend on the nature of the compliance issue. If intermediate sanctions fail to resolve the issue and a decision is ultimately made to decertify a QHP, the Insurance Commissioner will

be responsible for communicating decertification recommendations to HHS. Once the final decision to decertify is made, Rates and Forms will flag the QHP as decertified in SERFF.

The OIC does not intend to perform appeals of non-certification and decertification decisions since it is only making QHP certification and decertification recommendations to HHS, which has ultimate decision-making through the ratification process.

Regarding transitioning of enrollees who are in decertified plans, the OIC will partner with HHS to assure they have access to contact information for in-person assisters to assist with transitioning to new QHPs. The OIC will also provide oversight of issuers to assure they are complying with State and Federal requirements related to termination of enrollee coverage. The OIC does not intend to send notices to affected enrollees since, in an FFE, HHS is responsible for sending Exchange-related notices.

BP 4.7 TIMELINE FOR QHP ACCREDITATION

THE EXCHANGE HAS SET A TIMELINE FOR QHP ISSUER ACCREDITATION IN ACCORDANCE WITH 45 CFR 155.1045. THE EXCHANGE ALSO HAS SYSTEMS AND PROCEDURES IN PLACE TO ENSURE QHP ISSUERS MEET ACCREDITATION REQUIREMENTS (PER 45 CFR 156.275) AS PART OF QHP CERTIFICATION IN ACCORDANCE WITH APPLICABLE RULEMAKING AND GUIDANCE

TIMELINE BY WHICH QHP ISSUERS MUST BE ACCREDITED IN ACCORDANCE WITH 45 CFR 155.1080

West Virginia will require QHP issuers that are not already accredited to schedule accreditation according to the requirements proposed by HHS. In the first year of certification, QHP issuers without existing accreditation must schedule accreditation; by the second year of certification they must be accredited on QHP policies and procedures; and by the fourth year of certification, all QHP issuers must be accredited on the QHP product type. In years 1-3, issuers with existing Commercial/Medicaid accreditation in the State will be required to attest that accredited policies and procedures for those plans are comparable to the QHP.

SYSTEMS AND PROCEDURES IN PLACE TO ENSURE QHP ISSUERS MEET ACCREDITATION REQUIREMENTS PER 45 CFR 156.275 AS PART OF QHP CERTIFICATION

The NAIC has confirmed that the SERFF team is working with the Phase I accreditation entities (NCQA and URAC) and with HHS to automate the collection and display of accreditation data; this includes an enhancement in the fall release of SERFF v5.17 to Enable SERFF to better identify insurers for purposes of accreditation. The NAIC is planning to provide fields so that states have all the necessary information to verify these requirements without having to collect the data directly from the insurers.

There will be an exception process to allow the insurer to provide documentation outside the normal avenue, such as when an insurer has not applied for accreditation and is within a grace period. The NAIC SERFF team has confirmed that they intend to support the submission of such an exception through SERFF.

BP 4.8 QHP QUALITY REPORTING

THE EXCHANGE HAS SYSTEMS AND PROCEDURES IN PLACE TO ENSURE THAT QHP ISSUERS MEET THE MINIMUM CERTIFICATION REQUIREMENTS PERTAINING TO QUALITY REPORTING AND PROVIDE RELEVANT INFORMATION TO THE EXCHANGE AND HHS PURSUANT TO AFFORDABLE CARE ACT 1311(C)(1), 1322(E)(3), AND AS SPECIFIED IN RULEMAKING.

TYPE OF DATA THAT WILL BE USED FOR CERTIFICATION, MONITORING AND DISPLAY

The OIC awaits additional Federal guidance related to receipt, review, and display of quality and quality improvement data. Additionally, the State has partnered with the WV School of Osteopathic Medicine to develop a strategy to maximize and report on provider quality in the Exchange, including strategies on how to promote quality through measurement and reporting, promote quality and value through purchasing and other strategies, and engage consumers through better information. The OIC will integrate and align these strategies with future Federal efforts.

Based on information shared with states during the Health Insurance Exchange System-Wide Meeting on May 21-23, 2012, the OIC understands that, if available, HHS intends to display Consumer Assessment of Health Providers and Systems (CAHPS) NCQA on the Exchange website. The OIC further understands that HHS proposes to map CAHPS results from the commercial and/or Medicaid product lines to the same QHP product types and adult/child populations for this purpose. The OIC has shared this proposal with WV carriers at a stakeholder meeting and will support HHS as needed with this interim approach.

OUTSTANDING QUESTIONS AND DECISIONS

The following is an aggregated list of the areas with undetermined policies and process as a result of the OIC awaiting further federal guidance. In partnership with HHS, the OIC will develop policies, processes, and procedures when that guidance becomes available.

- Requirements related to **stand-alone dental plans**
- Criteria and Federal tools for evaluation of **discriminatory benefit design**
- Criteria and Federal tools for evaluation of **meaningful difference**
- Data collection and reporting standards and requirements related to **transparency in coverage**
- Process and systems to support **integration of enrollee complaints** between the OIC and HHS
- Role of **Federal Issuer Account Manager** and integration of efforts with the OIC
- Roles, responsibilities, and requirements for **decertification, appeals, and enrollee transitions**

COMPUTER POLICY

I. PURPOSE

The purpose of this policy is to establish written guidelines pertaining to the use of Insurance Commission-provided information technology (IT) resources by employees of the West Virginia Office of the Insurance Commissioner (hereinafter referred to as "Commission"). This document is not all-inclusive and management has the authority and discretion to appropriately address any unacceptable behavior not specifically mentioned herein.

II. SCOPE

This policy shall cover all employees of the Commission, including executive, administrative, classified, classified-exempt, exempt, contract and temporary employees who perform work using IT resources provided by the Commission.

III. DEFINITIONS

- A. Authorized Software:** Software, including trial versions, that meets the following three criteria:
1. Approved by the IT Director or designee for use, on Commission computers and/or networks,
 2. Legally obtained, and
 3. Required in the support of the function to which the computer and/or network is assigned.
- B. Computer Virus:** A manmade program or piece of executable code that is loaded onto any computer usually surreptitiously, including PCs and servers. All computer viruses will disrupt the operation of the infected computer. Some computer viruses are destructive, permanently damaging data files or programs on a computer.
- C. E-Mail:** Electronic transfer of information typically in the form of electronic messages and attached documents from a sending party to one or more receiving parties via an intermediate telecommunication system. A message may be transmitted within the agency, between parties of the State, or to/from a destination outside the State e-mail system.
- D. Electronic Document Imaging System (EDIS):** Software that utilizes a scanner to convert paper records to digitized, electronic images to be viewed, verified, assigned an address in the storage medium, and indexed for later retrieval.
- E. IT Personnel:** Employees whose job it is to oversee the Information Technology for the Commission.
- F. Informal communication:** Records that do not set policy nor establish guidelines or procedures, document a transaction, or become a receipt.

- G. Non-Record or Non-Official Record:** Materials that do not qualify as records and include duplicate copies of records where original copies exist, or records used for informal communication of information.
- H. Official Record:** Information recorded on any medium created or received by the agency in transaction of public business and preserved as evidence of official government policies, guidelines, procedures, actions, decisions, or transactions, or retained because of the value of its informational content.
- I. Record:** Information that is generated internally or received from external sources that is documented and either utilized in the transaction of agency business, related to the agency's legal obligations, memorializing a transaction, or verifying a receipt.
- J. Remote Office:** Any Commission office where IT does not have support staff nearby to respond rapidly to a virus 'attack' or other technology issue.
- K. Third Party Software:** Any software, including shareware and freeware that was not developed for the exclusive use of the Commission, its employees or its agents.
- L. Commission-Provided IT Resources:** Applications, software, desktop PC's, laptop PC's, printers, data networks, servers, e-mail, the Internet, electronic voice and video communications, document management/imaging copiers or scanners, microform, facsimile, and any future technologies that the Commission may use to accomplish its mission and goals.

IV. POLICY

Individuals performing work using Commission IT resources are expected to use the Commission's IT resources in such a way as to not compromise the integrity, functionality or security of such systems or reflect discredit on the abilities, capabilities and integrity of Commission employees. Failure to comply with the directives established by this policy may result in disciplinary action up to and including dismissal, suspension of privileges, and/or prosecution under state and/or federal statutes - depending on the circumstances of the incident.

Employee Use of Commission-Provided IT Resources

1. Employee use of Commission-provided IT resources shall be consistent with the specific objectives of the job, project, and/or task for which the employee's use of IT resources was authorized.
2. An employee may use Commission-provided IT resources for the following purposes (This list is not all inclusive):
 - a. To deliver Commission products and services and provide for and facilitate communications with injured workers, employers, health care providers, vendors, citizens, other State and federal agencies, and business partners of State agencies;
 - b. To perform research, authorized by the employee's supervisor, on subject material relevant to his or her current job assignment;
 - c. To apply for or administer grants or contracts for work-related applications;

- d.** To communicate, exchange, and debate issues related to professional development of the employee's professional/vocational discipline if applicable to his or her present job assignment (e.g., professional society, university association, government advisory panel, and/or standardization activities);
 - e.** College studies that are reimbursed by the Commission and are approved in advance by his or her Division Director. Such use is only permitted during the employee's own time (i.e., break, lunch, or before or after work);
 - f.** To access only files, data, and protected accounts publicly available, or to which you have been given authorized access;
 - g.** To perform other authorized work activities.
- 3.** An employee shall not use Commission-provided IT resources for the following purposes (This list is not all inclusive):
 - a.** To conduct illegal or malicious activities;
 - b.** To gamble;
 - c.** To download, display or distribute statements or images that are offensive or harassing to a reasonable person, or that disparages others based on race, national origin, gender, sexual orientation, age, ancestry, disability, political or religious beliefs, or any other category that is protected by law;
 - d.** To download, display or distribute statements or images that might incite violence or describe or promote the use of weapons or devices associated with terrorist activities;
 - e.** To download unauthorized use of copyrighted materials or another person's original writings;
 - f.** To introduce a virus into the Commission's computers and/or networks and withhold information necessary for the effective implementation of virus protection procedures or to use software or data that has not been properly scanned for viruses;
 - g.** To monopolize systems, overload networks with excessive data, or waste computer time, connect time, disk space, printer paper, or other IT resources;
 - h.** To access accounts within or outside the Commission facilities for which he or she does not have authorization;
 - i.** To knowingly store any unauthorized data, information, or software;
 - j.** To deliberately attempt to degrade or disrupt the performance of Commission computer systems or networks, or any other computer system;
 - k.** To transmit confidential information without proper authorization and/or security;
 - l.** To broadcast a bulletin to all employees without obtaining authorization from his or her immediate supervisor;
 - m.** To send forged e-mails;
 - n.** To misrepresent himself or herself or the State;
 - o.** To conduct personal and/or profit-making activities;
 - p.** To conduct religious, union, or political lobbying or proselytizing;

- q. To distribute “junk” or “spam” mail such as chain letters, advertisements, fundraising promotions, or unauthorized solicitations;
 - r. To download or participate in or play any recreational game;
 - s. To download any screen savers;
 - t. To download software, including third-party software, without prior written approval from the IT designated manager; or
 - u. To access or use another employee’s IT equipment or passwords without a business need and prior authorization.
4. At all times, an employee shall only use Commission-provided IT resources for Commission work-related purposes and shall not use Commission-provided IT resources for personal purposes (without the explicit prior knowledge and permission from his or her Division Director).
 5. An employee shall not give or loan Commission-provided IT resources to outside parties including injured workers, employers, health care providers, vendors, family, friends, etc. unless prior written approval of the Insurance Commissioner or his or her designee is obtained.
 6. An employee shall only access, copy, or modify his or her own e-mails, files, data, passwords, programs, and protected accounts unless they are publicly available, or to which he or she has been given authorized access.
 7. An employee shall only use authorized software on Commission-provided IT resources. If unauthorized software is found on Commission-provided IT resources, Commission IT shall immediately remove the unauthorized software.
 8. An employee shall not use his or her own personal e-mail or Internet service provider account while at work or while using Commission-provided IT resources without written approval from the IT Director or his or her designee.
 9. An employee shall not participate in instant messaging, blogging or chat room sessions while at work or while using Commission-provided IT resources.
 10. An employee must report to his or her immediate supervisor any instance of receipt of data and/or information which he or she is not entitled; when he or she detects possible breaches of security and/or confidentiality; or of any inappropriate use of Commission-provided IT resources.

Access to Commission-Provided IT Resources

The immediate supervisor shall make IT personnel aware of any individual requiring IT resources as soon as the decision has been made to post for the vacant position by completing the form found at:

http://wviconnet/pdf/programming_request_form.pdf

Confidentiality

An employee should be aware that deleting electronic mail does not ensure erasure of all copies of the file.

An employee should not expect his or her electronic communications to be private, and should not use electronic mail for communications not intended for disclosure to third parties.

E-mail and other electronic files are the property of the State of West Virginia and as such the State retains the right to retrieve computer records and review usage history for legitimate business reasons including, but not limited to, recovery of system failures, State operational standards, investigations of alleged wrongful acts, location of lost data, and to investigate employees' failure to comply with agency e-mail and Internet use policies. Employees should be aware that documents created and sent by electronic mail for official business or as evidence of official acts might constitute official records of the agency, and as such, may be subject to the Freedom of Information Act (FOIA). As a practice, all employees should be aware that what they include in their e-mail messages might one day be subject to a FOIA request and should always draft their written communications accordingly. For more information concerning FOIA, contact the Commission's Legal Division.

Copyright/License

An employee shall use Commission-provided software in accordance with its copyright and licensing agreement. Unless otherwise provided for, any duplication of software or its documentation, except for backup and/or archival purposes, subjects the employee and/or the Commission to civil and criminal penalties including fines and imprisonment. Therefore, duplication of software or its documentation is not permitted without the prior written approval of the IT Director or his or her designee.

Software and its documentation are protected under the United States Copyright Act and West Virginia Code §61-3C-1 et. Seq.

Backing Up/Archiving

An employee is responsible for backing up files he or she maintains on his or her workstation. Before backup, the employee shall scan the files for viruses. [NOTE: It is recommended that all files be maintained on the network server supporting the employee's workstation.]

The IT Unit is responsible for the backup of all file server programs and data. As with workstation backup, the hard disk must be scanned for viruses before backup.

An employee who wishes to save e-mails should either print the e-mail or archive it to his or her hard drive. The e-mail system is a communication system and should not be used to retain messages for extended periods of time. An employee who needs assistance in archiving e-mail shall contact IT personnel. Messages retained on the e-mail system will be automatically deleted by the system after 120 days.

Archival Retention

E-mail created or received in the normal course of official business and retained as evidence of official policies, actions, decisions, or transactions are official records subject to the State's record retention requirements and should be moved to the agency's digital imaging system or filed manually to the

appropriate correspondence file for accessibility by all users. Examples of messages sent by e-mail that typically are archival records include:

- 1) Policies and directives;
- 2) Correspondence or memoranda related to official business;
- 3) Responses from customers;
- 4) Work schedules and assignments;
- 5) Agendas and minutes of meetings;
- 6) Documents that initiate, authorize or complete a business transaction; and
- 7) Final reports or recommendations.

Electronic Document Imaging System

The EDIS system is utilized to ensure that the public records of the Commission are accessible, protected, and preserved for administrative, fiscal, legal and historical purposes. For more information, see *Electronic Document Imaging System Procedure* (IC-P29).

Monitoring/Auditing

The Commission reserves the right to monitor all transmissions to/from Commission-provided IT resources and/or audit all of its system configurations, as well as the files on those systems, for such purposes as: maintaining business continuity in the absence of employees; responding to a complaint of computer abuse, such as harassment; or protecting Commission resources from misuse. Audits shall be conducted randomly and without notice to ensure compliance with this policy.

An employee does not have an expectation of privacy in any of the information contained in Commission-provided IT resources.

Objectionable Content

The nature of e-mail provides the ability to send/receive electronic messages to/from any individual or entity that has an e-mail address. Employees are advised that they may receive messages (with attached material) that may be offensive and/or objectionable in nature or content. Further, employees are advised that the Commission is not responsible for the contents of any e-mail sent using Commission-provided IT resources. Receipt of such content shall be immediately reported to the IT Unit.

Passwords

To safeguard data and personal information, passwords and authorization codes, and all confidential data, an employee shall use file security mechanisms built into the computing systems; choose passwords wisely and change them periodically; and follow the security policies and procedures established to control access to and use of information resources.

Password-protecting an e-mail account does not confer a special status on e-mail records with respect to privacy and applicability of laws, policies, and practices.

Purchasing

IT personnel shall consider the following before approving a request for additional IT resources:

- 1) Will it perform the function required,
- 2) Applicability of purchasing rules and regulations,
- 3) Can it operate within the Commission environment without negatively impacting operations, and
- 4) What is the true cost of ownership, including product and support costs.

Revocation of Privileges

Access to Commission-provided IT resources is a privilege, not a right; therefore, access may be denied or revoked at any time for any reason without notice.

Reconfiguring Commission-Provided IT Resources

The Commission neither guarantees against, nor shall it be responsible for, the destruction, corruption or disclosure of personal material on or by its Commission-provided IT resources. Specifically, the Commission reserves the right to remove, replace or reconfigure its Commission-provided IT resources without formal notice to employees.

Viruses

Virus Protection Procedures:

IT personnel shall:

- 1) Oversee computer virus protection activities within the Commission;
- 2) Evaluate, recommend, and maintain virus protection software and/or tools for use on Commission desktop computers and network servers;
- 3) Provide support for the evaluation, acquisition, and maintenance of virus protection software and/or tools for other systems maintained;
- 4) Ensure that virus protection software is installed on all desktop computers and network servers acquired by the Commission before they are made available for use by the Commission, its employees or its agents;
- 5) Provide information necessary for the effective implementation of virus protection procedures;
- 6) Investigate every report of an apparent computer virus infection, and make every reasonable effort to determine the source of the infection. IT personnel will keep all affected personnel advised of the investigation;
- 7) Before installation, scan the following for viruses:
 - Shrink-wrapped software (i.e., software shipped in tamper-proof packaging) procured directly from commercial sources such as Microsoft, Novell, etc.
 - Shareware and freeware obtained from electronic bulletin boards or on disk (diskette or CD-ROM),
 - Diskettes,
 - Custom-developed software, and

- Software received through business sources (such as Department of Labor, other state agencies, federal agencies, regulated companies, consultants, law offices, etc.).
- 8) Immediately after installation, scan the following for viruses:
- All data and program files that have been electronically transmitted to a Commission computer from another location, internal or external, and
 - Software distributed in compressed form.

Each employee shall:

- 1) Use only software or data that has been properly scanned for viruses in Commission computers and/or networks. Most scanning of software or data can be done through each employee's PC.

Virus Reporting and Documentation:

When an employee detects what appears to be a virus, the employee shall take the following steps:

- 1) Document the virus' name if known;
- 2) Document any recent unusual system activities (e.g. unexpected disk access, error messages or screen displays, or sluggish computer functionality) and, if possible, include when these activities were first noticed;
- 3) Immediately shut down and disconnect computer;
- 4) Immediately notify the IT Help Desk (558-2293); and
- 5) Post a warning note on the infected computer.

Upon receipt of a notice of a possible virus, IT personnel shall take the following steps:

- 1) Clarify symptoms with the employee;
- 2) Verify if there is a virus;
- 3) Determine the source of the infection;
- 4) Isolate the source from the Commission's environment;
- 5) Assess the damage;
- 6) Verify that all potentially affected users have been notified;
- 7) If it is a new virus and/or the amount of damage is significant, isolate the virus and develop a course of action for restoring the network and/or computer(s) to normal; and

- 8) Remove the virus from the affected computer(s), scan for viruses on any other computers that were connected to the affected computer(s), and scan any diskettes that were used in the affected computer(s).

V. RESPONSIBILITIES

Employee

1. Adhere to all Commission and Division of Personnel (DOP) policies, guidelines, and procedures when using Commission-provided IT resources including, but not limited to: *Computer Policy* IIC-060); *Private and Confidential Information Policy* (IC-100); *Conduct Policy* (IC-030), and; and Division of Personnel's *Prohibited Workplace Harassment Bulletin* (DOP-B6).
2. Report to his or her immediate supervisor, if he or she:
 - Receives or obtains data and/or information to which he or she is not entitled. Under most cases, also notify the owner and/or sender of such data and/or information;
 - Receives obscene, abusive, threatening, or offensive material;
 - Knows of any inappropriate use of Commission-provided IT resources;
 - Becomes aware of possible breaches of security and/or confidentiality; or
 - Experiences unusual or suspicious IT-related occurrences.

Supervisor

1. Distribute a copy of the policy and the Computer Policy Acknowledgment Form (Appendix A) to each current employee and to new employees at orientation and to maintain a copy of the signed acknowledgment form in each employee's office reference file, give a copy to each new employee and send the original to Human Resources to maintain in the employee's agency personnel file.
2. Enforce the provisions of this policy and administer appropriate disciplinary action for any violation.

VI. REFERENCES

- A. United States Copyright Act
- B. West Virginia Code § 61-3C-1, *et seq.*
- C. West Virginia Code § 29B-1-4, *Freedom of Information Act.*
- D. West Virginia Division of Personnel Interpretive Bulletin DOP-B6, *Prohibited Workplace Harassment*

E. *Conduct Policy*, IC-030

F. *Privacy and Confidential Information Policy*, IC-100

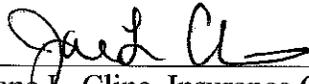
G. *Electronic Document Imaging System Procedure*, IC-P29

VII. EFFECTIVE DATE: February 15, 2006.

VIII. DISCLAIMER

The information and procedures in this policy should not be construed to supercede any State or federal law or regulation. In the event any section, portion or clause of this policy is deemed to be void, unlawful or unconstitutional, such invalidity shall not affect the remaining sections, paragraphs, clauses or provisions, and the remaining paragraphs and clauses thereof shall be and remain in full force and effect.

Approved and Issued By:



Jane L. Cline, Insurance Commissioner

2-10-06

Date

**INSURANCE COMMISSION
COMPUTER POLICY**

EMPLOYEE ACKNOWLEDGMENT FORM

I, _____, certify that I have received a copy of the West Virginia Office of the Insurance Commission Computer Policy.

I agree to abide by the terms of the policy and all attended references and I am aware that with any violation, I will be subject to disciplinary action, up to and including dismissal.

My signature acknowledges my receipt of the policy and my understanding of its contents. My signature does not indicate that I agree with the content of the policy.

Employee's Name (Print)

Supervisor's Name (Print)

Employee's Signature

Supervisor's Signature

Employee's Social Security No. (last 4 digits only)

Date Signed

Date Signed

TO BE COMPLETED BY IMMEDIATE SUPERVISOR

I, _____, certify that I have discussed with and provided the above listed employee a copy of the West Virginia Office of the Insurance Commissioner Computer Policy.

I agree to abide by the terms of and enforce the policy and all attended references and I am aware that with any violation, I will be subject to disciplinary action, up to and including dismissal.

Supervisor's Name (Print)

Supervisor's Signature

Date Signed

Distribution: Original to employee; 1 copy to Human Resources; 1 copy to supervisor

PRIVACY AND CONFIDENTIAL INFORMATION POLICY

I. PURPOSE

The purpose of this policy is to safeguard any and all information maintained at the West Virginia Office of the Insurance Commissioner (hereinafter referred to as "Commission") from inappropriate disclosure, and to ensure that all information defined within this policy as "confidential" is not divulged to unauthorized persons. In order to accomplish its regulatory mission, the Commission receives and uses information about individuals, groups, and entities, some of which is public information and some of which is not public and would be exempt from a request under the Freedom of Information Act (FOIA) (West Virginia Code §29B-1-1, et seq.). Although certain information received and used by the Commission may be public information, it is the Commission's policy to protect as private all information it receives unless an employee's legitimate duties require access to and/or disclosure of the information. Therefore, the employees of the Commission have an affirmative and continuing obligation to respect the privacy of the Commission's information, and to protect the security of all confidential information in the possession of the Commission. The purpose of this policy is to govern the behavior of Commission employees in their personal and professional capacities, and not to interfere with the use and disclosure of information received by the Commission in the normal course of each employee's regulatory duties or to prohibit disclosures of information pursuant to appropriate FOIA requests.

West Virginia State law provides penalties for the unlawful release of private or confidential information. Depending upon the severity of the breach of confidentiality, disciplinary action could include a written reprimand, suspension, demotion, and/or dismissal. Violations could also result in civil or criminal prosecution.

II. ACCOUNTABILITY

Under the direction of the Insurance Commissioner, the Division Directors shall ensure compliance and implementation of this policy for their sections/units.

III. APPLICABILITY

This policy applies to all employees of the Commission.

IV. DEFINITIONS

Private Information: Information about individuals, groups, or entities served or regulated by the Commission that is not generally known to the public or among persons in the industries or trades in which an entity competes and information protected by West Virginia Code §5A-8-21 and 22.

Confidential Information: Information that would be exempt from the FOIA under West Virginia Code §29B-1-4, including information concerning individual health and medical history records, individual financial information or other nonpublic personal information that would constitute an invasion of privacy if disclosed, criminal investigation files, proprietary data, internal memoranda or the information contained in memoranda that are prepared by the Commission, and trade secrets

maintained by the Commission. Any questions concerning the application of FOIA or the confidential nature of any information should be directed to the Legal Division. All FOIA request must be directed to the Legal Division.

V. POLICY

Personal information is to be used strictly for the business purposes for which it is collected and the confidentiality of the information is to be preserved. Any information concerning an individual, entity, or group which an employee becomes aware of in the course of Commission employment shall not be discussed with or disclosed to others without a legitimate business need outside that employee's official capacity. Although much of the information provided to the Commission is available to the public at request, the Commission has an inherent obligation to respect the privacy of the information received, and Commission employees shall only disclose information relevant to their official duties and only during such times when they are acting in their official capacity.

Employees afforded access to private and confidential data by virtue of their position shall at no time, during or after the term of employment, disclose or divulge private or confidential data to unauthorized persons.

Electronic data and manually maintained records regarded as private or confidential in nature, shall be held in trust, and protected against unauthorized disclosure or use.

All employees having access to private and confidential data in any form are required to take proper precautionary steps to avoid any breach of privacy of any customer, agent, insurer, or employee of the Commission.

The Agency shall maintain in its records only such information as is relevant and necessary to accomplish the purpose of the Commission.

Employees shall access only the data required to accomplish their official duties

Information regarding the Commission's network system, including all hardware and software, shall be private and shall not be discussed with outside parties. All requests for such information shall be directed to the Commission's Systems Administrator.

VI. RESPONSIBILITIES

Employee

1. Comply with this policy in its entirety.
2. Complete the *Employee Privacy and Confidential Information Agreement* (Appendix A).

Supervisor

1. Distribute a copy of the policy to each current employee and to new employees during orientation.
2. Enforce the provisions of this policy in a fair and impartial manner.

VII. REFERENCES

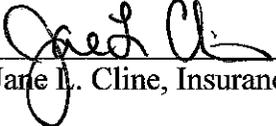
- A. West Virginia Code §29B-1-4, *Freedom of Information Act*.
- B. West Virginia Code §5A-8-22, *Personal information maintained by state entities*.
- C. West Virginia Code §5A-8-21, *Limitations on release of certain personal information maintained by State agencies and entities regarding State employees*.
- D. West Virginia Code §21-1-1 et seq.
- E. West Virginia Code §29B-1-1, *Freedom of Information Act*.
- F. *Conduct Policy*, IC-030
- G. *Computer Policy*, IC-060

VIII. EFFECTIVE DATE: February 15, 2006.

IX. DISCLAIMER

The information and procedures in this policy should not be construed to supercede any State or federal law or regulation. In the event any section, portion or clause of this policy is deemed to be void, unlawful or unconstitutional, such invalidity shall not affect the remaining sections, paragraphs, clauses or provisions, and the remaining paragraphs and clauses thereof shall be and remain in full force and effect.

Approved and Issued By:



Jane L. Cline, Insurance Commissioner

2-10-06

Date

**WEST VIRINGIA INSURANCE COMMISSION
EMPLOYEE PRIVACY AND CONFIDENTIAL INFORMATION
AGREEMENT**

This agreement serves to stipulate and clarify the responsibilities of each employee of the West Virginia Office of the Insurance Commissioner (hereinafter referred to as the "Commission") with regard to private and confidential information in the custody of the State of West Virginia. In consideration of my employment by the Commission, I hereby agree to the following:

1. I shall not disclose confidential information to any third party or co-worker without appropriate clearance and legitimate need to know. Confidential information includes, but is not limited to:
 - A. Information obtained by the Commission regarding employers pursuant to W.Va. Code § 21-1-1 et. seq.;
 - B. Information obtained by the Commission regarding injured workers pursuant to W.Va. Code § 21-1-1 et. seq.;
 - C. Information regarding Commission employees, such as addresses, social security numbers, marital status, maiden names, salaries, medical information, disciplinary matters, and participation in grievances;
 - D. Investigatory records of the Office of the Inspector General;
 - E. Passwords or access codes;
 - F. Commission, employee, or client credit or debit card information; and
 - G. Driver's license numbers.
2. I shall not use confidential information for any purpose except to perform my job duties for the Commission.
3. I shall not use confidential information for my own private gain or the private gain of another.
4. I shall protect confidential information from unauthorized use, transfer, sale, disclosure, alteration, or destruction whether accidental or intentional and will take necessary precautions to secure such information located at my work station.
5. I shall adhere to the computer security practices as set forth in Commission's *Computer Policy* (IC-060) to assure that confidential information is not disclosed to persons who have not been authorized access to such information by the Commission. I will protect passwords and access codes from disclosure. I will avoid using easily guessed passwords.

6. I shall immediately document and report any occurrence or incident that appears to compromise data security or confidentiality to my immediate supervisor.
7. I understand and acknowledge that my access to confidential information, if granted, is at the sole discretion of the Commission and such access may be modified, suspended, or terminated at any time by the Commission.
8. I understand that all requests from the news media for information or documents shall be coordinated, answered and distributed by the Commission's Public Information Specialist and in accordance to the Commission's *Conduct Policy* (IC-030).
9. I agree that immediately upon expiration or termination of my employment with the Commission, I will promptly return, without copying or summarizing, all confidential information to my immediate supervisor and take whatever other lawful steps my immediate supervisor requires of me to protect the Commission's confidential information.
10. I will not be involved in any way with the access, review or processing of personal claims or claims of relatives, friends or acquaintances. The term "friend" means a person whom you know, like and trust. An "acquaintance" is a person whom you know but who is not a friend. The processing of a claim includes, but is not limited to, rulings, authorizing medical services, and processing benefits.

I understand that the West Virginia State law provides penalties for the unlawful release of privileged information. Depending upon the severity of the breach of confidentiality, disciplinary action could result in an oral or written reprimand, suspension, demotion or dismissal. Violations could also result in civil or criminal prosecution. By signing this document, I acknowledge that these statements have been explained to me, that I have read and understand the statements included herein, and agree to the terms of this agreement. I also acknowledge that I have had ample opportunity to ask any questions that I may have regarding this matter.

Employee's Name (Print)

Supervisor's Name (Print)

Employee's Signature

Supervisor's Signature

Employee's Social Security No. (last 4 digits only)

Date Signed

Date Signed

Distribution: Original to Human Resources; 1 copy to supervisor; 1 copy to employee



WEST VIRGINIA EXECUTIVE BRANCH CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement, including any addenda, (collectively this "Agreement") is entered into between the State of West Virginia (the "State") and the undersigned, a member of the Workforce (the "User"). The State and the User are jointly referred to herein as the "Parties".

WHEREAS, the purpose of this Agreement is to secure the Confidential Information the State collects, stores, uses and discloses. Accordingly, the State is concerned with protecting the Privacy, Confidentiality, Integrity and Availability of this information, in its paper, electronic and verbal forms; and

WHEREAS, this Agreement is being instituted to ensure that all members of the Workforce fully understand their obligations to limit their Use of Confidential Information and to protect such information from Unauthorized Disclosure.

NOW, THEREFORE, the Parties agree as follows:

1. Definitions:

a. **Confidential Information** means information that includes, but is not limited to, demographic, medical, and financial information in any form protected by statute or when the release of which would constitute an unreasonable invasion of Privacy, unless the public interest by clear and convincing evidence requires Disclosure in the particular instance, as approved by the designated State counsel or designee. Confidential Information also includes Personally Identifiable Information (PII), as that term is defined below. Confidential Information may be in paper, electronic and verbal forms, and includes images as well as text. Confidential Information includes all information designated confidential by law, rule, policy or procedure, as may be amended from time to time, (collectively referred to herein as "Policy"), such as passwords, client names, trade secrets, information concerning any taxpayer (from any return, declaration, application, audit, investigation, film, record or report) and security audits.

b. **Disclosure** means the release, transfer, provision of access to, sale, divulgence or communication in any other manner of information outside the entity holding the information, in accordance with Policy, as may be amended from time to time.

c. **Need to Know** means the principle that states a User shall only have Access to the minimum information necessary to perform a particular function in the exercise of his or her responsibilities.

d. **Personally Identifiable Information** or PII means all information that identifies, or can be used to identify, locate, contact, or impersonate a particular individual. PII also includes Protected Health Information (PHI) as that term is defined below. PII is contained in public and non-public records. Examples may include but are not limited to a specific individual's: first name (or initial) and last name (current or former); geographical address; electronic address (including an e-mail address); personal cellular phone number; telephone number or fax number dedicated to contacting the individual at his or her physical place of residence; social security account number; credit and debit card numbers; financial records, including checking, savings and other financial account numbers, and loan accounts and payment history; consumer report information; mother's maiden name; biometric identifiers, including but not limited to, fingerprints, palm prints, facial recognition, full face image and iris scans; driver identification number; birth date; birth, adoption or death certificate numbers; physical description; genetic information; medical, disability or employment records, including salary information; computer information, including information collected through an internet Cookie; and criminal records and history. When connected with one or more of the items of information specified above, PII includes any other information concerning an individual that, if disclosed, identifies or can be used to identify a specific individual physically or electronically.

e. **Protected Health Information** or PHI is a subset of PII and means, with regard to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities (*see* 45 C.F.R. §106.103), individually identifiable health information, including demographic information, whether oral or recorded in any form or medium that relates to an individual's health, health care services and supplies, or payment for services or supplies, and which identifies the individual or could reasonably be used to identify the individual. This includes information that relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual including, but not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care as well as counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status of an individual or that affects the structure or function of the body; or the past, present, or future payment for the provision of health care to an individual; and which includes identity information, such as social security number or driver's license number, even if the name is not included, such that the health information is linked to the individual. Protected Health Information does not include records covered by the Family Educational Right and Privacy Act, 20 U.S.C. 1232g, and employment records held by the entity in its role as employer.

f. **Use** means the access, utilization, employment, application, examination or analysis of information within an entity that maintains such information.

g. **Workforce** means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the State, is under the control of the State, whether or not the State pays them. Workforce does not include Vendors.

h. Any terms not defined herein shall have the definitions afforded them within the Privacy Policy Definitions currently located at www.privacy.wv.gov.

2. Treatment of Confidential Information:

a. The User shall only collect and retain Confidential Information in conformity with Policy.

b. To the extent that the User has a Need to Know Confidential Information, the User may have Access to and shall use such Confidential Information, in conformity with Policy, as may be amended from time to time.

c. The User shall not disclose to anyone, directly or indirectly, any such Confidential Information, unless the individual who is the subject of the Confidential Information consents to the Disclosure in writing or the Disclosure is made pursuant to Policy. At no time shall the Confidential Information be disclosed or used for a personal or non-work-related reason. If information-specific release provisions and restrictions do not exist, then the User shall only disclose Confidential Information (1) upon approval of the designated State counsel or designee; or (2) to individuals who are known by the User to have prior authorization by his or her supervisor to have Access to the information. All of the above applies to release of information in total or fragmented form. When Confidential Information is disclosed, care should be taken to prevent the redisclosure of that information to unauthorized persons or entities. Further, the User shall not misuse any media, documents, forms, or certificates in any manner which might compromise Confidentiality or Security or be otherwise illegal or violate policy, such as altering a record or using a certificate improperly.

d. The User shall protect Confidential Information from unauthorized collection, Use, Access, transfer, sale, Disclosure, alteration, retention or destruction whether accidental or intentional and shall take necessary precautions to secure such Confidential Information to the extent possible.

e. The User is bound by this Agreement and shall continue to protect the Confidential Information to which the User previously had Access, even when he or she no longer has Access to the same, including after termination of the Workforce relationship. The User shall report Incidents pursuant to the Response to Unauthorized Disclosures procedure located at www.privacy.wv.gov.

f. If the User has any questions about this Agreement or the Confidentiality of information or its collection, Use or release, he or she shall request clarification from his or her immediate supervisor or appropriate Privacy Officer.

g. Any document, report, study, article or other written information in whatever format that the User prepares, or information in whatever format that might be given to the User as a member of the Workforce, and any software, computer equipment, or any other property including, but not limited to, copyrighted materials that may be made available from time to time, are the property of the State, or in the custody or control of the State, and shall remain in the State's possession, except as specifically consented to by the State. The User has no ownership rights to or interest in any information owned by or in the custody or control of the State.

h. The User's Access to Confidential Information is at the sole discretion of the State, and may be monitored, audited, modified, suspended, or terminated at any time.

i. The User shall comply with this Agreement and any applicable Privacy or Security policy. Such Compliance is a condition of employment and the User's failure to so comply may subject the User to disciplinary action up to and including dismissal. In addition, the State reserves the right to seek any remedy available at law or in equity for any violation of this Agreement. Further, the User may be subject to civil and criminal penalties for the unauthorized Use or Disclosure of Confidential Information.

Printed Name: _____

Signature: _____

Date: _____



Section 11.3: The Exchange has instituted procedures and policies that promote compliance with the financial integrity provisions of Affordable Care Act 1313 (and will supplement those policies and procedures to implement regulations promulgated under the Affordable Care Act 1313), including the requirements related to accounting, reporting, auditing, cooperation with investigations, and application of the False Claims Act.

The WV Offices of the Insurance Commissioner is subject to the State's statutory and regulatory requirements controlling the financial management of all grant funds, including funds awarded by federal sources. The grant funds are placed into a special grants account fund to ensure proper utilization of the funds and that all accounting practices are adhered to. Internal checkpoints with the WVOIC must be met prior to approval of expenditures and submission of invoices to the WV Revenue Department. The expenditure of grant funds is subject to the control and procedures contained in the regulations promulgated by State Revenue, and ultimately the State Treasury. In addition, all funds, and expenditures related to, are subject to State audits by the WV State Auditor's Office.

All WVOIC contracts include provisions requiring the proper financial management of federal funds, including proper reporting of activities and expenditures from each contractor and grant sub-recipient. Monthly reports are submitted with each invoice to track expenditures and to tie the expenditures to each project's corresponding work plan and objectives and overall funding award requirements. To ensure prevention of waste, fraud, and abuse related to state and federal expenditures, the WVOIC administers funding for Exchange-related projects under rigorous statutory and regulatory requirements. The WVOIC follows OMB Circular A-87, as well as generally accepted accounting standards (GAAP) for state government via the Governmental Accounting Standards Board.

West Virginia Health Benefit Exchange Contracts and MOUs

Procurement	Vendor	Type	Scope	Status	Value	Start Date	Projected End Date
Oral Health Initiative	WV State Oral Health Program	MOU	-Dental Census Survey -Phone Survey regarding consumer insurance coverage and care experience -Surveillance project for adults -Surveillance project for seniors -Recommendations on stand-alone dental plans from a provider perspective	Completed	\$144,000	2/2/2012	12/31/2012
Actuarial Analysis and Economic Modeling Study	CCRC	RFP	-Economic and Actuarial Modeling Study -Review of Financial Modeling Documents -Medicaid analysis -Assessment of Individual and Small Group Markets	On-Going	\$861,500	8/28/2012	4/1/2013
Study for Children in the HBE	WV CHIP	MOU	-Assessment of children in the Health Benefit Exchange -Transition of children from CHIP to Medicaid and vice versa	On-Going	\$86,100	6/8/2012	3/31/2013
Statewide Meeting Facilitation	CESD/WVU	MOU	-Statewide meeting facilitation -Stakeholder planning sessions	Completed	\$24,987.50	10/10/2010	6/30/2011
Stakeholder Meeting Facilitation	CESD/WVU (2)	MOU	-Stakeholder meeting facilitation -Development of meeting materials, agendas, etc.	On-Going	\$57,400	2/2/2012	On-Going
Regional Exchange Study	NASHP	Sole-Source	-Analysis of Regional Exchange concept -Interviewing of other states to get feedback on sharing of administrative costs and risk pools	On-Going	\$111,830	8/1/2012	8/1/2013
Essential Health Benefits Analysis	United Actuaries	RFQ	-Analysis of EHB -Final report	Completed	\$26,110.27	5/1/2012	9/14/2012
WV HBE Evaluation and Assessment	WVU HRC/BBER	MOU	-5 year performance evaluation plan of the implementation, impact, and outcomes of the WVHBE from the standpoint of key business and economic indicators and population health to ultimately improve Exchange performance	On-Going	\$94,919	5/1/2012	2/28/2013
Provider Quality Initiative	WVSOM	MOU	-Provider quality initiative -Analysis of data currently used to measure provide quality -Recommendation on how data should be collected and reported to consumers -Cost analysis for collecting data	On-Going	\$60,000	2/13/2012	6/30/2013
Health Insurance Literacy Study	Marshall University	MOU	-Health Insurance Literacy Study -Interviewing of WV residents to determine level of health literacy comprehension	On-Going	\$57,834	6/1/2012	2/1/2013
Plan Management IT Functions	NAIC/SERFF Phase 1	Addendum	-Modifications to current SERFF system	Completed	\$22,250	6/1/2012	10/1/2012
Plan Management IT Functions	NAIC/SERFF Phase 2	Addendum	-Modifications to current SERFF system	On-Going	\$62,201	10/1/2012	12/31/2012
Project Management Assistance	BerryDunn	ITECH-10	-Project Management -Health Policy Consultation -Exchange Budget and Cost Allocation Methodology -IT Gap Analysis, IT RFI Development/Analysis, IT RFP Development, APD Development -Program Management -Financial Management Assistance -Eligibility Assistance	On-Going	\$2,000,000	6/7/2011	6/6/2013
Website/Branding/Marketing Development	Arnold Agency	Piggyback	-Original website development -Branding/Marketing strategy -Comprehensive professional advertising campaign	Completed	\$44,632.50	11/16/2010	11/15/2011



Section 13.2: The State has the capacity to interface with the Federally-Facilitated Exchange, as necessary, to ensure a seamless consumer experience.

The WV OIC understands the importance of ensuring a seamless consumer experience. The NAIC is currently working with CCIIO to assure SERFF integrates between the WV Rates & Forms Division and the Federally-Facilitated Exchange for Plan Management purposes. The OIC is currently working with the NAIC and CMS on integration plans for the consumer including the potential use of SBS (state-based systems) to track consumer complaints. The OIC also conducts a monthly Consumer Assistance workgroup meeting with several state agencies to help develop strategies that will be most productive in creating a seamless consumer experience. The following goals have been developed by the group:

- Discuss and analyze Partnership and HHS Questions/Answers as additional information becomes available
- Defining parameters for interagency MOU agreements
- Collaboratively working on RFP development for IPA Technical Assistance Contractor
- Develop program design decisions for the State's In-Person Assistance Program (including county eligibility workers)
- Collaborate on grant development
- Identify call center work flow (cascade between state and federal centers)



Section 13.3a: The appropriate State entity has established or has a process in place to support, administer, and oversee (as applicable) aspects of the Federally-Facilitated Exchange Navigator program consistent with the applicable requirements of 45 CFR 155.210, including ensuring that Navigators are adhering to the training and conflict of interest standards established by the Federally-Facilitated Exchange and to the privacy and security standards developed by the Federally-Facilitated Exchange pursuant to 4 CFR 155.260.

Per deliberations with CMS, including a phone conversation on February 11, 2013, the State has acquired exempt status from this requirement of the Consumer Assistance Partnership. Provided that the Navigator program is a federally-operated program, with the selection, training and funding source of Navigators being at the federal level, State leadership feels it is in the best interest of the State to be removed from the Navigator program and have all functions administered at the federal level.

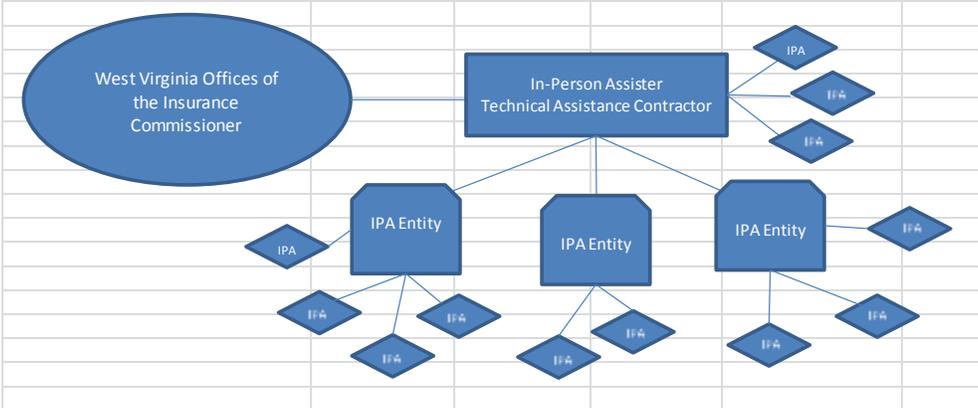
Section 13.3b: The appropriate State entity has established an in-person assistance program distinct from the Navigator program, and has a process in place to operate the program consistent with the Federally-facilitated Exchange guidance, policies, and procedures.

The West Virginia Offices of the Insurance Commissioner (OIC) will be the overseeing authority for the West Virginia In-Person Assister (IPA) program. The OIC understands the necessary duties that must be fulfilled by the In-Person Assister, including the assistance of WV consumers through a seamless enrollment process. The OIC has a well-respected Consumer Services Division that has been providing consumer assistance for several years and is well-positioned to assist the Health Policy Division with overseeing the Consumer Assistance program. The Health Policy Division has identified several key goals of the program via a Consumer Assistance workgroup the Insurance Commission currently conducts with Medicaid, CHIP, the Bureau for Children and Families, and SHIP.

West Virginia has identified a primary strategy for implementing the In-Person Assistance program that is currently under consideration dependent on the direction of the federal Navigator program so as not to duplicate efforts.

The State plans to contract with a vendor to provide oversight of the IPA program. Through a competitive bid process, WV will seek a vendor with experience in providing consumer assistance support to become the State’s IPA Technical Assistance Contractor. This contractor will be responsible for working with the State to develop an IPA application, develop and administer any additional training the State may decide is necessary, provide monthly reports of the progress being made with each IPA Entity that is being overseen, and assist in developing a funding approach for the program. The Technical Assistance Contractor will provide assistance in selecting the IPA Entities that will operate around the state, and the IPA Entity will then utilize its own staff to form a network of In-Person Assistants. The Contractor may also provide its own IPAs to provide support to consumers.

Below is a diagram of the anticipated structure of the IPA program:





These individuals will be specifically targeted towards assisting vulnerable and underserved populations in the individual market, both private and public markets, although some level of training regarding the small group market is likely to be provided to assist individuals that do not have an agent-consumer relationship.

The State retains the ability to develop additional training modules beyond the federal baseline that are West Virginia-specific to best meet the needs of WV consumers. The In-Person Assister may also be required to pass a certification exam based on the training materials beyond the federal certification program. It is critical that the State ensure the In-Person Assister is adequately trained and meets the same training, privacy and security, and conflict of interest standards outlined in federal guidance for the Navigator program for the safety of our residents.

Through 1311 funding received by the state, the Technical Assistance Contractor will subcontract with IPA Entities, per OIC approval, which will outline the necessary compliance requirements each entity will be held to. Potential candidates for selection must demonstrate knowledge of health insurance or the ability to easily understand complex materials and then communicate them effectively to West Virginians. The In-Person Assister would be on a 1-year contract, with the option for the State to extend for additional years, pending the passage of a recertification course by the Assister. The Contractor, in conjunction with the OIC, would also conduct on-going performance reviews of each entity as part of its oversight responsibility. The OIC would be responsible for the oversight and auditing of the Technical Assistance Contractor.

The ratio of entities to citizens and the level of funding for the program are still under review by the State. Based on analyses of other states, the State is currently estimating a need for approximately 225 IPAs to be dispersed throughout the State during open enrollment with approximately 30 IPAs during non-peak periods, but this figure, along with the associated cost, still needs to be refined. The State is making the assumption that there will be two Navigator entities in WV beginning in 2013 and will be building its program based on this assumption. As part of the State’s current actuarial and economic modeling study, a market analysis will be conducted that will display which areas of the state are the highest need populations.

Below is an anticipated work plan for the In-Person Assister program:

Date	Activity
February 2013	Submission of Exchange Blueprint and Declaration Letter
February - March 2013	Receive Approval/Conditional Approval of Blueprint
March 2013	Issue RFP Procurement for In-Person Technical Assistance Contractor
April 2013	Award Procurement to Contractor
April - May 2013	Begin work with Contractor to develop IPA Entity application, training, etc.
May - June 2013	Select IPA Entities
June - July 2013	Train IPA Entities and IPAs and ensure completion of federal training and certification
August - September 2013	Begin Outreach Efforts to Inform Consumers of Exchange
October 2013 - March 2014	Assist Consumers During Open Enrollment
October 2013 - Ongoing	Evaluation of Program



State of West Virginia

Joe Manchin III

Governor

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September 20, 2010

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
200 Independence Avenue, S. W.
Washington, DC 20201

Dear Secretary Sebelius:

I am in receipt of your September 10, 2010, letter in which you request clarification of West Virginia's position with respect to our State's ability to enforce the provisions of the Affordable Care Act (ACA).

Please be advised that the West Virginia Insurance Commissioner intends to use the tools that are currently available under State law to enforce the provisions of the ACA. These tools include requiring insurers to incorporate the reforms into their form filings with our Insurance Commissioner. Absent compliance with the ACA, insurers' forms will not be approved. The authority for disapproval of insurance forms is found in the West Virginia Code, which includes a provision that requires the Insurance Commissioner to disapprove a form if the coverages provided therein are not sufficiently broad to be in the public interest. Any form that does not include insurance reforms in the ACA cannot be sufficiently broad to be in the public interest; and, therefore, should not be sold to our West Virginia consumers.

The Insurance Commissioner is currently reviewing filings for ACA compliance and intends to contact insurers selling health insurance in our State to inform them that they must submit filings that reflect the ACA reforms if they have not already done so. In addition, the Insurance Commissioner's staff will notify the Office of Consumer Information and Insurance Oversight whenever non-compliant terms are discovered. It is among the Insurance Commissioner's responsibilities to ensure that carriers in our State are offering legal insurance products to West Virginia consumers, and that the insurers' solvency isn't threatened by actions arising from noncompliance with the ACA.

OFFICE OF THE GOVERNOR

The Honorable Kathleen Sebelius
September 20, 2010
Page Two

While we are fully cognizant of the goals embedded in the health reform legislation and are committed to enforcement of its provisions, there has been careful review of our State Insurance Commissioner's statutory authority to enforce this federal law. Clear State statutory authority is always preferred, and we will continue to look at these issues to determine whether our enforcement capabilities can be enhanced with the passage of additional legislation when our Legislature convenes in January. However, under current law it is believed that our Insurance Commissioner can move forward with enforcement, and it is our intention to do so as outlined above.

With warmest regards,

A handwritten signature in black ink, appearing to read "Joe Manchin III", written in a cursive style.

Joe Manchin III
Governor

DRAFT: Qualified Health Plan Submission Guide v1.0

**West Virginia Offices of the Insurance Commissioner
February 2013**

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Versioning Table		
Version	Delivered Date	Update Reason
Working Draft v1.0	February 12, 2013	Initial release

DRAFT

Section I. General Information and Background

1.1 Purpose

The purpose of this document is to provide guidance to health insurance issuers regarding the certification standards for individual and/or Small Business Health Options Program (SHOP) Qualified Health Plans (QHPs) offered through the federal Health Insurance Exchange. This document is for informational purposes and has no legal force or effect; issuers should refer to applicable WV State Code and federal statute, rules, and regulations for a more comprehensive and thorough understanding of requirements related to qualified health plans offered in the Exchange. Federal statute and regulations referenced in this document may not be final, and the citations to the same will be updated in future versions of this document when such regulations are made final.

1.2 Context

The Patient Protection and Affordable Care Act of 2010 (ACA) provides the regulatory framework for the establishment of an Affordable Insurance Exchange (Exchange) and the certified qualified health plans that will be made available to consumers through them. Effective January 1, 2014, the Exchange will offer issuers a state-wide marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance. The Exchange is the only distributional channel through which individuals and small employers will be able to purchase coverage that will be eligible for certain affordability subsidies, including:

- Advanced premium tax credits and/or cost-sharing reductions available to households purchasing coverage in the individual market
- Affordability tax credits available to eligible employers offering coverage in the small group market

To be certified as a QHP, the issuer and its health plans must meet all pertinent federal and state statutory requirements. Operating in partnership with the US Department of Health and Human Services (HHS), the West Virginia Offices of the Insurance Commissioner (OIC) will review and recommend certification of QHPs to HHS for ratification of the certification recommendation, allowing for participation in the Exchange. The Affordable Care Act authorizes QHP certification as well as other operational standards for the Exchange in following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411, and 1412. Standards for QHP issuers are codified in 45 CFR 155 and 156.

An Exchange will need to collect data from issuers as part of QHP certification and recertification and to monitor compliance with QHP certification standards on an ongoing basis. QHP issuer and plan data will also support additional operational activities, including the calculation of each individual's advance payment of the premium tax credit, the display of plan information on the Exchange web site, and managing the ongoing relationships between QHP issuers, the OIC, and the Exchange. Much of the

information collected for QHP certification purposes will support these operational activities on an ongoing basis.

An individual or SHOP health insurance plan certified as a QHP in 2013 will be offered through the Exchange beginning October 1 to any eligible consumer wanting to purchase coverage, with an effective date of coverage beginning no sooner than January 1, 2014. Health insurance issuers will offer certified QHPs for a term of one year beginning January 1, 2014 and ending December 31, 2014. Only OIC-approved health plans certified by HHS may be offered as QHPs through the Exchange during this period.

1.3 General Exchange Participation Requirements

To be certified for participation in the Exchange, a QHP must:

- Meet the legal requirements of offering health insurance in West Virginia
- Satisfy the certification criteria as established by the State
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts 155 and 156
- Receive a recommendation for certification by the OIC, have the recommendation ratified by HHS, and enter into a Certification Agreement with HHS

In addition, to participate in the Exchange an issuer must:

- Submit at least one silver plan and one gold plan (45 CFR 156.200(c)(1))
- Provide a child-only option for each metal tier for which the issuer offers a QHP (45 CFR 156.200(c)(2))
- Submit three variations to each silver plan reflecting reduced cost-sharing on the essential health benefits (45 CFR 156.420(a))

1.4 Timetable

The following table provides estimated dates for QHP certification process in 2013. Please note that dates are subject to change based on several factors, including many beyond the control of the OIC such as delays in federal guidance, federal timelines, and SERFF enhancements. Issuers will be kept informed of delays through monthly OIC stakeholder meetings and other existing communication mechanisms.

Table 1. Estimated Dates for 2013 QHP Certification Process	
Action	Dates
Issuers request HIOS Product ID and Plan IDs in HIOS ¹	February-March 2013 ²

¹Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review.

²Dates are only estimates as they will be established by CCIO.

Table 1. Estimated Dates for 2013 QHP Certification Process	
Action	Dates
Issuers submit QHPs	April 1 – May 31, 2013
OIC reviews QHP submissions, requests additional information and works through any concerns with issuers, and submits certification recommendations to HHS for approval/disapproval	April 1 – July 31, 2013
HHS ratifies OIC certification recommendations	August 2013
Issuer enters into certification agreement with HHS ³	August 2013
Carriers preview plan data and confirm it is correctly uploaded	August 2013
Open enrollment period	October 1, 2013 – March 31, 2014
2014 plan year	January 1 – December 31, 2014

1.5 Contact Information

For questions, please contact Jeremiah Samples, Director, Health Policy Division, at the West Virginia Offices of the Insurance Commissioner, as follows:

E-mail: jeremiah.samples@wvinsurance.gov

Phone: 304-558-6279 ext. 1131

Mailing Address: 1124 Smith St, Charleston, WV 25301

³ Dates are only estimates as they will be established by CCIIO.

Section II. Specifications for QHP Certification

This section outlines the various issuer- and plan-level components that the OIC will require in the QHP submission. *Please note* that prior to completing a “Plans and Benefits Data Template,” issuers must register their HIOS Product IDs via CCIIO’s Health Insurance Oversight System (HIOS)⁴. Each Product ID will come with fifty Plan IDs, each of which is made up of the Standard Component ID and a Variance ID.

QHP data and information will be submitted by issuers to the OIC in SERFF using the methods numbered below. For each QHP certification requirement included in this section, the primary proposed method issuers will use to submit supporting data information is listed. However, this may change prior to the opening of the QHP submission window subject to new guidance and information from CCIIO and the NAIC. As permitted by the ACA, issuer and plan data and information required for initial QHP certification and ongoing monitoring will be forwarded by the OIC securely and directly to HHS through SERFF.

At the time of drafting this Guide, the CCIIO MS Excel Data Templates referenced below are in proposed form and can be found at the following location under “Documentation – Business”: <http://www.serff.com/hix.htm>

1. Built-in Onscreen SERFF Data Entry Fields
 - E.g., Plan Binder Name, Plan Year, Market Type
2. CCIIO Standard MS Excel Data Templates (as attachments)
 - E.g., Administrative Data, Plan and Benefit Data, Rate Data, Formulary Data
3. Supporting Documents (as attachments)
 - E.g., Certification of Compliance, Actuarial Memorandum, and Certificate of Readability
4. Attestations (as a PDF attachment)
 - E.g., “Issuer will adhere to all requirements contained in 45 CFR 156, applicable law and applicable guidance”

2.1 Issuer Administrative Information

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

Not applicable

⁴Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review.

OIC/HHS Approach to Certification

The QHP filing process requires submission of certain general administrative data that will be utilized for operational purposes. This basic information is required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information⁵.

Please see the “Administrative Data Template” for detail on the data elements to be collected.

Primary data submission method(s): CCIIO MS Excel Data Templates

2.2 Licensure, Solvency, and Standing

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

An issuer must be licensed, meet State solvency requirements, and have unrestricted authority to write its authorized lines of business in West Virginia State in order to be considered “in good standing” and to offer a QHP through the Exchange. Good standing means that the issuer has no outstanding sanctions imposed by the OIC (45 CFR 156.200(b)(4)).

OIC/HHS Approach to Certification

Financial Conditions Division will review and confirm issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an issuer’s license, solvency, and standing. Consequently, issuers licensed in West Virginia will not be required to submit supporting documentation for this certification standard initially unless concerns are identified and additional review is required. Issuers that are not currently licensed will be required to complete the WV licensing process, which is handled by the OIC’s Financial Conditions Division. West Virginia is a NAIC Uniform Certificate of Authority Application (UCAA) participant state; therefore, West Virginia accepts the UCAA Primary and Expansion Applications. To obtain a license in West Virginia, insurers and stand-alone dental plans must follow the procedures outlined in the UCAA Primary and Expansion Applications.

Primary data submission method(s): Attestations

⁵ See 508 Appendices A1 and A4 of Paperwork Reduction Act package, CMS Form Number CMS-10433, for additional information.

2.3 Benefit Standards and Product Offerings

This information will be QHP-specific and will need to be included for each submitted QHP in the issuer's application. With the exception of 2.3.5, this section does apply to stand-alone dental plans.

Plan-specific information not captured in other sections will be collected, including data elements such as Plan ID, whether or not the plan is offered in the individual or SHOP Exchange market and/or off of the Exchange, and plan effective date.

Additionally, issuers must submit benefits information for each QHP. QHP issuers must ensure that each QHP complies with the benefit design standards (specified in the ACA and subsequent rules (45 CFR §156.200(3)), including⁶:

- Federally approved State-specific essential health benefits (EHB)
- Cost-sharing limits
- Actuarial value (AV) requirements
- Non-discriminatory benefit design
- Mental health parity

QHP offerings must also reflect meaningful differences amongst products to ensure that a manageable number of distinct plan options are offered.

Sections 2.3.1 – 2.3.5 provide additional requirements related to benefit design standards.

2.3.1 Essential Health Benefits

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Exchange must cover a core set of “essential health benefits” as defined by HHS. Coverage must be substantially equal to the coverage offered by a benchmark plan, and the plan must cover at least the greater of one drug in every USP category and class or the same number of drugs in each category and class as benchmark plan (45 CFR 156.110, 156.115, 156.120⁷).

In West Virginia, the benchmark plan is Highmark Blue Cross Blue Shield West Virginia Super Blue Plus 2000 1000 Ded. Additionally, pediatric dental benefits are supplemented using the State's separate Children's Health Insurance Program (CHIP) program, and pediatric vision benefits are supplemented using the Federal Employees Dental and Vision Insurance Program.

⁶Standards are contained in proposed Federal rules expected to be final in early 2013.

OIC/HHS Approach to Certification

In its review, the OIC will confirm the following:

- Issuer offers coverage that is substantially equal to the benchmark plan
- Issuer has demonstrated actuarial equivalence of substituted benefits if the issuer is substituting benefits
- Issuer provides required number of drugs per category and class

EHB substitutions will require an actuarial certification to support that the substitutions are compliant and actuarially equivalent substitutions (45 CFR 156.115(b)(2)). HHS is working on an actuarial tool to determine actuarially-equivalent EHB substitutions, and further HHS guidance is expected. Data will be collected on health benefits, including covered drugs, and issuers will submit Summary of Benefits and Coverage (SBC) Scenario results. Please see the “Plans and Benefits Data Template” and “Prescription Drug Data Template” for additional detail on the data elements to be collected.

Primary data submission method(s): CCIO MS Excel Data Templates, Attestations, Supporting Documents

2.3.2 Annual Cost-Sharing Limitations

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Exchange must meet the following annual cost-sharing limits in 2014 (45 CFR 156.130):

- **Out-of-Pocket Limits:** The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.
- **Deductibles:** Employer-sponsored plans may not have a deductible in excess of \$2,000 for a plan covering a single individual or \$4,000 for other coverage. The deductible limit may be increased by the maximum amount of reimbursement reasonably available to an employee under a flexible spending arrangement.

Beginning in 2015, all of the cost-sharing limits will be indexed to per-capita growth in premiums in the United States as determined by HHS.

While the annual limitation on cost-sharing for a QHP must be consistent with 45 CFR 156.130, proposed rule 45 CFR 156.150 indicates the annual limitation on cost-sharing for a stand-alone dental plan would be considered separately. The plan must demonstrate the annual limitation on cost-sharing for the stand-alone dental plan is “reasonable” for coverage of the pediatric dental EHB.

OIC/HHS Approach to Certification

The OIC will review plan data for compliance with ACA cost-sharing limitations. Benefit cost-sharing (e.g., quantitative limits, co-payments, and co-insurance by benefit), plan cost-sharing (e.g., in-network and out-of-network deductibles), and pharmacy benefit cost-sharing data elements will be collected; please see the “Plans and Benefits Data Template” and “Prescription Drug Data Template” for additional detail on required data elements.

Primary data submission method(s): CCIO MS Excel Data Templates, Attestations

2.3.3 Actuarial Value

Statutory/Regulatory Standard

Except for the impact of cost-sharing reduction subsidies and a *de minimis* variation of +/- 2 percentage points, each plan in a metal tier must meet the specified AV requirements based on the cost-sharing features of the plan (45 CFR 156.140):

- Bronze plan – AV of 60 percent
- Silver plan – AV of 70 percent
- Gold plan – AV of 80 percent
- Platinum plan – AV of 90 percent
- Catastrophic plan – N/A⁸

With exceptions for unique plan designs, issuers must use an actuarial value calculator, provided by HHS for use within the SERFF application, to produce computations of a QHP’s metallic level based upon benefit design features. The AV calculator *may* also be used by issuers informally for plan design. For unique plan designs for which the calculator does not provide an accurate summary of plan generosity, an actuarial certification is required from the issuer indicating compliance with one of the calculation methods described in 45 CFR 156.135(b)(2).

Per proposed rule 45 CFR 156.150, standalone dental plans may not use the HHS-developed AV calculator. Instead, any stand-alone dental plan certified to meet a 75 percent AV, with a *de minimis* range of +/- 2 percentage points, be considered a “low” plan and anything with an AV of 85 percent, with a *de minimis* range of +/- 2 percentage points, be considered a “high” plan. The “high/low” actuarial value standard would apply to the pediatric dental EHB only in a stand-alone dental plan; when the pediatric dental EHB is included in a health plan, the AV calculator would apply to the pediatric dental EHB.

⁸Please see ACA §1302(e) for details on catastrophic plans and individuals eligible for them.

OIC/HHS Approach to Certification

The OIC will review and confirm that the AV for each QHP meets specified levels and review unique plan designs and the accompanying actuarial certification, if applicable.

Primary data submission method(s): CCIO MS Excel Data Templates, Attestations, Supporting Documents

2.3.4 Non-Discrimination

Statutory/Regulatory Standard

An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125). In addition, QHPs must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR 156.200(e)) and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

OIC/HHS Approach to Certification

Issuers will be required to attest to non-discrimination on these factors. In addition, State standards for evaluation of compliance with non-discriminatory benefit design are still under development; however, the OIC may conduct outlier tests to identify potentially discriminatory benefit designs when a Federal analytic tool becomes available.

Primary data submission method(s): CCIO MS Excel Data Templates, Attestations

2.3.5 Mental Health Parity and Addiction Equity Act

Statutory/Regulatory Standard

All individual and small group plans sold inside and outside of the Exchange are required to comply with the Mental Health Parity and Addiction Equity Act (ACA § 1311(j)).

OIC/HHS Approach to Certification

The OIC will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Primary data submission method(s): CCIO MS Excel Data Templates, Attestations

2.4 Rating Factors and Rate Increases

This information will be QHP-specific and will need to be included for each submitted QHP in the issuer's application. At this time, HHS has not further defined specific information related to dental plan rating factors.

Statutory/Regulatory Standard

Issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014, and the large group market if such coverage is available through an Exchange starting in 2017, must limit variation in plan premiums to age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography (45 CFR 147.102; 45 CFR 156.255). The Federal rule prohibits the use of other rating factors such as health status, medical history, gender, and industry of employment to set premium rates.

Proposed Federal rules related to rate-setting are listed below⁹; review and analysis of WV-specific factors is underway and will be defined within 30 days of the publication of the final Federal rules.

- *Tobacco Use.* Rates based on tobacco use may vary by up to 1.5:1.
- *Family Composition.* Issuers must add up the premium rate of each family member to arrive at a family rate. However, the rates of no more than the three oldest family members who are under age 21 would be used in computing the family premium.
- *Geography.* A state is to have a maximum of seven rating areas. The rating area factor is required to be actuarially justified for each area.
- *Age.* Issuers must use 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 proposed 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: single age band covering children 0 to 20 years of age, where all premium rates are the same
 - Adults: one-year age bands starting at age 21 and ending at age 63
 - Older adults: a single age band covering individuals 64 years of age and older, where all premium rates are the same
 - Rates for adults age 21 and older may vary within a ratio of 3:1

Issuers must set rates for an entire benefit year, or for the SHOP, plan year; must charge the same premium rate without regard to whether the plan is offered through the FFE or directly from the issuer through an agent and is sold inside or outside of the Exchange; must submit rate information to the Exchange at least annually; must submit

⁹Standards are contained in proposed Federal rules expected to be final in early 2013.

a justification for a rate increase prior to the implementation of the increase; and must prominently post the justification on its Web site (45 CFR 156.210).

Rate increases for QHPs are subject to the reporting and review requirements in 45 CFR 154.215 related to the submission of a Rate Filing Justification, inclusive of:

- An HHS standardized Unified Rate Review data template
- A Consumer Narrative Justification (for increases subject to the review threshold)
- An actuarial memorandum providing the reasoning and assumptions that support the data submitted in the data template and an actuarial attestation

OIC/HHS Approach to Certification

The OIC will review rates for compliance with rating standards, as well as issuer attestations. For rate increases, a review of the Rate Filing Justification, including actuarial memorandum, will be performed. Please see the “Rates,” “Rate Review,” and “Business Rules” Data Templates for detail on the data elements to be collected.

Primary data submission method(s): CCIO MS Excel Data Templates, Attestation, Supporting Documents

2.5 Accreditation Standards

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

During an issuer’s initial year of QHP certification (e.g., in 2013 for the 2014 coverage year), a QHP issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in West Virginia granted by a HHS recognized accrediting entity¹⁰ or must have scheduled, or plan to schedule, a review of QHP policies and procedures with a recognized accrediting entity (45 CFR 155.1045).¹¹ Accreditation must be on the basis of local performance in the following categories (45 CFR 156.275):

- Clinical quality measures, such as the HEDIS
- Patient experience ratings on a standardized CAHPS survey

¹⁰Accrediting entities approved by HHS as defined in 45 CFR Parts 156.275.

¹¹ Per proposed 45 CFR 155.1045, prior to a QHP issuer’s second and third year of QHP certification (e.g. in 2014 for the 2015 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 or must have commercial or Medicaid plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is offering Exchange coverage and 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. Prior to a QHP issuer’s fourth year of QHP certification and in every subsequent year of certification, an issuer must be accredited in accordance with 45 CFR 156.275.

- Consumer access
- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs

OIC/HHS Approach to Certification

In 2013, data verifying accreditation status is expected to be received directly in SERFF from the NCQA and URAC. Issuers meeting accreditation standards in the initial year must authorize the release of accreditation survey data to the OIC and Exchange. An accreditation data file will be received by the NAIC from accrediting entities, loaded into SERFF, and made available for display as part of the plan submission (data will also be sent to HHS). In addition, issuers, regardless of accreditation status, must provide attestations including acknowledgment that, prior to 2016, CAHPS[®] data may be used on the Exchange Internet website and the website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid or Exchange product lines.

Primary data submission method(s): Built-in SERFF Fields, Attestations

2.6 Network Adequacy and Provider Data

This information may be issuer or QHP-specific. If the provider network within the service area is consistent across all products and plans sold by the issuer, the issuer may provide required information and attestations only once. If there is any variation in the provider networks across QHPs, information will need to be provided for each product and/or plan. With the exception of 2.6.3, Mental Health and Substance Abuse providers, this section does apply to stand-alone dental plans.

2.6.1 General

Statutory/Regulatory Standard

Per 45 CFR 155.1050, the Exchange must ensure that enrollees of QHPs have a sufficient choice of providers. A QHP's provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay (45 CFR 156.230(a)(2)).

OIC/HHS Approach to Certification

To fulfill the network adequacy requirement, an issuer must be accredited with respect to network adequacy by an HHS-recognized accrediting entity and attest to complying with the following standards to demonstrate it has an adequate range of providers for the intended service areas:

1. Issuer will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2)
2. Issuer's network meets applicable WV network adequacy requirements as defined in West Virginia Informational Letter No. 112
3. Issuer's network reflects executed contracts for the year in which the issuer is applying

If the issuer is not accredited or is accredited but cannot respond affirmatively to each of the attestations, a network access plan must be submitted. In general, the access plan may include, but is not limited to, the following types of information based on the NAIC Model Act #47 requirements:

1. Standards for network composition
2. Referral policy
3. Needs of special populations
4. Health needs assessment
5. Communication with members.
6. Coordination activities
7. Continuity of care

Primary data submission method(s): Attestations, Supporting Documents

2.6.2 Essential Community Providers

Statutory/Regulatory Standard

Issuers must ensure that the provider network for a QHP has a sufficient number and geographic distribution of Essential Community Providers (ECPs)¹², where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area (45 CFR 156.235).

¹²ECPs are defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act. ECPs are provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care.

OIC/HHS Approach to Certification

In this section, issuers must denote the ECP's with which they have contracts for each network in which they plan to provide coverage. This must be provided for each service area to which the applicant is applying for QHP certification.

Based on an HHS-developed ECP list, the OIC will verify one of the following¹³:

- Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers
- Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.

Justifications submitted by issuers that fail to achieve either standard will undergo stricter review by the OIC.

Issuers that provide a majority of covered services through employed physicians or a single contracted medical group must comply with the alternate standard established by the Exchange (45 CFR 156.235(b)), as follows:

- Issuer has at least the same number of providers located in designated low-income areas¹⁴
- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission

Data elements requested may include Essential Community Provider name, an in-network indicator, or alternative documentation for non-standard essential community providers. Please see the "Essential Community Providers Data Template" for more detail on the data elements to be collected.

Primary data submission method(s): Attestation, CCIIO MS Excel Data Templates, Supporting Documents

¹³ECP standards outlined in this document are transitional policies to accommodate first year timeframes.

¹⁴HHS will consider a low-income area a Health Professional Shortage Area (HPSA) or a zip code in which at least 30 percent of the population have incomes below 200 percent of the federal poverty limit.

2.6.3 Mental Health and Substance Abuse Services

Statutory/Regulatory Standard

Issuers must ensure that the provider network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay (45 CFR 156.230(a)(2)).

OIC/HHS Approach to Certification

Issuers must establish a standard to assure that the QHP network complies with the Federal standard. A copy of this standard must be included in this application, and the issuer must certify that the provider network for this QHP meets this standard.

Primary data submission method(s): Attestation, Supporting Documents

2.6.4 Service Area

This information will be QHP-specific and will need to be included for each QHP in the issuer's submission. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

The QHP service area must be at minimum an entire county, or a group of counties, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and was established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high-utilizing, high-cost, or medically-underserved populations (45 CFR 155.1055).

OIC/HHS Approach to Certification

QHP service areas will be set by county in WV.¹⁵

Data elements such as service area ID and name will be collected from issuers using the CCIIO standard data template. Please see the "Service Area Data Template" for additional detail on the data elements to be collected.

Primary data submission method(s): CCIIO MS Excel Data Template, Attestation

¹⁵Please note that the standard SERFF template used includes a field to indicate whether or not the service area is a partial county; this does not apply in West Virginia.

2.6.5 Provider Directory

Statutory/Regulatory Standard

A QHP issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request (45 CFR 156.230 (b)).

OIC/HHS Approach to Certification

For benefit year 2014, issuers will be asked to provide their network names, IDs, and URL in a Network Template (included as part of the “Plans and Benefits Data Templates”).

Primary data submission method(s): CCIO MS Excel Data Templates

2.7 Marketing, Applications, and Notices

This information may be issuer-specific or QHP-specific. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

Issuers must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP (45 CFR 156.225). In addition, all QHP enrollee applications and notices must comply with Federal standards in 45 CFR 155.230 and 156.250, including being provided in plain language and language that is accessible to people with Limited English Proficiency and disabilities. Issuers must also comply with existing standards related to advertising and marketing in WV based on the NAIC Model Act for Advertisement of Accident and Sickness Insurance (“WV Legislative Rules Title 114 Series 10”).

OIC/HHS Approach to Certification

Issuers will be asked to attest to compliance with the ACA requirements related to non-discrimination in marketing practices. Issuers must also submit a copy of all marketing materials, application, and notices for approval and provide a Certificate of Readability per WV 33-29-5.

Primary data submission method(s): Attestation; Supporting Documents

2.8 Quality Standards

This information may be issuer-specific or QHP-specific. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

By 2016, HHS will develop a rating system that will rate QHPs offered through an Exchange in each benefits level on the basis of the relative quality and price (ACA § 1311(c)(3)) and an enrollee satisfaction survey system (ACA § 1311(c)(4)). In addition, issuers must implement a Quality Improvement Strategy (QIS) that complies with the description in ACA § 1311(g)(1), i.e., uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, and implement wellness programs.

HHS intends to propose in future rulemaking that quality reporting requirements related to all QHP issuers (other than accreditation reporting) become a condition of QHP certification, beginning in 2016, based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act § 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h).

OIC/HHS Approach to Certification

Issuers will be required attest to compliance with various Federal quality requirements (see section 3.2 for details). Future quality and quality improvement standards will be developed for 2016.

Primary data submission method(s): Attestation

2.9 Segregation of Funds for Abortion Services

This information is QHP-specific. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

In the case of issuers that cover abortions for which federal funding is prohibited, the ACA bars the use of federal funds "attributable" to either the advance refundable tax credit or cost-sharing reduction under the Act for those abortions. The ACA requires issuers to create allocation accounts that separate the portion of premiums/tax credits/cost-sharing subsidies for covered services *other* than non-excepted abortions from the premium amount equal to the actuarial value of the coverage of abortion services. Issuers must exclusively use funds from these separate accounts to pay for the services for which the funds were allocated (e.g., funds for services other than non-excepted abortions cannot be used to pay for non-excepted abortions).

Additionally, the ACA requires issuers to provide a notice to enrollees of abortion coverage as part of the summary of benefits and coverage explanation at the time of enrollment; specifies that notices provided to enrollees, advertisements about qualified plans, information provided by Exchanges, and any other information specified by the Secretary, must provide information with respect to the total amount of the combined premium/tax credit/cost sharing subsidy payments for services covered by the plan and in connection with abortions for which federal funding is prohibited; and prohibits qualified health plans from discriminating against any health care provider or any health

care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.

Issuers offering coverage for non-excepted abortion services¹⁶ must submit a segregation plan that details its process and methodology for meeting the requirements of Section 1303(b)(2)(C), (D), and (E) of the ACA. The segregation plan must describe the health plan's financial accounting systems, including appropriate accounting documentation and internal controls¹⁷, which would ensure the segregation of funds required by the ACA. The plan should address items including the following:

- The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services, which may be supported by Federal premium tax credits and cost-sharing reduction payments
- The financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for non-excepted abortion services are reimbursed from the appropriate account
- An explanation of how the health plan's systems, accounting documentation, and controls meet the requirements for segregation accounts under the law

OIC/HHS Approach to Certification

Issuers will be asked to annually attest that they will comply with Federal requirements related to segregation of funds for abortion services, as well as provide a segregation plan. The OIC will perform periodic financial audits of each QHP to assure compliance with Section 1303 of the ACA.

Primary data submission method(s): Attestation, Supporting Documents

2.10 Past Complaints/Compliance

This review may be issuer-specific or QHP-specific. This section does apply to stand-alone dental plans.

Statutory/Regulatory Standard

The Exchange may certify a health plan as a QHP if it determines it is in the interest of qualified individuals and qualified employers in the State to do so (155.1000 (c)(2)).

¹⁶“Non-excepted services and other requirements are enumerated in “Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act (PL-111- 148): Issued Pursuant to Executive Order 13535 (March 24, 2010)” and finalized in 45 CFR 156.280.

¹⁷ For more information on internal control standards, please refer to the following Federal guidance: OMB Circular A-123, *Management's Responsibilities for Internal Controls*, located at http://www.whitehouse.gov/omb/circulars_a123_rev/ and the Government Accountability Office's *Standards for Internal Control in the Federal Government*, more commonly known as the “Green Book,” located at <http://www.gao.gov/products/AIMD-00-21.3.1>.

OIC/HHS Approach to Certification

As part of the “interest” standard, the OIC may perform an analysis of past compliance and complaints for existing insurers. Existing data sources will be used for this analysis, therefore issuers are not required to complete or upload any specific data for this standard.

Primary data submission method(s): None

2.11 Other Issuer and QHP Requirements

In addition to the initial QHP certification requirements listed in the preceding sections 2.1-2.10, QHP issuers must comply with several other requirements in the ACA and associated Federal rules initially and on an ongoing basis as a condition of participation in the Exchange. These requirements are summarized below, and additional information is provided in the QHP certification checklist in Appendix A. Issuers will be required to attest to compliance with several of these requirements; please see section 3.2 for a full list of HHS-required attestations.

1. Transparency requirements (45 CFR 155.1040; 45 CFR 156.220)
2. Enrollment period (45 CFR 155.410; 45 CFR 155.410)
3. Enrollment process for qualified individuals (45 CFR 156.265; 45 CFR 156.400 (d))
4. Termination of coverage of qualified individuals (45 CFR 155.430; 45 CFR 156.270)
5. SHOP-specific requirements (45 CFR 156.285)
6. Recertification and decertification (45 CFR 156.290)
7. Other substantive and reporting requirements (45 CFR 156.200(b); 45 CFR 156.200(e); 45 CFR 155.1000(c)(2); 45 CFR 147.136; 45 CFR 156.245; 45 CFR 156.295)

2.12 Summary of Required Attachments

Documents listed in this section may or may not apply to stand-alone dental plans, as indicated in previous sections.

The following required documentation should be submitted as attachments in SERFF.

- A. Actuarial certification for EHB substitutions (*if applicable*)
- B. Actuarial certification for unique plan designs using approved calculation methodology to determine plan actuarial value as an alternative to the AV calculator (*if applicable*)

- C. Actuarial memorandum and rate abstract for the review of rates
- D. Network access plan for issuers not accredited by an HHS-approved accrediting entity on network adequacy (*if applicable*)
- E. Network adequacy standard regarding mental health and substance abuse providers
- F. Narrative justification for not meeting ECP standards
- G. Marketing materials, enrollee applications and notices, and associated Certificate(s) of Readability
- H. Segregation plan for funds used for abortion services
- I. Compliance plan, in or ready for implementation, consisting of:
 - a. Written policies, procedures, and standards of conduct
 - b. Designated Compliance Officer and a compliance committee
 - c. Compliance training and education
 - d. Effective lines of communication
 - e. Well-publicized disciplinary standards
 - f. A system for routine monitoring and the identification of compliance risks
 - g. Procedures and a system for prompt responses to compliance issues
- J. Organization chart

Section III. Attestations

Documents including all attestations will be available for download by issuers in SERFF. Issuers will review, complete, provide an electronic signature, and upload back into SERFF.

3.1 West Virginia Requirements

3.1.1 Network Adequacy

1. Issuer attests that it will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2).
2. Issuer attests that its provider network meets applicable WV network adequacy requirements in defined in West Virginia Informational Letter No. 112.
3. Applicant attests that its provider network reflects executed contracts for the year in which the issuer is applying.
4. Issuer attests that the provider network for this QHP has a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area.
5. Issuer attests that the provider network for this QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services (MHSAPs) to assure that mental health and substance abuse services will be accessible without unreasonable delay.

3.2 HHS Requirements

The following attestations were developed by HHS and are therefore subject to change by them. CCIIO and the NAIC have indicated issuers will be able to download a PDF document with the attestations in SERFF, provide an electronic signature, and upload back into SERFF for submission to the State and HHS.

3.2.1 General

1. As a QHP issuer, applicant will adhere to all requirements contained in 45 CFR 156, applicable law, and applicable guidance.
2. Applicant attests that it has a compliance plan that adheres to all applicable laws, regulations, and guidance and that the compliance plan is ready for implementation.
3. If yes, upload a copy of the applicant's compliance plan.
4. Applicant agrees to adhere to the compliance plan provided.
5. Applicant attests that it will inform HHS of any significant changes to the organizational chart submitted that occur after the submission of this application.
6. If yes, upload a copy of the applicant's organizational chart.

7. As a QHP issuer, applicant attests that it will notify and obtain HHS approval prior to making any change in ownership that impact the entity(ies) that directly impact the QHP issuer.
8. As a QHP issuer, applicant will:
 - (1) Comply with all QHP requirements on an ongoing basis
 - (2) Comply with Exchange processes, procedures, and requirements
 - (3) Comply with all benefit design standards
 - (4) Have a license, be in good standing, and be authorized to offer each specific type of insurance coverage offered in each State in which the issuer offers a QHP
9. Applicant 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 45 CFR 147.
10. The applicant (under a current or former name) attests that there are no Federal or State Government past (within 3 years of this submission), current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration against the applicant, its principals, or any of its subcontractors.
11. The applicant (under current or former name) attests that none of its principals, nor any of its affiliates is presently debarred, suspended, proposed for debarment, or declared ineligible to participate in Federal programs under 2 CFR 180.970 or any other applicable statute or regulation.
12. Applicant, Applicant staff, and its affiliated companies, subsidiaries, or subcontractors (first tier, downstream, and related entities), and subcontractor staff agree that they are bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff, or major stockholder of the Applicant and its affiliated companies, subsidiaries, or subcontractors (first tier, downstream, and related entities).
13. The applicant agrees that as a QHP issuer it will adhere to all applicable state and federal law.
14. As a QHP issuer, applicant will provide updated rate and benefit information for QHPs offered in the SHOP, if applicable, on a quarterly basis consistent with 45 CFR 156.285(a)(2) and all applicable guidance.
15. As a QHP issuer, applicant will adhere to requirements related to the segregation of funds for abortion services consistent with 45 CFR 156.280 and all applicable guidance.
16. Applicant agrees to use of FFE systems and tools for communication with HHS.

17. Applicant agrees to technical requirements related to the use of FFE Plan Management system.
18. As a QHP issuer, applicant agrees to make available the amount of enrollee cost-sharing under an individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of an individual, consistent with 45 CFR 156.220. At a minimum, such information must be made available to such individuals through an Internet website and such other means for individuals without access to the Internet.
19. As a QHP issuer, applicant will set rates for the rates for an entire benefit year and will submit the rate information to the Exchange, including a justification for a rate increase prior to implementation consistent with 45 CFR 156.210.
20. As a QHP issuer, applicant agrees to prominently post rate increase justifications on its website.
21. As a QHP, applicant agrees to adhere to all rating variation requirements pursuant to 45 CFR 156.255.
22. As a QHP issuer, applicant agrees to adhere to provisions addressing payment of federally-qualified health centers in 45 CFR 156.235(e).
23. As a QHP issuer, applicant agrees to offer through the Exchange a minimum of one silver and one gold coverage plans, one child-only plan, and a QHP at the same premium rate in accordance with the requirement of 45 CFR 156.200(c).
24. As a QHP issuer, applicant will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
25. As a QHP issuer, applicant will provide transparency in coverage in accordance with 45 CFR 156.220.
26. As a QHP issuer, applicant will market its QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.
27. As a QHP issuer, applicant agrees to pay all users fees in accordance with 45 CFR 156.200(b)(6).
28. As a QHP issuer, applicant agrees to adhere with all non-renewal and decertification requirements in accordance with 45 CFR 156.290.
29. As a QHP issuer, applicant attests that the premium rates for its QHPs comply with federal rating requirements or the state's more restrictive rating requirements.
30. As a QHP issuer, applicant attests that its QHPs provide coverage for each of the 10 statutory categories of EHB in accordance with the applicable EHB benchmark plan and federal law.

31. As a QHP issuer, applicant attests that its QHPs provide benefits that are substantially equal to those covered by the EHB-benchmark plan.
32. As a QHP issuer, applicant attests that any benefits substituted in designing QHP plan benefits are actuarially equivalent to those offered by the EHB benchmark plan.
33. As a QHP issuer, applicant attests that its QHPs' benefits reflect an appropriate balance among the EHB categories, so that benefits are not unduly weighted toward any category.
34. As a QHP issuer, applicant attests that its QHPs include all applicable state required benefits.
35. As a QHP issuer, applicant attests that its QHPs comply with preventive services requirements.
36. As a QHP issuer, applicant attests that it will not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs in accordance with 45 CFR 156.225.
37. As a QHP issuer, applicant attests that its drug list will be in compliance with federal regulations.
38. As a QHP issuer, applicant agrees to abide by all cost-sharing limits.
39. As a QHP issuer, applicant attests that each QHP complies with benefit design standards in accordance with 156.200(b)(3).
40. As a QHP issuer, applicant attests that its QHPs provide coverage for emergency department services without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.
41. As a QHP issuer, applicant attests that the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement for in-network and out-of-network providers for emergency department services.
42. As a QHP issuer, applicant attests to follow all Actuarial Value requirements and meet the metal tiers, as appropriate.
43. As a QHP issuer, applicant attests that its catastrophic QHPs will only enroll individuals under the age of 30.
44. Issuer attests that its stand-alone dental plans are limited scope dental plans.
45. Issuer attests that its stand-alone dental plans meet AV requirements.

3.2.2 Quality

1. As a QHP issuer, applicant will comply with the specific quality disclosure, reporting and implementation requirements of 45 CFR §156.200(b)(5) as will be detailed in future guidance.

2. Issuer Accreditation attestation

a. Issuers with accreditation will attest to the following statements:

1. The QHP issuer authorizes the release of its accreditation data from the accrediting entity to the FFE (if applicable).

2. The QHP issuer understands and acknowledges that for issuers with accreditation, prior to 2016, the Exchange Internet website may display data gathered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) measures, which correspond to the commercial market. If commercial market data is unavailable but data corresponding to Medicaid accreditation is available, the latter may be displayed. This data will be displayed if the following conditions are met:

- The QHP issuer has authorized the release of its accreditation data as required for QHP certification
- CAHPS[®] data was considered as part of the QHP issuer's accreditation on Medicaid or commercial lines of business and was submitted to the Exchange by the accrediting entity
- CAHPS[®] data that was submitted to the Exchange by the accrediting entity is available for the same product type as the QHP that is being offered in the Exchange (e.g., HMO Adult CAHPS[®] data for HMO QHP, PPO Adult CAHPS[®] data for PPO QHP, HMO Child CAHPS[®] data for Child-Only QHP HMO, PPO Child CAHPS[®] data for Child-Only QHP PPO)

3. The QHP issuer understands and acknowledges that prior to 2016, the Exchange Internet website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid, or Exchange product lines by one of the recognized accrediting entities. An accredited status for a QHP issuer will not be displayed if the issuer does not have any products that have achieved at least "provisional" or "interim" status (i.e., an issuer will not be displayed as "accredited" if the accreditation review is scheduled or in process).

b. Issuers who indicate that they are not accredited will attest to the following statements:

1. The QHP issuer understands and acknowledges that for issuers with accreditation, prior to 2016, the Exchange internet website may display data gathered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) measures, which correspond to the commercial market. If commercial market data is unavailable but data corresponding to Medicaid accreditation is

available, the latter may be displayed. This data will be displayed if the following conditions are met:

- The QHP issuer has authorized the release of its accreditation data as required for QHP certification
 - CAHPS[®] data was considered as part of the QHP issuer's accreditation on Medicaid or commercial lines of business and was submitted to the Exchange by the accrediting entity
 - CAHPS[®] data that was submitted to the Exchange by the accrediting entity is available for the same product type as the QHP that is being offered in the Exchange (e.g., HMO Adult CAHPS[®] data for HMO QHP, PPO Adult CAHPS[®] data for PPO QHP, HMO Child CAHPS[®] data for Child-Only QHP HMO, PPO Child CAHPS[®] data for Child-Only QHP PPO)
2. The QHP issuer understands and acknowledges that prior to 2016, the Exchange Internet website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid, or Exchange product lines by one of the recognized accrediting entities. An accredited status for a QHP issuer will not be displayed if the issuer does not have any products that have achieved at least "provisional" or "interim" status (i.e., an issuer will not be displayed as "accredited" if the accreditation review is scheduled or in process).

3.2.3 Enrollment

1. As a QHP issuer, the applicant will meet the individual market requirement to enroll a qualified individual during the initial and annual open enrollment periods; abide by the effective dates of coverage; make available, at a minimum, special enrollment periods; and abide by the effective dates of coverage established by the Exchange.
2. As a QHP issuer, the applicant will maintain termination records in accordance with Exchange standards.
3. As a QHP issuer, the applicant will abide by the termination of coverage effective dates requirements.
4. As a QHP issuer, the applicant will notify the qualified individual of his or her effective date of coverage in coordination with the standards.
5. As a QHP issuer, the applicant will adhere to enrollment information collection and transmission and will:
 - Collect enrollment information using the application adopted
 - Transmit the enrollment information to the Exchange consistent with the standards to facilitate the eligibility determination process

- Enroll an individual only after receiving confirmation that the eligibility process is complete and the individual has been determined eligible for enrollment in a QHP, in accordance with the standards
6. As an issuer of a QHP, the applicant will accept enrollment information in an electronic format from the Exchange that is consistent with requirements.
 7. As an issuer of a QHP, the applicant will provide new enrollees an enrollment information package.
 8. As an issuer of a QHP, the applicant will reconcile enrollment files with the Exchange no less than once a month.
 9. As an issuer of a QHP, the applicant will acknowledge receipt of enrollment information in accordance with Exchange standards.
 10. As a QHP issuer, the applicant will only terminate coverage as permitted by the Exchange.
 11. As a QHP issuer, if an enrollee's coverage with a QHP is terminated for any reason, the applicant will provide the Exchange and the enrollee with a notice of termination of coverage that is consistent with the effective date established by the Exchange.
 12. As a QHP issuer, the applicant will establish a standard policy for the termination of coverage of enrollees due to non-payment of premium as permitted by the Exchange.
 13. As a QHP issuer, the applicant will provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one month's premium.
 14. As a QHP issuer, if an enrollee is delinquent on premium payments, the applicant will provide the enrollee with notice of such payment delinquency.
 15. As a QHP issuer, if an enrollee receiving advance payments of the premium tax credit exhausts the grace period without submitting any premium payments, the applicant will terminate the enrollee's coverage effective at the end of the payment grace period.
 16. As a QHP issuer within an FFE, applicant agrees to develop, operate, and maintain viable systems, processes, and procedures for the timely, accurate, and valid enrollment and termination of enrollees' coverage within the exchange.
 17. As a QHP issuer within an FFE, applicant agrees to establish business processes and communication protocols for the prompt resolution of urgent issues affecting enrollees, such as changes in enrollment.
 18. As a QHP issuer within an FFE, applicant acknowledges that enrollees can make enrollment changes during open and special enrollment periods for which they are eligible.

19. As a QHP issuer within an FFE, applicant will comply with all Exchange requirements regarding involuntary termination of an enrollee initiated by the QHP for the following reasons: 1) Monthly premiums are not paid on a timely basis and is subject to the grace period for late payments, or 2) enrollee provides fraudulent information on his or her application form or permits abuse of his or her benefit cards.
20. As a QHP issuer, applicant agrees to provide required notices to enrollees, including enrollment materials consistent with HHS rules, including but not limited to summary of benefits, evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials, ID cards, and other standardized mandated notices.
21. As a QHP issuer within an FFE, applicant will give the enrollee written notice(s) of involuntary termination with an explanation of why the QHP is terminating the enrollee. Notices and reason must include an explanation of the enrollee's right to appeal.
22. As a QHP issuer within an FFE, applicant agrees to accurately and thoroughly process and submit the necessary data to validate enrollment and APTC credits on a monthly basis.
23. As a QHP issuer, applicant accepts that the FFE will calculate individuals' premiums and make determinations of individuals' eligibility for the premium tax credit and cost-sharing reduction.
24. As a QHP issuer, applicant approves of the use of the following information for display on the FFE Web site for consumer education purposes:
 - Information on rates and premiums
 - Information on benefits
 - The provider network URL(s) provided in this application
 - The URL(s) for the Summary of Benefits and Coverage provided in this application
 - The URL(s) for payment provided by this application
 - Information on whether the issuer is a Medicaid managed care organization
 - Quality information derived from the accreditation survey, including accreditation status and CAHPS data

3.2.4 Financial Management

1. As a QHP issuer, applicant acknowledges and agrees they are bound by Federal statutes and requirements that govern Federal funds. Federal funds include but are not limited to advance payments of the premium tax credit, cost-sharing reductions, and Federal payments related to the risk adjustment, reinsurance, and risk corridor programs.

2. As a QHP issuer, applicant agrees to make reinsurance contributions at the national contribution rate for the reinsurance program for all reinsurance contribution enrollees who reside in a State, in a frequency and manner determined by HHS as applicable.
3. As a QHP issuer, applicant agrees to make reinsurance contributions to each applicable reinsurance entity for the reinsurance contribution enrollees who reside in the applicable geographic area, if the State establishes or contracts with more than one applicable reinsurance entity.
4. QHP applicant agrees to submit contributions to HHS on a quarterly basis beginning January 15, 2014.
5. As a QHP issuer, applicant agrees to submit to HHS data required to substantiate the contribution amounts for the contributing entity in the manner and timeframe specified by the State or HHS.
6. As a QHP issuer, applicant acknowledges that only issuers of reinsurance-eligible plans may make a request for payment when an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth in annual HHS notice of benefit and payment parameters for the applicable year.
7. As a QHP issuer, applicant agrees that they will adhere to the risk adjustment issuer requirements set by HHS in 45 CFR 153.610.
8. As a QHP issuer, applicant agrees to adhere to the risk adjustment compliance standards set by HHS in 45 CFR 153.620.
9. As a QHP issuer, applicant agrees to adhere to the requirements set by HHS in 45 CFR 153.510 and the annual HHS notice of benefit and payment parameters for the establishment and administration of a program risk corridors for calendar years 2014, 2015, and 2016.
10. As a QHP issuer, applicant agrees to remit charges to HHS under the circumstances described in 45 CFR 153.510(c)
11. As a QHP issuer, applicant agrees to adhere to the risk corridor standards set by HHS in 45 CFR 153.520.
12. As a QHP issuer, applicant agrees to adhere to the risk corridor data requirements set by HHS in 45 CFR 153.530
13. As a QHP issuer, applicant agrees to adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit, including the provisions at 45 CFR 156.460, 156.440, and 156.470.
14. As a QHP issuer, applicant agrees to adhere to the standards set forth by HHS for the administration of cost-sharing reductions, including the provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, and 156.470.

15. As a QHP issuer, applicant agrees to submit to HHS the applicable plan variations that adhere to the standards set forth by HHS at 45 CFR 156.420.

3.2.5 SHOP

1. I attest that I will adhere to any current or future regulation and guidance with respect to conditioning a QHP issuer's ability to offer QHPs in the individual market Exchange with the offering of QHPs in the SHOP.
2. I attest that I understand QHP premiums in the SHOP may not vary based on the method of plan offering chosen by an employer; OR I attest that I understand QHP premiums in the SHOP may not vary based on method of offering (i.e., employee or employer choice).
3. I attest that I will adhere to any current or future regulation and guidance with respect to agent and broker appointments and commissions in the SHOP.
4. I attest that I will adhere to any current or future regulation and guidance with respect to the holder of a QHP policy, including the understanding that the qualified employer is considered the holder of the QHP policies sold to its employees through the SHOP.

3.2.6 Reporting Requirements

1. As a QHP issuer, the applicant agrees to provide to the Exchange the following "transparency" information in the manner identified by HHS:
 - Claims payment policies and practices
 - Periodic financial disclosures
 - Data on enrollment
 - Data on disenrollment
 - Data on the number of claims that are denied
 - Data on rating practices
 - Information on cost-sharing and payments with respect to any out-of-network coverage
 - Information on enrollee rights under title I of the Affordable Care Act
2. As a QHP issuer, applicant will report required data on prescription drug distribution and costs consistent with 45 CFR 156.295 and all applicable guidance.

Section IV. Appendices

Appendix A. QHP Certification Checklist

Introduction

The following checklist of issuer- and plan-level QHP certification requirements is intended to serve as a guide to issuers as they prepare their QHP submissions for benefit year 2014. Please note that the order of the requirements in the checklist does not necessarily imply the order in which an issuer must submit the QHP data and information in SERFF. Prior to submitting plan-level “Plans and Benefits Data Templates,” issuers must register their Product IDs via HIOS. Each Product ID will come with fifty Plan IDs, each of which is made up of the Standard Component ID and a Variance ID.

For ease of reference, requirements in the checklist align with Sections 2.1-2.11 from the main body of this document.

General Exchange Participation Requirements

In addition to the requirements included in the table below, to be certified for participation in the Exchange, a QHP must:

- Meet the legal requirements of offering health insurance in West Virginia
- Satisfy the certification criteria as established by the State
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts §155 and §156
- Receive a recommendation for certification by the OIC, have the recommendation ratified by HHS, and enter into a Certification Agreement with HHS

To participate in the Exchange, an issuer must also:

- Submit at least one silver plan and one gold plan (45 CFR 156.200(c)(1))
- Provide a child-only option for each metal tier for which the issuer offers a QHP (45 CFR 156.200(c)(2))
- Submit three variations to each silver plan reflecting reduced cost-sharing on the essential health benefits (45 CFR 156.420(a))

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
<input type="checkbox"/>	2.1	Issuer Administrative Information		Please see Administrative Data Template for details on information requested.
<input type="checkbox"/>	2.2	Licensure, Solvency, and Standing	45 CFR § 156.200(b)(4)	<p>OIC Financial Conditions Division will review and confirm issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an issuer's license, solvency, and standing.</p> <p>Issuers licensed in West Virginia are not required to submit supporting documentation unless concerns are identified and additional review is required.</p> <p>Issuers not currently licensed are required to complete the WV licensing process; West Virginia is a NAIC Uniform Certificate of Authority Application (UCAA) participant state and accepts the UCAA Primary and Expansion Applications.</p>
		<input type="checkbox"/> Is licensed or authorized in WV.		
		<input type="checkbox"/> Authorized by WV OIC to offer <u>health</u> insurance; or <input type="checkbox"/> Authorized by WV OIC to offer <u>dental</u> insurance.		
		<input type="checkbox"/> Is in good standing.		No outstanding sanctions imposed by the OIC
<input type="checkbox"/>	2.3	Benefit Standards and Product Offerings		Rules are not final as of January 20, 2013.
	2.3	<input type="checkbox"/> Reflects meaningful difference across product offerings.		
	2.3.1	<input type="checkbox"/> Covers the Essential Health Benefit Package.	45 CFR §156.110	

Table 2. QHP Certification Checklist

QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		§156.115 §156.120	
2.3.2	<input type="checkbox"/> Complies with annual limitation on cost-sharing. <input type="checkbox"/> <u>Cost-sharing</u> shall not exceed the dollar amounts in effect under §223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage. FOR SHOP ONLY: <input type="checkbox"/> Complies with annual limitations on deductibles for employer-sponsored plans. FOR STAND-ALONE DENTAL ONLY: <input type="checkbox"/> Cost-sharing is “reasonable” for coverage of the pediatric dental EHB.	45 CFR §156.130 §156.130	
2.3.3	<input type="checkbox"/> If health insurance, offers a plan that provides one of the following actuarial values (± 2%): <input type="checkbox"/> Bronze plan (AV 60%) <input type="checkbox"/> Silver plan (AV 70%) <input type="checkbox"/> Gold plan (AV 80%) <input type="checkbox"/> Platinum plan (AV 90%) <input type="checkbox"/> Catastrophic plan <input type="checkbox"/> If dental insurance, offers a plan that provides one of the following actuarial values(± 2%) : <input type="checkbox"/> Low plan (AV 75%) <input type="checkbox"/> High plan (AV 85%)	45 CFR §156.135 §156.140 45 CFR §156.150	Rules are not final as of January 20, 2013.
2.3.3	<input type="checkbox"/> If offers a catastrophic plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan. Eligible individuals:	ACA § 1302(e); 42 USC §18022(e)	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		<ul style="list-style-type: none"> <input type="checkbox"/> Individuals that have not attained the age of 30 before the beginning of the plan year <input type="checkbox"/> Individual has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. <input type="checkbox"/> If offered, catastrophic plans are offered only in the individual exchange and not in the SHOP. <input type="checkbox"/> If offered, catastrophic plan complies with specific requirements for benefits. 		
	2.3.4	<ul style="list-style-type: none"> <input type="checkbox"/> Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. <input type="checkbox"/> Does not discriminate based on individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, other health conditions, race, color, national origin, disability, age, sex, gender identity, or sexual orientation. 	45 CFR §156.125 45 CFR §156.225(b) 45 CFR §156.200(e)	
	2.3.5	<input type="checkbox"/> Complies with the Mental Health Parity and Addiction Equity Act.	ACA § 1311(j)	
<input type="checkbox"/>	2.4	Rating Standards		Rules are not final as of January 20, 2013.
		<ul style="list-style-type: none"> <input type="checkbox"/> Varies rates only based on: <ul style="list-style-type: none"> <input type="checkbox"/> Geographic area <input type="checkbox"/> Age (3 to 1) <input type="checkbox"/> Tobacco use (1.5 to 1) <input type="checkbox"/> Family composition: <ul style="list-style-type: none"> <input type="checkbox"/> Individual <input type="checkbox"/> Two-adult families <input type="checkbox"/> One-adult family with child(ren) 	45 CFR §147.102 45 CFR §156.255	Federal proposed standards; WV-specific requirements under development

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		<input type="checkbox"/> All other families		
		<input type="checkbox"/> Sets rates for an entire benefit year, or for the SHOP, plan year.	45 CFR §156.210(a)	
		<input type="checkbox"/> Rates must be the same for a QHP offered inside and outside Exchange and without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.	45 CFR §156.255(b)	
		<input type="checkbox"/> Submits rate information to the Exchange at least annually.	45 CFR §155.1020 45 CFR §156.210(b)	
		<input type="checkbox"/> Submits to the Exchange a justification for a rate increase prior to the implementation of the increase.	45 CFR §155.1020 45 CFR §156.210(c)	
		<input type="checkbox"/> Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.	45 CFR §155.1020 45 CFR §156.210(c)	
<input type="checkbox"/>	2.5	Accreditation Standards	45 CFR §1045 45 CFR §156.275	
		<input type="checkbox"/> Accredited on the basis of local performance in the following categories by an accrediting entity recognized by HHS: <ul style="list-style-type: none"> <input type="checkbox"/> Clinical quality measures, such as the HEDIS <input type="checkbox"/> Patient experience ratings on a standardized CAHPS survey <input type="checkbox"/> Consumer access <input type="checkbox"/> Utilization management <input type="checkbox"/> Quality assurance <input type="checkbox"/> Provider credentialing <input type="checkbox"/> Complaints and appeals <input type="checkbox"/> Network adequacy and access <input type="checkbox"/> Patient information programs 	45 CFR §156.275(a)(1)	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		<input type="checkbox"/> Authorizes the accrediting entity to release to the Exchange and HHS a copy of its most recent accreditation survey and survey-related information.	45 CFR §156.275(a)(2)	
		<input type="checkbox"/> Accredited within the timeframe established by the Exchange. <input type="checkbox"/> Maintains accreditation.	45 CFR §156.275(b)	During initial year of certification, issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in WV granted by an accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with the accrediting entity.
<input type="checkbox"/>	2.6	Network Adequacy and Provider Directory	45 CFR §155.1050 and §155.1055 45 CFR §156.230 45 CFR §156.235	
	2.6.1	<input type="checkbox"/> Complies with WV network adequacy laws and regulations in addition to the specific requirements listed below. <input type="checkbox"/> Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.	45 CFR §156.230	WV Informational Letter No. 112 provides standards related to distance/time and provider to enrollee ratios
	2.6.2	<input type="checkbox"/> Has sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area.	45 CFR §156.230(a)(1) 45 CFR §156.235	
	2.6.3	<input type="checkbox"/> Network must include providers that specialize in mental health and substance abuse services.	45 CFR §156.230	
	2.6.4	<input type="checkbox"/> Has a minimum service area of an	45 CFR §155.1055	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
	2.6.5	entire county. <input type="checkbox"/> Makes its provider directory available: <input type="checkbox"/> To the Exchange for publication online in accordance with guidance from the Exchange <input type="checkbox"/> To potential enrollees in hard copy upon request. <input type="checkbox"/> Provider directory identifies providers that are not accepting new patients.	45 CFR §156.230(b)	
<input type="checkbox"/>	2.7	Marketing, Applications, and Notices		
		<input type="checkbox"/> Complies with all WV marketing laws & regulations. <input type="checkbox"/> Certificate of Readability provided.	45 CFR §156.225(a)	WV Legislative Rules Title 114 Series 10; WV 33-29-5.
		<input type="checkbox"/> Marketing practices do not discourage the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	
		<input type="checkbox"/> Provides applications and notices to applicants and enrollees all applications and other material: <input type="checkbox"/> In plain language <input type="checkbox"/> In a manner that is accessible and timely to: <input type="checkbox"/> Individuals living with disabilities <input type="checkbox"/> Individuals with limited English proficiency through the provision of language services at no cost to the individual.	45 CFR §155.230(b)	
<input type="checkbox"/>	2.8	Quality Standards		
		<input type="checkbox"/> Attests to comply with future Federal rule-making related to 45 CFR §156.200(b)(5).	45 CFR §156.200 (b)(5) ACA § 1311(c)(1), 1311(c)(3), 1311(c)(4), and 1311(g)	HHS indicates they intend to address specific requirements in future rulemaking related to quality data reporting, quality improvement strategies, and enrollee satisfaction surveys described in these statutory provisions.

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
<input type="checkbox"/>	2.9	<p>Segregation of Funds for Abortion Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Does not use federal funds for abortion. <input type="checkbox"/> Complies with procedures to ensure Federal funds are not misused, depositing payments into separate allocation accounts. <ul style="list-style-type: none"> <input type="checkbox"/> Submits segregation plan. <input type="checkbox"/> Provides annual assurance statement. <input type="checkbox"/> If provides for coverage of abortion services, provides a notice to enrollees as part of the summary of benefits and coverage explanation at the time of enrollment. <input type="checkbox"/> Does not discriminate against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion. 	45 CFR §156.280 ACA §1303	
<input type="checkbox"/>	2.10	<p>Past Complaints and Compliance</p> <ul style="list-style-type: none"> <input type="checkbox"/> Is determined to be in the “best” interest of WV consumers based on Market Conduct analysis. 	45 CFR §155.1000(c) (2)	As part of the “best interest” test, the OIC’s Market Conduct Division may perform an analysis of an issuer or plan’s past complaints and compliance with WV requirements.
<input type="checkbox"/>	2.11.1	<p>Transparency Requirements</p> <ul style="list-style-type: none"> <input type="checkbox"/> Makes available to the public, Exchange, HHS, and the WV Insurance Commissioner in an accurate and timely manner, and in plain language: <ul style="list-style-type: none"> <input type="checkbox"/> Claims payment policies and 	45 CFR §155.1040 45 CFR §156.220	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		practices <input type="checkbox"/> Periodic financial disclosures <input type="checkbox"/> Data on enrollment <input type="checkbox"/> Data on disenrollment <input type="checkbox"/> Data on the number of claims that are denied <input type="checkbox"/> Data on rating practices <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage <input type="checkbox"/> Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient’s Bill of Rights)		
		<input type="checkbox"/> Makes available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual. <input type="checkbox"/> Makes available such information through: <input type="checkbox"/> Internet website <input type="checkbox"/> Other means for individuals without access to the Internet	45 CFR § 156.220(d)	
		<input type="checkbox"/> Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.	45 CFR §147.136(e)	
<input type="checkbox"/>	2.11.2	Enrollment Periods <input type="checkbox"/> Provides an initial open enrollment period October 1, 2013 to March 31, 2014. <input type="checkbox"/> Provides an annual open enrollment period October 15 to December 7. <input type="checkbox"/> Provides special enrollment periods for qualified enrollees. <input type="checkbox"/> Provides notice to individuals eligible to enroll during a special enrollment		
		<input type="checkbox"/> Provides an initial open enrollment period October 1, 2013 to March 31, 2014.	45 CFR §155.410(b)	
		<input type="checkbox"/> Provides an annual open enrollment period October 15 to December 7.	45 CFR §155.410(e)	
		<input type="checkbox"/> Provides special enrollment periods for qualified enrollees. <input type="checkbox"/> Provides notice to individuals eligible to enroll during a special enrollment	45 CFR §155.420	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		period.		
<input type="checkbox"/>	2.11.3	Enrollment Process for Qualified Individuals <input type="checkbox"/> Enrolls a qualified individual when Exchange notifies the issuer that the individual is a qualified individual and transmits information to the issuer. <input type="checkbox"/> If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: <input type="checkbox"/> Directs the individual to file an application with the Exchange <input type="checkbox"/> Ensures that the individual received an eligibility determination for coverage through the Exchange via the Exchange Internet website. <input type="checkbox"/> Accepts enrollment information consistent with the privacy and security requirements established by the Exchange. <input type="checkbox"/> Uses the premium payment process established by the Exchange. <input type="checkbox"/> Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards. <input type="checkbox"/> Reconciles enrollment files with HHS and the Exchange no less than once a month. <input type="checkbox"/> Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.	 45 CFR §156.265 (b)(1) 45 CFR §156.265 (b)(2) 45 CFR §156.265 (c) 45 CFR §156.265 (d) 45 CFR §156.265 (e) 45 CFR §156.265 (f)45 CFR §156.400 (d) 45 CFR §156.265 (g)	
<input type="checkbox"/>	2.11.4	Termination of Coverage of Qualified Individuals	45 CFR §155.430 45 CFR	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
			§156.270	
		<ul style="list-style-type: none"> <input type="checkbox"/> Terminates coverage only if: <ul style="list-style-type: none"> <input type="checkbox"/> Enrollee is no longer eligible for coverage through the Exchange <input type="checkbox"/> Enrollee’s coverage is rescinded <input type="checkbox"/> QHP terminates or is decertified <input type="checkbox"/> Enrollee switches coverage: <ul style="list-style-type: none"> <input type="checkbox"/> During an annual open enrollment period <input type="checkbox"/> Special enrollment period <input type="checkbox"/> Obtains other minimum essential coverage <input type="checkbox"/> For non-payment of premium only if: <ul style="list-style-type: none"> <input type="checkbox"/> Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances <input type="checkbox"/> Enrollee is delinquent on premium payment <input type="checkbox"/> Provides the enrollee with notice of such payment delinquency <input type="checkbox"/> Provides a grace period of at least three consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month’s premium 	45 CFR §155.430(b) 45 CFR §156.270	
		<ul style="list-style-type: none"> <input type="checkbox"/> Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination). 	45 CFR §155.430 (d)45 CFR §156.270 (b)	
		<ul style="list-style-type: none"> <input type="checkbox"/> Maintains records of terminations of coverage for auditing. 	45 CFR §155.430(c) 45 CFR §156.270(h)	
<input type="checkbox"/>	2.11.5	SHOP-Specific Requirements	45 CFR §156.285	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		<ul style="list-style-type: none"> <input type="checkbox"/> Accepts payment from the SHOP on behalf of a qualified employer or employee. <input type="checkbox"/> Adheres to the SHOP timeline for rate setting. <input type="checkbox"/> Charges the same contact rate for a plan year. 		
		<ul style="list-style-type: none"> <input type="checkbox"/> Adheres to the SHOP enrollment timeline and process. <input type="checkbox"/> Receives enrollment information electronically. <input type="checkbox"/> Provides new enrollees with an enrollment information package. <input type="checkbox"/> Reconciles enrollment files with the SHOP at least monthly. <input type="checkbox"/> Acknowledges receipt of enrollment information in accordance with SHOP standards. <input type="checkbox"/> Enrolls all qualified employees consistent with the employer's plan year. <input type="checkbox"/> Enrolls a qualified employee in accordance with the qualified employer's annual open enrollment period. <input type="checkbox"/> Provides special enrollment periods. <input type="checkbox"/> Provides an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period. <input type="checkbox"/> Adheres to effective dates of coverage. 		
		<ul style="list-style-type: none"> <input type="checkbox"/> Complies with requirements with respect to termination of employees. 		
		<ul style="list-style-type: none"> <input type="checkbox"/> If a qualified employer withdraws from the SHOP, terminates coverage for all enrollees of the withdrawing employer. 		
<input type="checkbox"/>	2.11.6	Recertification and Decertification	45 CFR §156.290	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		<input type="checkbox"/> If elects not to seek recertification with the FFE: <ul style="list-style-type: none"> <input type="checkbox"/> Notifies the FFE of its decision prior to the beginning of the recertification process and procedures adopted by the FFE <input type="checkbox"/> Fulfills its obligation to cover benefits for each enrollee through the end of the plan or benefit year <input type="checkbox"/> Fulfills data reporting obligations from the last plan or benefit year of the certification <input type="checkbox"/> Provides written notice to enrollees <input type="checkbox"/> Terminates coverage for enrollees in the QHP. 		
		<input type="checkbox"/> If decertified by the FFE, terminates coverage for enrollees only after: <ul style="list-style-type: none"> <input type="checkbox"/> The FFE has made notification <input type="checkbox"/> Enrollees have an opportunity to enroll in other coverage 		
<input type="checkbox"/>	2.11.7	Other Substantive and Reporting Requirements		
		<input type="checkbox"/> Complies with all Exchange processes, procedures, requirements.	45 CFR §156.200(b)(2)	
		<input type="checkbox"/> Pays the Exchange user fee.	45 CFR §156.200(b)(6)	
		<input type="checkbox"/> Complies with risk adjustment program.	45 CFR §156.200(b)(7)	
		<input type="checkbox"/> Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.	45 CFR §156.200(e)	
		<input type="checkbox"/> Is in the interest of qualified individuals.	45 CFR §155.1000(c)(2)	
		<input type="checkbox"/> Complies with internal claims and appeals and external review process.	45 CFR §147.136	
		<input type="checkbox"/> If provides coverage through a direct primary care medical home:	45 CFR §156.245	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		<ul style="list-style-type: none"> <input type="checkbox"/> Medical home meets criteria established by HHS <input type="checkbox"/> Issuer meets all requirements otherwise required <input type="checkbox"/> Issuer coordinates the services covered by the direct primary care medical home 		
		<ul style="list-style-type: none"> <input type="checkbox"/> Collects and transmits data to and from Exchanges, HHS, Treasury, and reinsurance entities. <input type="checkbox"/> Provides a description of system infrastructure’s capacity to securely interface with these entities for data transfers, including enrollment, reconciliation, claims encounter data, and reports. 		
		<ul style="list-style-type: none"> <input type="checkbox"/> Reports to U.S. DHHS on prescription drug distribution and cost the following information (paid by PBM or issuer): <ul style="list-style-type: none"> <input type="checkbox"/> Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies <input type="checkbox"/> Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: <ul style="list-style-type: none"> <input type="checkbox"/> Independent pharmacy <input type="checkbox"/> Supermarket pharmacy <input type="checkbox"/> Mass merchandiser pharmacy <input type="checkbox"/> Aggregate amount and type of rebates, discounts, or price concessions that the issuer or its contracted PBM negotiates that are: <ul style="list-style-type: none"> <input type="checkbox"/> Attributable to patient utilization <input type="checkbox"/> Passed through to the issuer <input type="checkbox"/> Total number of prescriptions that were dispensed. <input type="checkbox"/> Aggregate amount of the difference 	45 CFR §156.295	

Table 2. QHP Certification Checklist

	QHP Submission Guide Reference	QHP Requirements	Federal Source	Notes
		between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.		

DRAFT

Appendix B. Reference Table for Federal Requirements

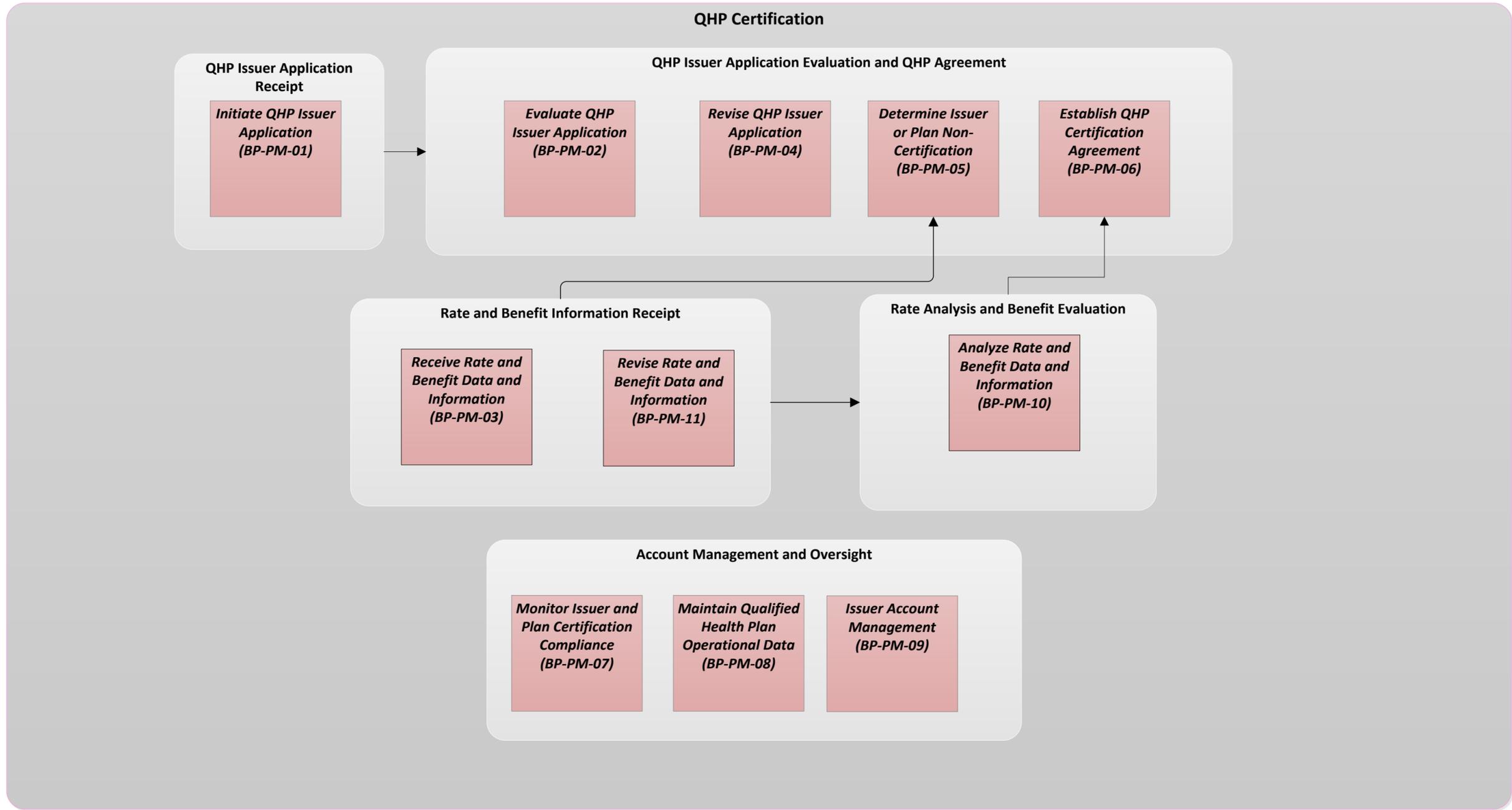
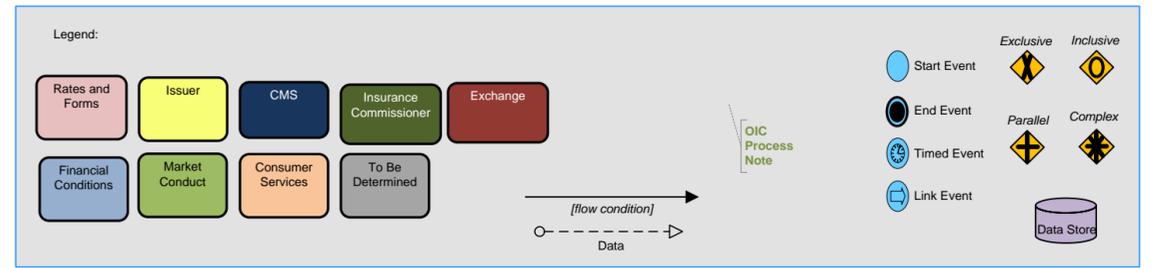
Requirement Category	Federal Requirement	Reference
Licensing and Standing	State Licensure	45 CFR §156.200(b)(4)
QHP Certification Process	Timing of QHP Certification	45 CFR §155.1010(a)
	Frequency of QHP Certification	45 CFR §155.1075
Continued Compliance with Certification Criteria	Exchange monitoring of QHP for compliance	45 CFR §155.1010(d)
Actuarial Value	Actuarial Value Standards	45 CFR 156.135, 156.40, 156.50
Abortion Services	Compliance with State Abortion Laws	45 CFR §156.280(a)
	Abortion Funds Segregation	45 CFR §156.280
Premium Rate and Benefit Information	Rate Plan Year	45 CFR §156.210(a)
	Rate Submission	45 CFR §156.210 (b)
	Rate Increase Justification	45 CFR §156.210(c), 45 CFR §155.1020(a)
	Rate Increase Consideration	45 CFR §155.1020 (b)
	Benefit and Rate Information	45 CFR §155.1020(c)
Plan Benefits	QHP Requirement to Cover	45 CFR §156.200(b)(3)
	EHB Benchmark Plan Standards	45 CFR 156.110
	EHB Standards	45 CFR 156.115
	EHB Formulary Review	45 CFR 156.120
	Cost-Sharing	45 CFR 156.130
Rating Variations	Product Pricing	45 CFR §156.255(b)
	Allowable Variability	45 CFR §156.255(a)
Plan Offering Requirements	Actuarial Value Tiers	45 CFR §156.200(c)(1)
	Child-only Plan	45 CFR §156.200(c)(2)
Accreditation	General requirement	45 CFR §156.275(a)
	Timeframe for Accreditation	45 CFR §155.1045
Health Care Quality Requirements	Quality Improvement Initiative	45 CFR §156.200(b)(5), Section 1311(g) of the ACA

Requirement Category	Federal Requirement	Reference
	Quality and Outcomes Reporting	45 CFR §156.200(b)(5), Section 1311(c)(1)(I) of the ACA
	Enrollee Satisfaction Surveys	45 CFR §156.200(b)(5), Section 1311(c)(4) of the ACA
Transparency in Coverage	Required Information Related to Coverage Transparency	45 CFR §156.220(a)
	Reporting Requirement	45 CFR §156.220(b), 45 CFR §156.220(c)
	Enrollee Cost-sharing	45 CFR §156.220(d)
Service Area	Minimum Service Area	45 CFR §155.1050(a)
	Non-Discriminatory Service Area	45 CFR §155.1050(b)
Network Adequacy	Network Adequacy Standards	45 CFR §156.230
	Provider Directory	45 CFR §156.230(b)
	Essential Community Providers	45 CFR §156.235
User Fees	Issuer Payment of Fees	45 CFR §156.200(b)(6)
Marketing	Marketing Rule Compliance	45 CFR §156.225(a)
	Non-discrimination	45 CFR §156.225(b)
Enrollment Processes and Periods	Enrollment Periods and Processes	45 CFR §156.260, §156.265 (small employer: 45 CFR §155.725)
	Termination	45 CFR §156.270
Risk Adjustment	Participation in Risk Adjustment Programs	45 CFR §156.200(b)(7)
Non-Discrimination	Non-Discrimination	45 CFR §156.200(e), 45 CFR §156.125, 45 CFR 156.225(b)
Cost-Sharing Reduction	Cost-Sharing Reductions	§1402(a)-(d) of the ACA

Plan Management

Synopsis
 This diagram illustrates the major process flows in the Plan Management process.

Notes

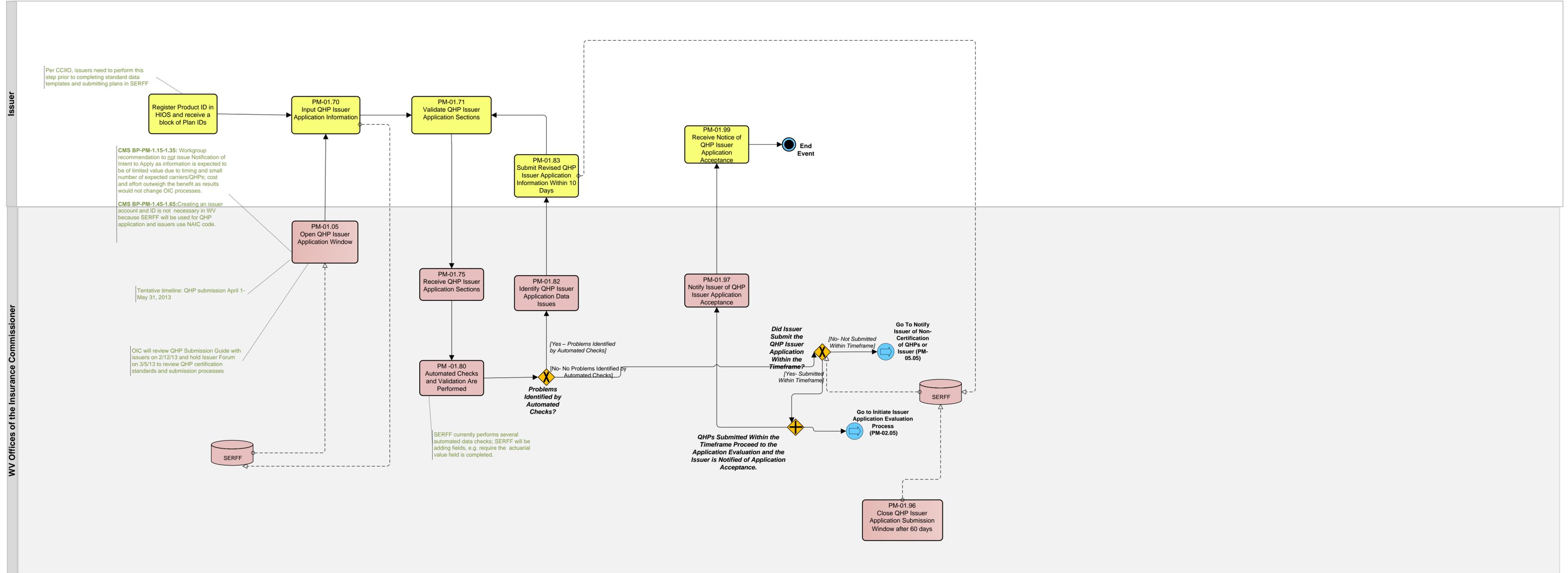
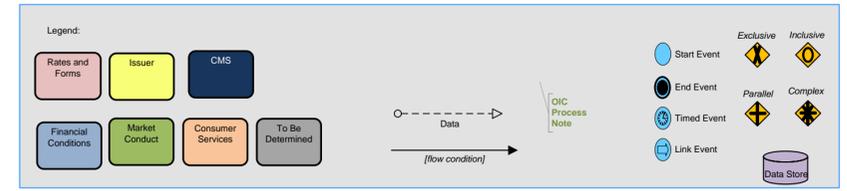


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WV OIC Notes
Initiation of the QHP application process is expected to largely mirror and leverage existing OIC processes for receiving issuer filings since the QHP application will be submitted via SERFF and received by the OIC's Rates and Forms Division. Issuers will use their existing NAIC company code to access and submit the application in SERFF, and communications between the OIC and issuer are expected to be handled in SERFF.

Unlike existing processes, however, a window will be established for QHP application submittal. Proposed dates for the QHP application window are from April 1-May 31, 2013, pending Federal requirements and the on-time release of SERFF v6.0 on March 28, 2013.

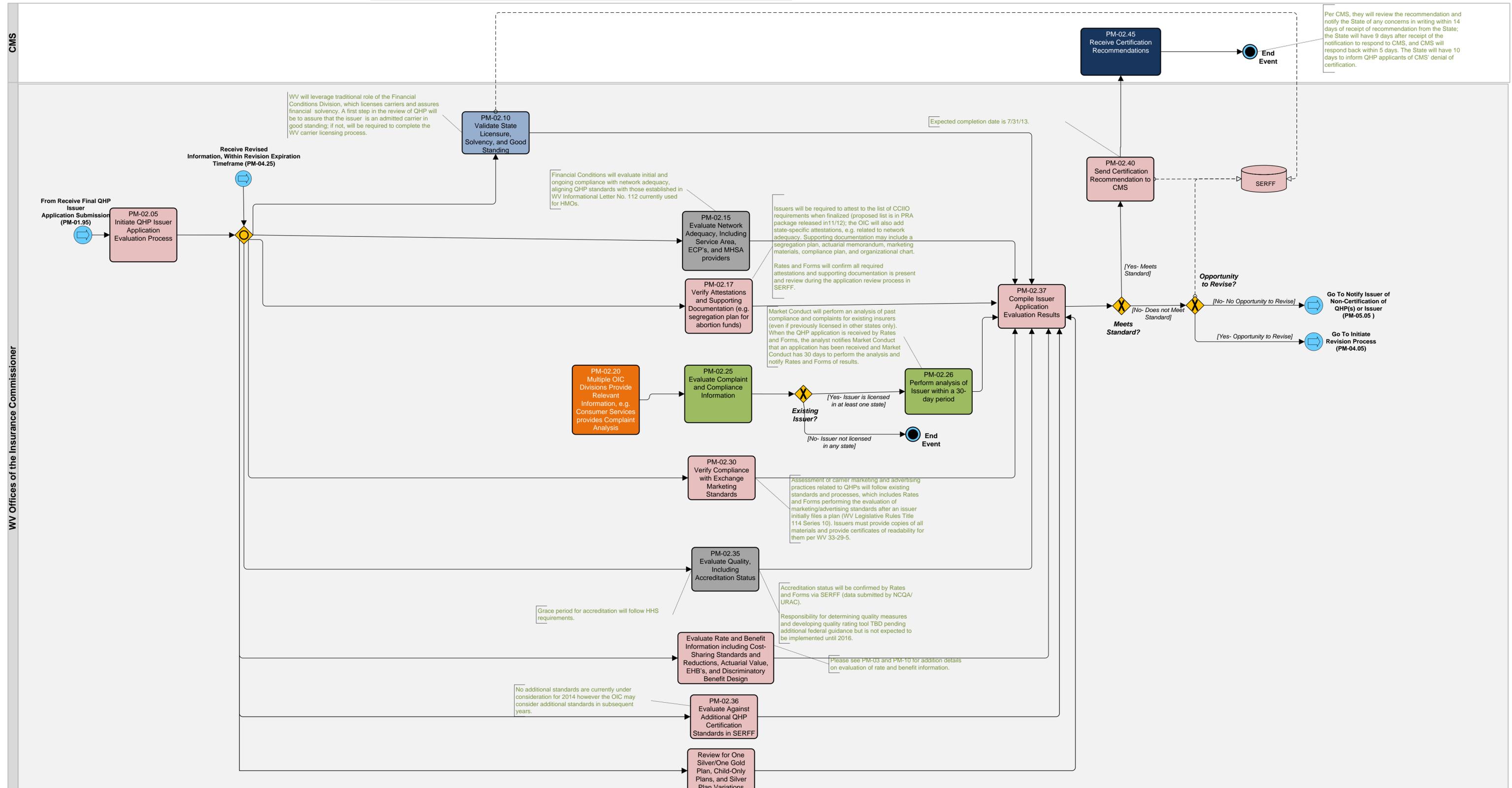
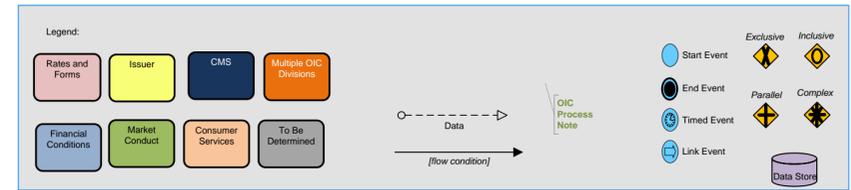
In addition, CCIIO has indicated issuers will need to register their Product ID and receive a block of Plan IDs prior to completing standard data templates and submitting plans in SERFF.



WV OIC Notes

West Virginia will build off of existing processes currently performed by the OIC to complete a review of issuer and plan compliance with QHP certification requirements. The OIC has established a certification "checklist" or set of standards against which the QHP application will be evaluated, and the review of the QHP application will be performed by Rates and Forms, who will reach out to other Divisions within the OIC, e.g. Market Conduct, Rates and Forms, Consumer Services, and Financial Conditions, as necessary. SERFF will be the primary IT system used to manage all steps in these business processes, including communications (via the "Correspondence" tools) between the OIC and issuers during initial evaluation and revisions to the plan. The OIC intends to leverage the CCIIO standard Excel data templates to collect data from issuers and to share with CCIIO via an interface between SERFF and HIOS.

The OIC will comply with CMS' timeline, as defined in the MOU between CMS and the State, related to submission of certification recommendations, responding to CMS' concerns about recommendations, and communicating certification decisions to issuers.



Per CMS, they will review the recommendation and notify the State of any concerns in writing within 14 days of receipt of recommendation from the State; the State will have 9 days after receipt of the notification to respond to CMS, and CMS will respond back within 5 days. The State will have 10 days to inform QHP applicants of CMS' denial of certification.

Expected completion date is 7/31/13.

Grace period for accreditation will follow HHS requirements.

No additional standards are currently under consideration for 2014 however the OIC may consider additional standards in subsequent years.

Please see PM-03 and PM-10 for addition details on evaluation of rate and benefit information.

Assessment of carrier marketing and advertising practices related to QHPs will follow existing standards and processes, which includes Rates and Forms performing the evaluation of marketing/advertising standards after an issuer initially files a plan (WV Legislative Rules Title 114 Series 10). Issuers must provide copies of all materials and provide certificates of readability for them per WV 33-29-5.

Market Conduct will perform an analysis of past compliance and complaints for existing insurers (even if previously licensed in other states only). When the QHP application is received by Rates and Forms, the analyst notifies Market Conduct that an application has been received and Market Conduct has 30 days to perform the analysis and notify Rates and Forms of results.

Issuers will be required to attest to the list of CCIIO requirements when finalized (proposed list is in PRA package released in 11/12); the OIC will also add state-specific attestations, e.g. related to network adequacy. Supporting documentation may include a segregation plan, actuarial memorandum, marketing materials, compliance plan, and organizational chart.

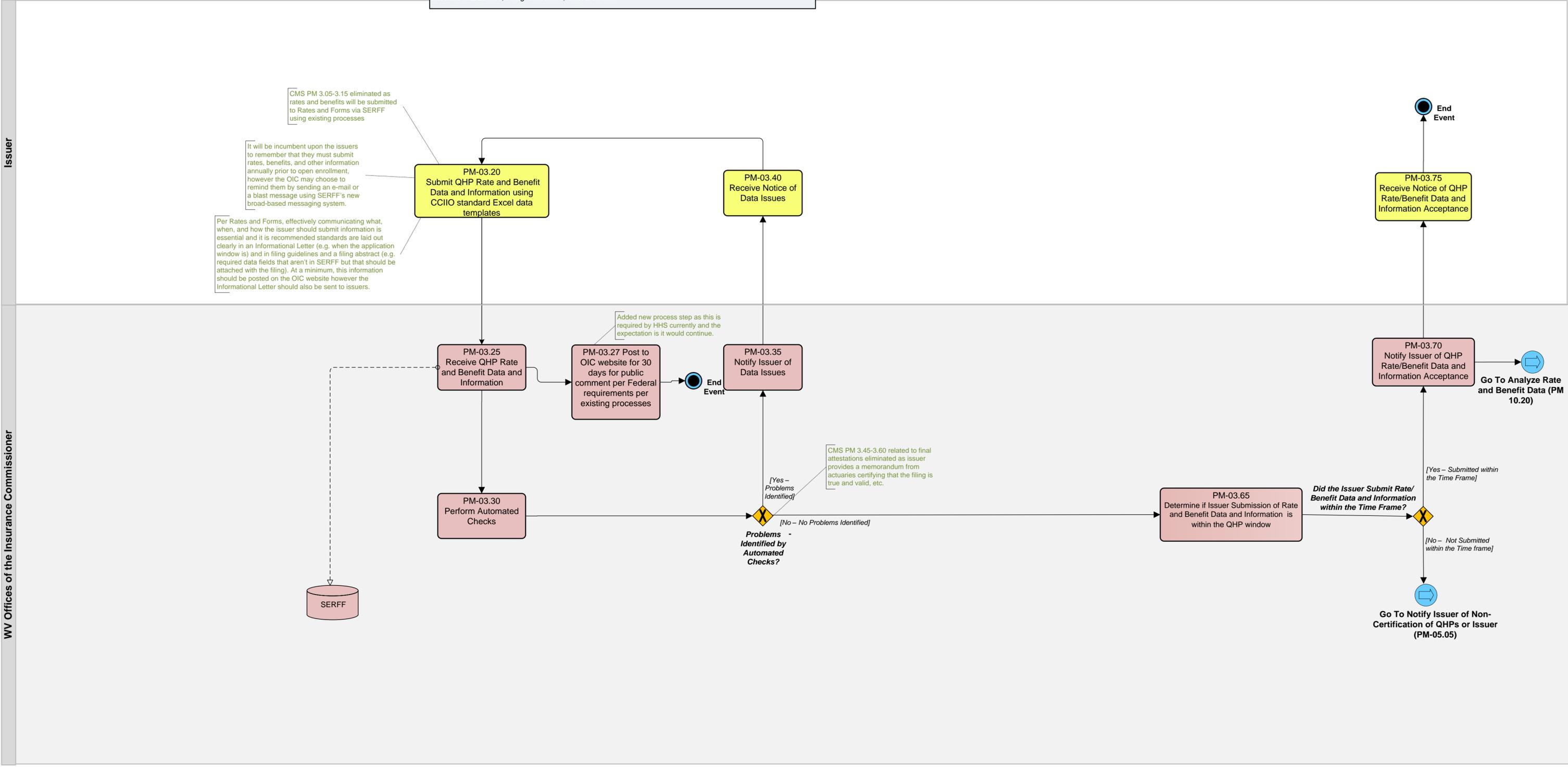
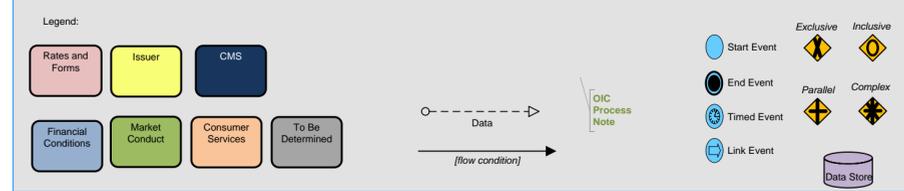
Financial Conditions will evaluate initial and ongoing compliance with network adequacy, aligning QHP standards with those established in WV Informational Letter No. 112 currently used for HMOs.

WV will leverage traditional role of the Financial Conditions Division, which licenses carriers and assures financial solvency. A first step in the review of QHP will be to assure that the issuer is an admitted carrier in good standing; if not, will be required to complete the WV carrier licensing process.

WV OIC Notes

Existing Rates and Forms processes using SERFF will be leveraged for receipt of QHP rate and benefit data in WV for initial QHP certification and for annual renewal and recertification prior to annual open enrollment. Issuer representatives will attest to the validity of the data and information submitted in the initial SERFF filing and will submit actuarial memorandums and certifications as appropriate.

The expectation is that responsibility for remembering to submit required rate and benefit data annually in the submission window prior to annual open enrollment falls on the issuer, however the OIC may choose to send reminders using various forms of communication such as e-mail and broad-based messaging in SERFF. Standards and expectations will be clearly outlined upfront using various existing mechanisms such as Informational Letters, Filing Guidelines, and Abstracts.

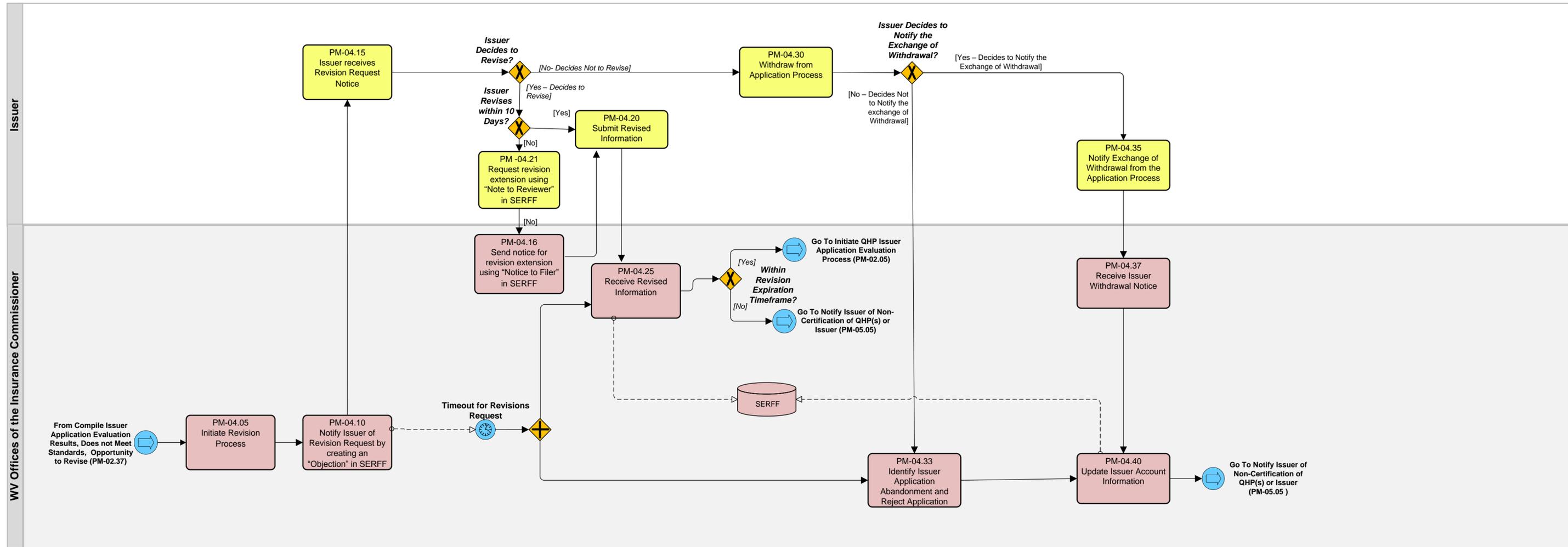
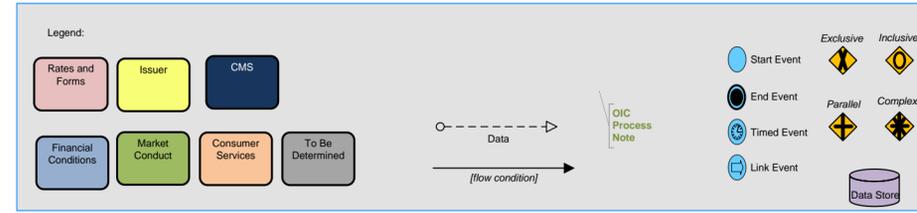


**WV OIC Blueprint Process Model
Plan Management**

**DRAFT: Revise QHP Issuer
Application
BP-PM-04**

WV OIC Notes
Revision of the QHP application is expected to largely mirror and leverage existing OIC processes for revising issuer filings since the QHP application will be submitted via SERFF and evaluated in large part by the OIC's Rates and Forms Division, who will serve as the "coordinator" of the various application components. Communications between the OIC and issuer are expected to be handled in SERFF.

Similar to existing processes, the OIC will have 60 days after application submittal from the issuer to review and approve the application, and the issuer will have 10 days to respond to requests for revisions or additional information from Rates and Forms with the ability to request an extension.

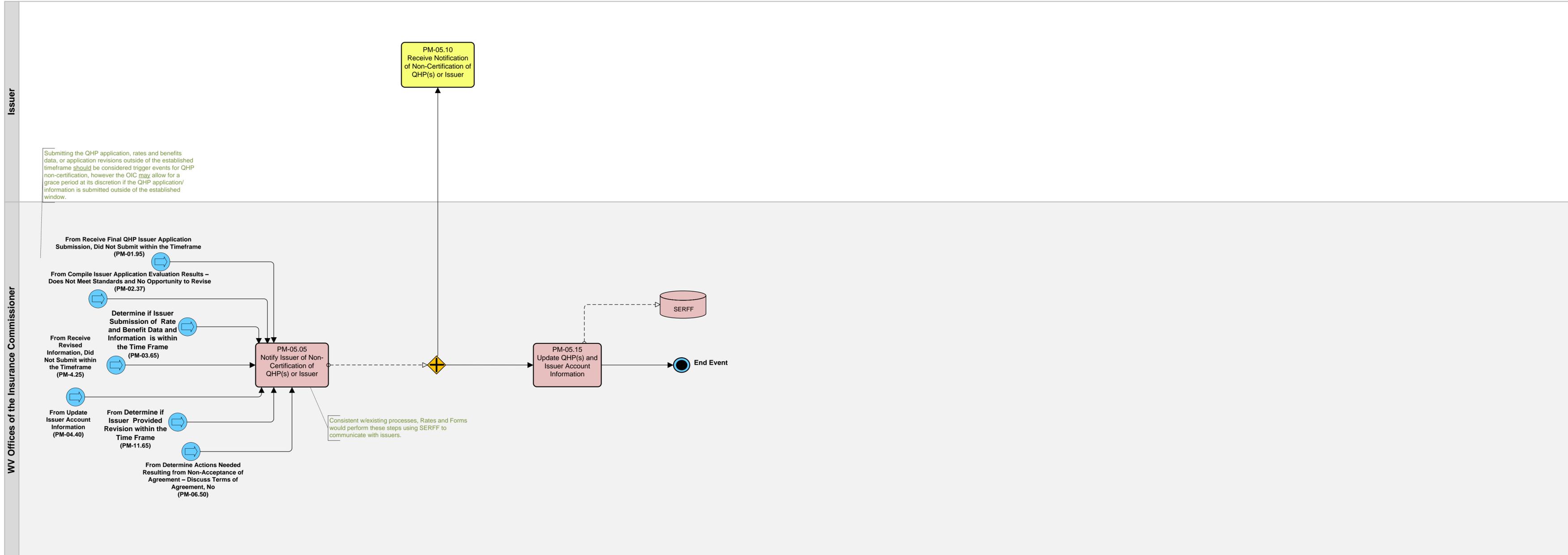
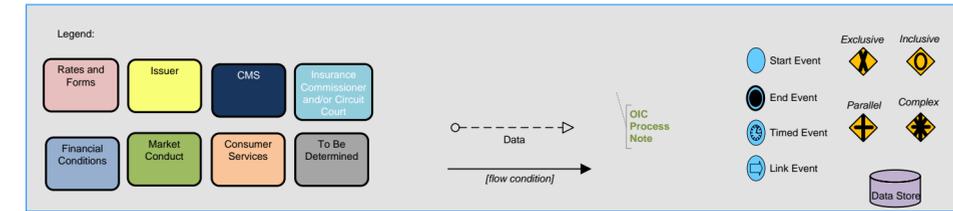


DRAFT: Determine Issuer or Plan Non-Certification
BP-PM-05

WV OIC Notes

Non-certification of QHPs will be determined by Rates and Forms based upon whether or not the plan meets the certification criteria (or certification "checklist") as established by Federal statute and rule and the WV Exchange Board. Trigger events for non-certification may also include submittal of plan information outside of the established QHP application window, however Rates and Forms has the discretion to allow for a grace period if it is deemed in the best interest of consumers (e.g. to provide for more QHP selection).

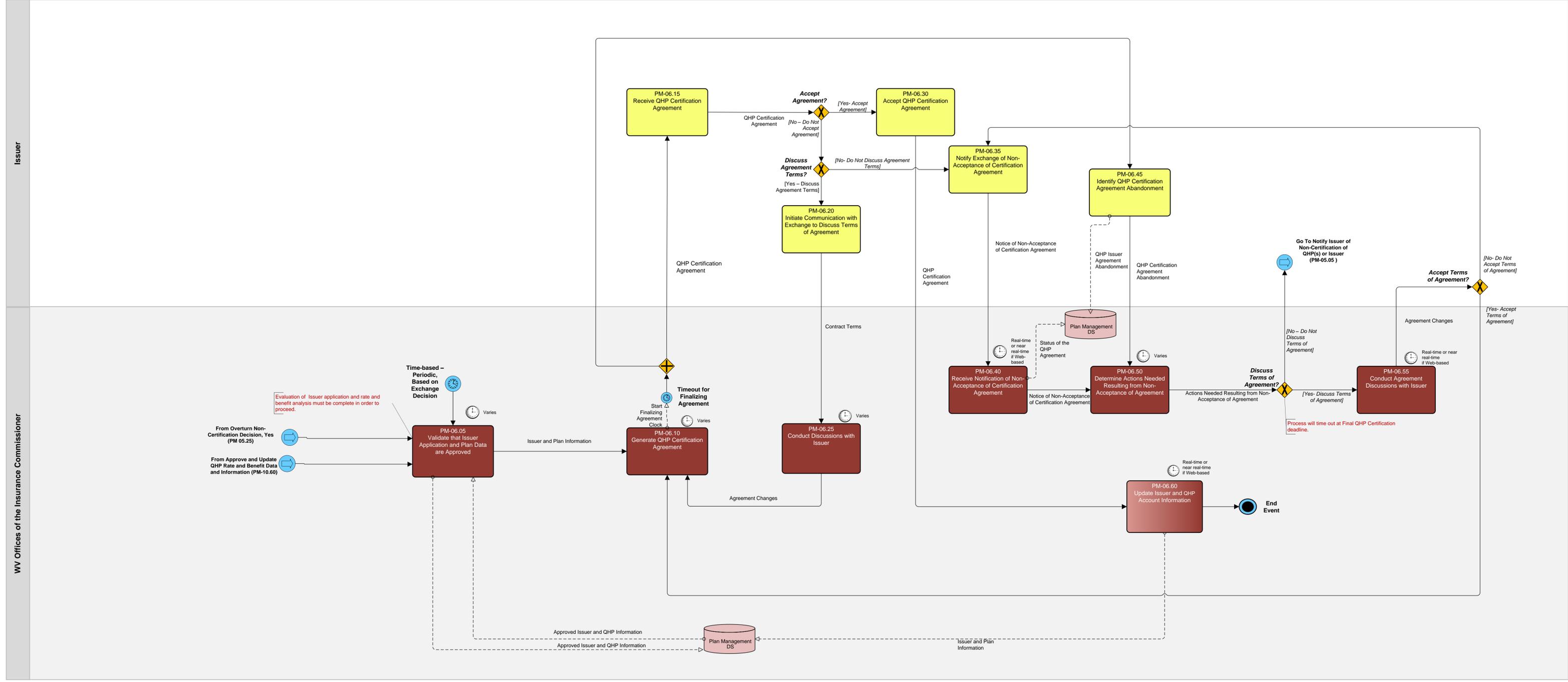
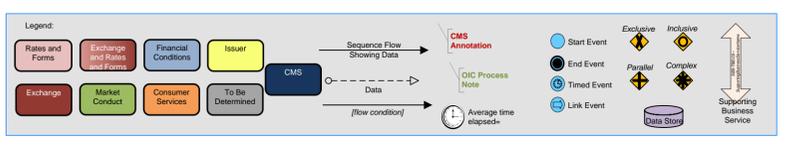
The OIC does not intend to perform appeals of non-certification and decertification decisions since it is only making QHP certification and decertification recommendations to HHS, which has ultimate decision-making through the ratification process.



Submitting the QHP application, rates and benefits data, or application revisions outside of the established timeframe should be considered trigger events for QHP non-certification, however the OIC may allow for a grace period at its discretion if the QHP application/ information is submitted outside of the established window.

CMS Synopsis
This process is performed at the end of the certification process to establish an agreement between the Exchange and a QHP Issuer. This process is only performed for those Issuers who met the standards as evaluated by the Exchange in the QHP Issuer application evaluation, rate analysis and benefit evaluation processes. This process will likely vary by state.

WV OIC Notes
Not applicable in a State Partnership model as certification agreement will be between Feds and issuer.

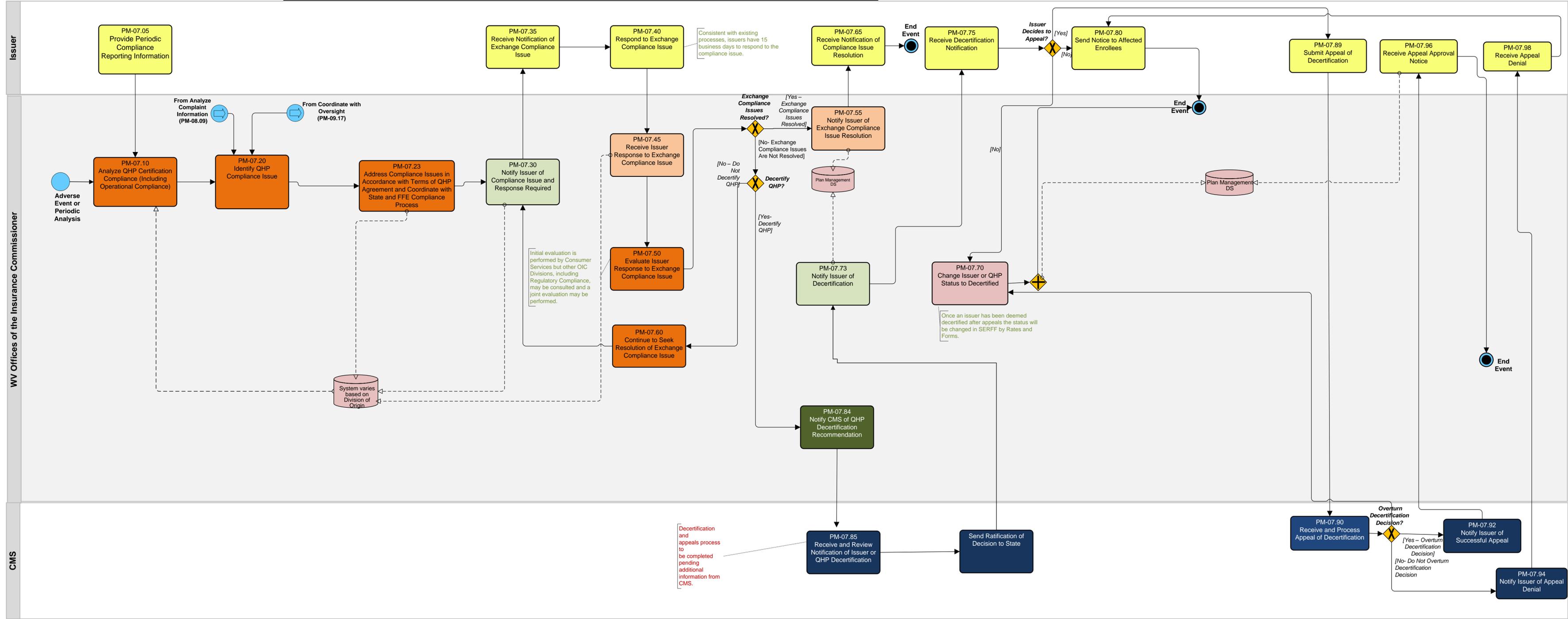
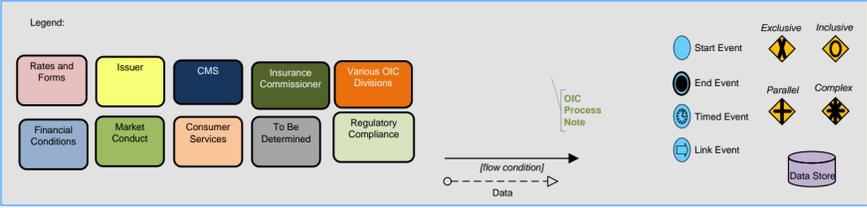


DRAFT: Monitor Issuer and Plan Certification Compliance
BP-PM-07

When compliance issues have been identified via the ongoing monitoring process, the OIC's Regulatory Compliance Division will communicate compliance issues to the issuer via mail; issuers will have 15 business days to respond to a compliance issue. The decision to take action against a QHP, including decertification, will follow existing processes, e.g. OIC Divisions, including Regulatory Compliance, may meet to review the issue and the issuer's response and discuss required actions. OIC Divisions included in the discussions will depend on the nature of the compliance issue. If intermediate sanctions fail to resolve the issue and a decision is ultimately made to decertify a QHP, the Insurance Commissioner will be responsible for communicating decertification recommendations to HHS. Once the final decision to decertify is made, Rates and Forms will flag the QHP as decertified in SERFF.

The OIC does not intend to perform appeals of non-certification and decertification decisions since it is only making QHP certification and decertification recommendations to HHS, which has ultimate decision-making through the ratification process.

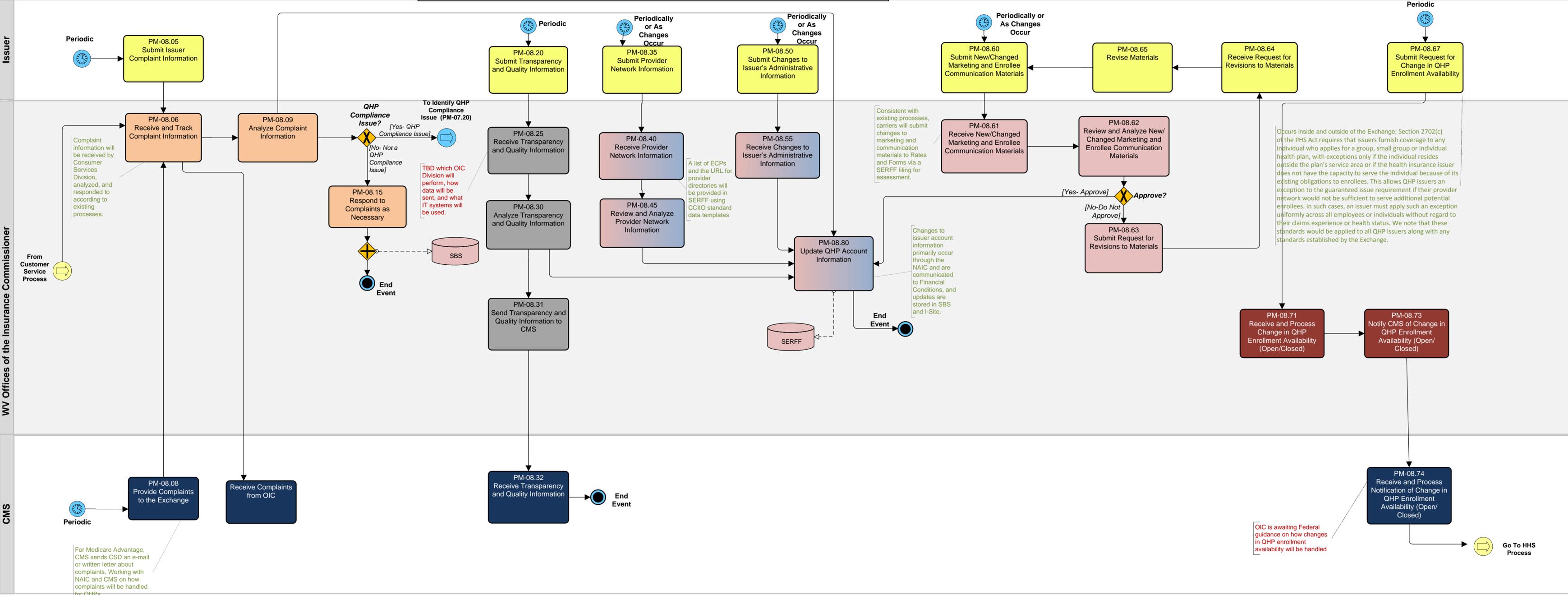
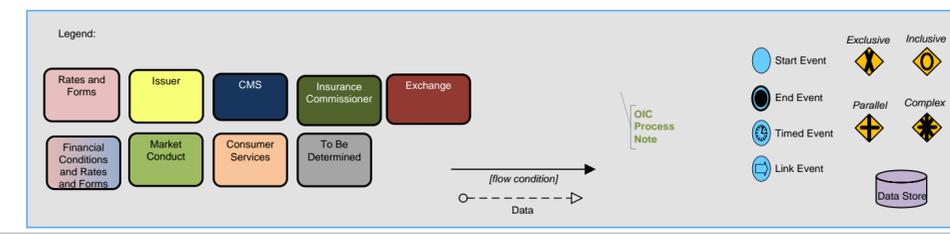
Regarding transitioning of enrollees who are in decertified plans, the OIC will partner with HHS to assure they have access to contact information for in-person assisters to assist with transitioning to new QHPs. The OIC will also provide oversight of issuers to assure they are complying with State and Federal requirements related to termination of enrollee coverage. The OIC does not intend to send notices to affected enrollees since, in an FFE, HHS is responsible for sending Exchange-related notices.



WV OIC Notes
The OIC is awaiting Federal guidance on how changes in QHP enrollment availability will be handled.

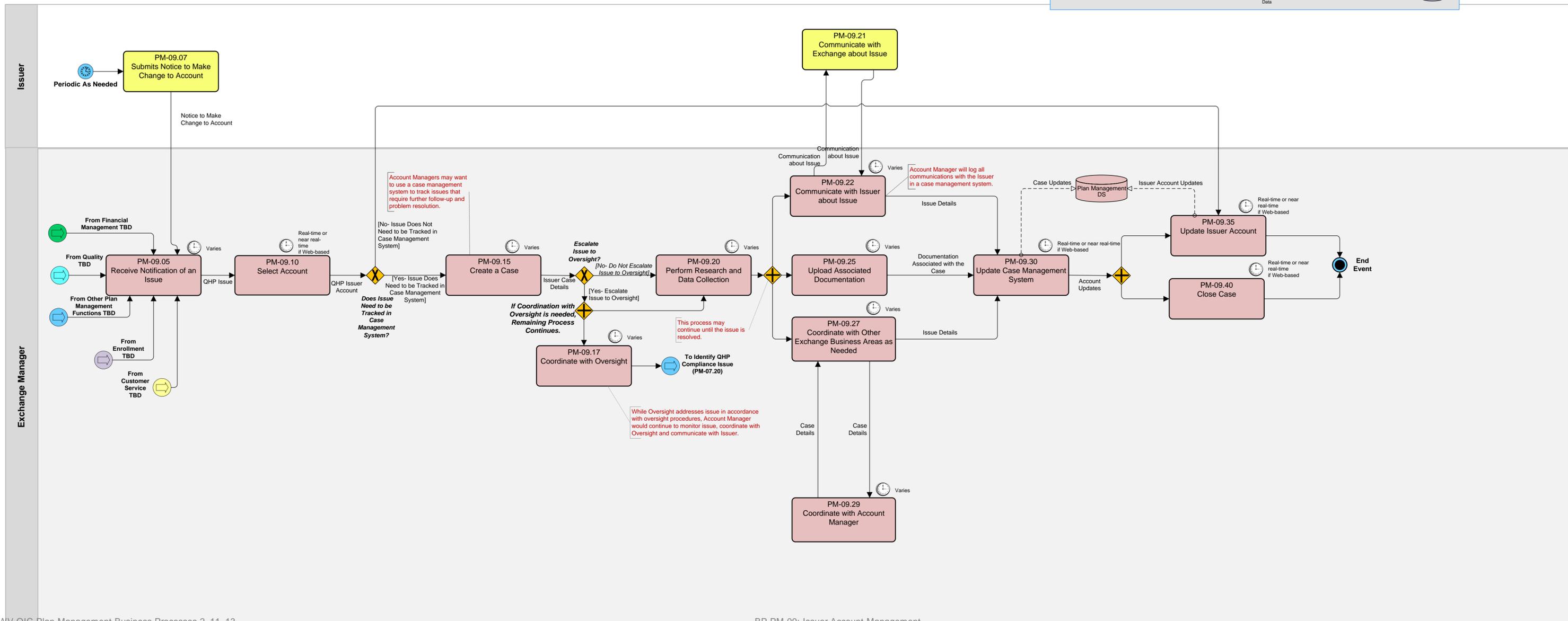
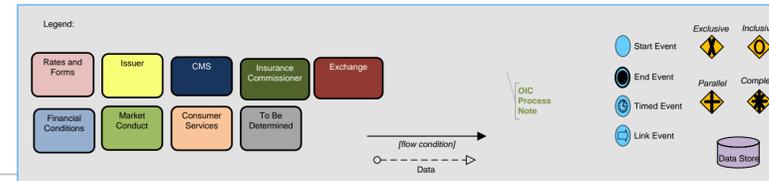
Several areas under maintaining QHP operational data fall within the purview of existing OIC Divisions, e.g. Consumer Services acts as the primary conduit for adverse events/complaints Financial Conditions receives changes to issuer account information, and Rates and Forms reviews marketing materials and enrollee communications materials.

Decisions about how information in several areas will be managed remain open, however, i.e. transparency and quality information (pending Federal guidance), provider network information (pending OIC decision on ownership and clarification if SERFF will be enhanced to handle data), and changes in QHP enrollment availability (team made preliminary recommendation that this is HIX responsibility however further discussion is warranted).

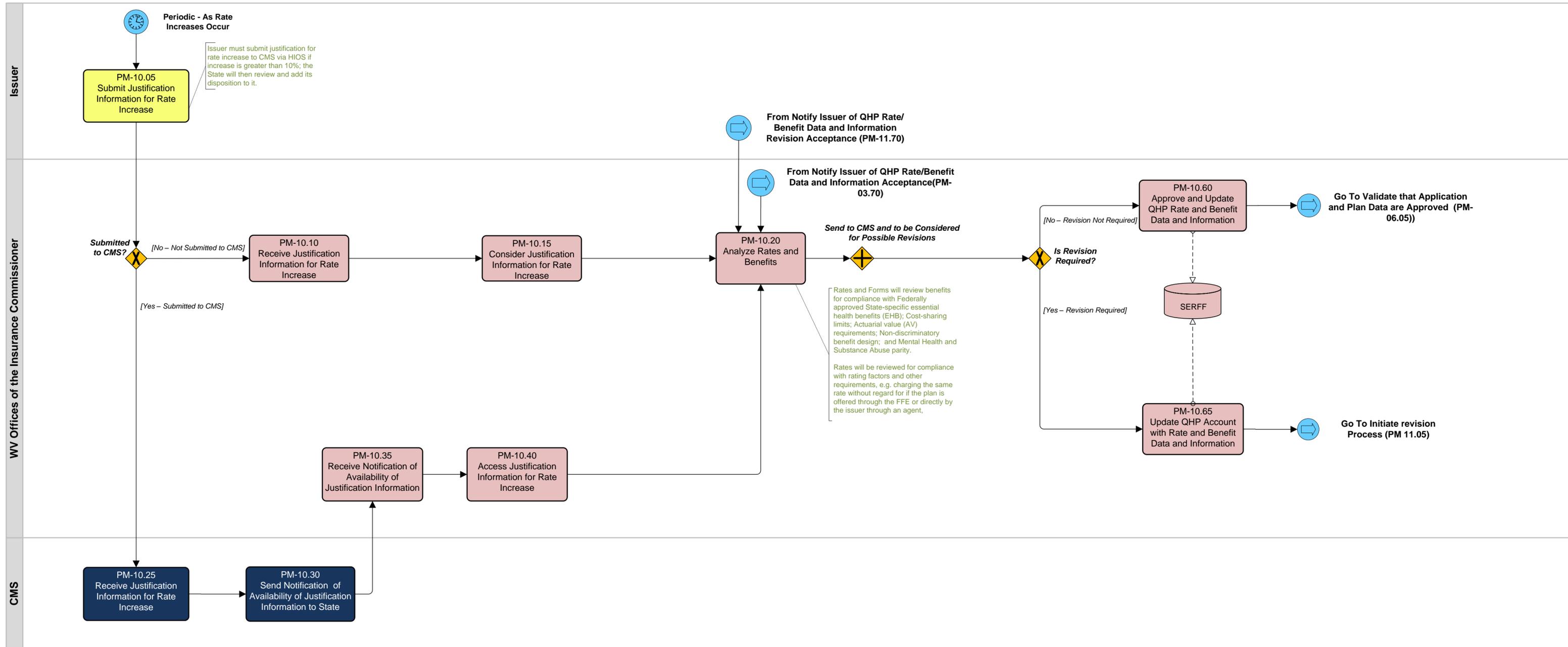
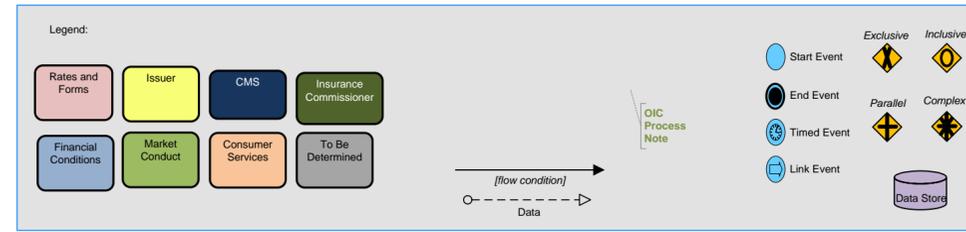


WV OIC Blueprint Process Model
 Plan Management
 Issuer Account Management
 BP-PM-09

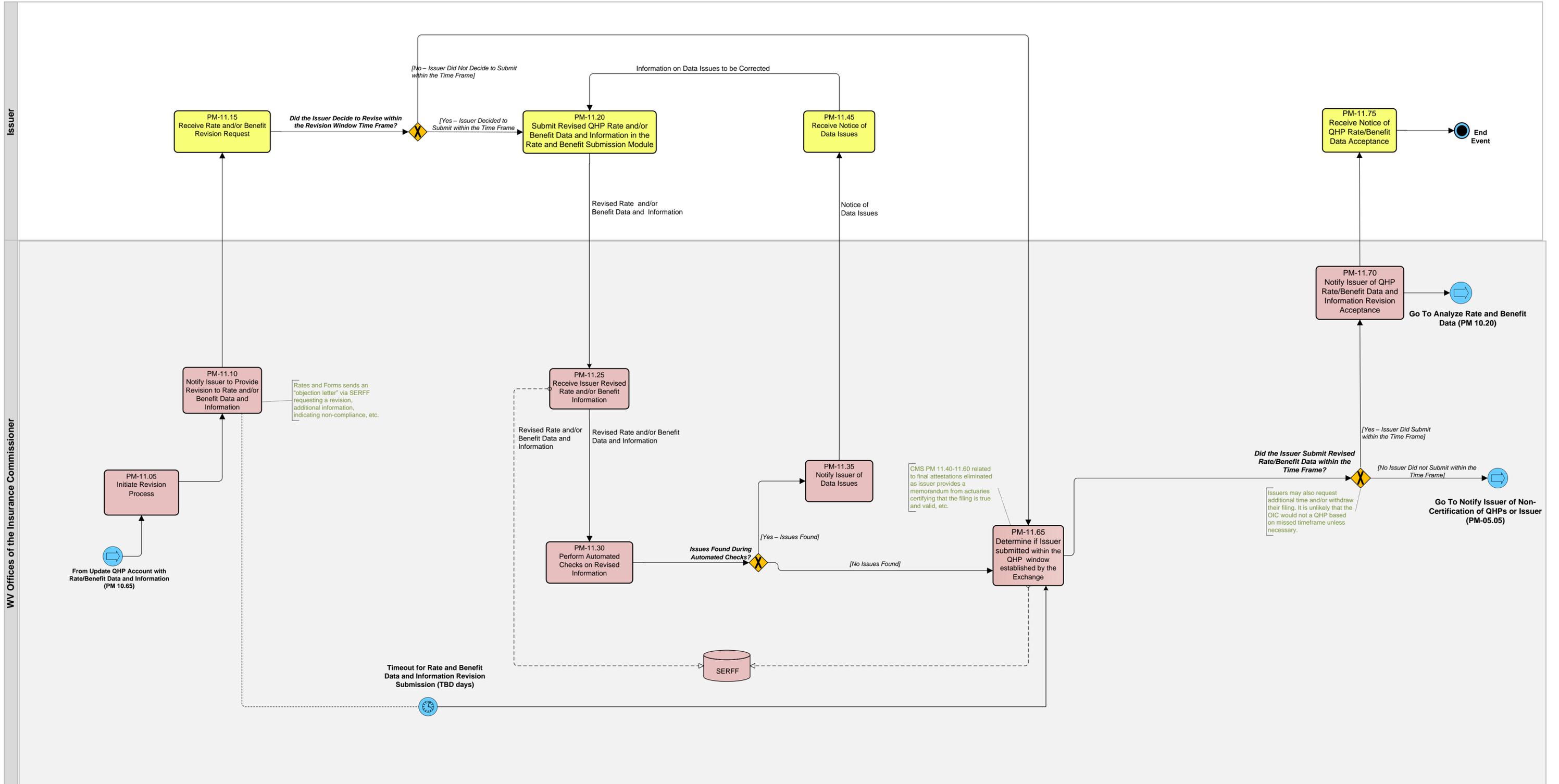
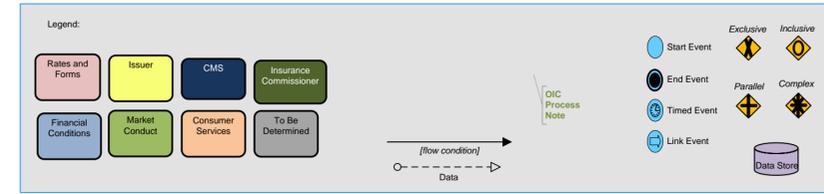
WV OIC Notes
 Existing OIC processes and communication channels for interacting with issuers will be leveraged for issues falling within the purview of existing OIC Divisions such as Consumer Services and Rates and Forms. A separate issuer case management system is not needed in WV due to the small number of issuers.
Process below is not applicable to WV.



WV OIC Notes
Existing Rates and Forms processes using SERFF will be leveraged for analysis of QHP rate and benefit data in WV for initial QHP certification, for annual renewal and recertification prior to annual open enrollment, and when rate increases are requested. Rates and Forms is accustomed to "surges" in activity as a result of new state or federal statute/rules and other factors and the anticipate being able to handle the annual rate and benefit review with existing staff. In addition, two existing Rates and Forms staff members are being cross-trained to assist the two Rates and Forms Analysts who currently review Life and Health filings, and, consistent with existing processes, actuarial subcontractors may be leveraged as needed to perform actuarial review of rate filings and plan actuarial value. Per Rates and Forms, the key is clear communication with issuers about what is expected in the annual review; these expectations are often clarified in an Informational Letter and in Filing Guidelines posted on the OIC website and in SERFF.



WV OIC Notes
Existing Rates and Forms processes using SERFF and existing staff resources will be leveraged for revisions to QHP rate and benefit data in WV for initial QHP certification and for annual renewal and recertification prior to open enrollment.



WV OIC Carrier Stakeholder Meeting QHP Submission Guide Review

February 12, 2013

Agenda

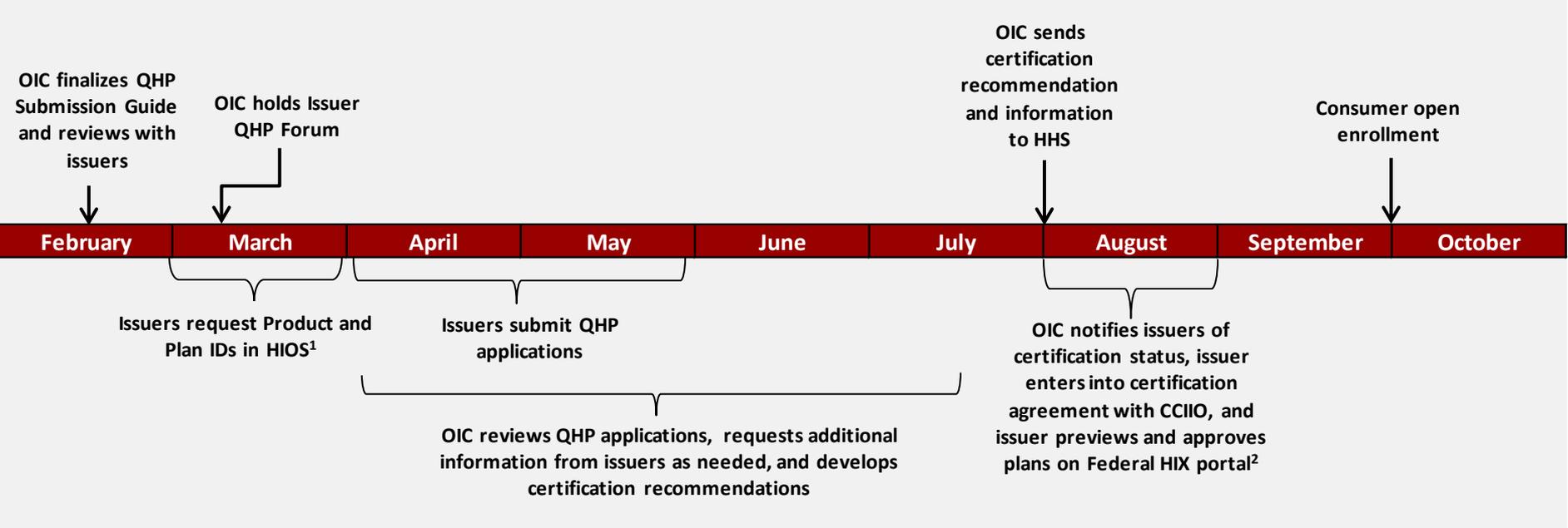
- QHP Submission and Certification Timeline
- Submission Guide Overview
 - Purpose
 - Layout
- QHP Submission and Certification Requirements
 - Data Submission
 - General Exchange Participation
 - QHP Certification
- Next Steps and Questions

QHP SUBMISSION AND CERTIFICATION TIMELINE

QHP Submission and Certification Timeline

- Projected dates for QHP submission and certification in 2013 are outlined below
- **Please note prior to entering plan information into SERFF, issuers must register Product IDs in HIOS and receive a block of Plan IDs**

WV OIC Proposed QHP Certification Timeline -2013



¹Estimated dates only as dependant upon CCIIO

²Dependent on timing of HHS ratification of OIC decisions and processing of data sent from the State



SUBMISSION GUIDE OVERVIEW

Purpose

- Provide guidance to health insurance issuers regarding the certification standards for individual and/or SHOP Qualified Health Plans (QHPs) offered through the federal Health Insurance Exchange
- Intended for informational purposes and has no legal force or effect
 - Issuers should refer to WV State Code and federal statute, rules, and regulations for a comprehensive understanding of requirements related to qualified health plans offered in the Exchange
- Federal statute and regulations referenced may not be final (e.g. rating factors, essential health benefits)

Layout

Section I. General Information and Background

- Purpose
- Context
- General Exchange Participation Requirements
- Timetable
- Contact Information

Section II. Specifications for QHP Certification

- Components included for each key QHP Certification area (such as benefit standards, rating standards, and network adequacy) include:
 - Statement (*italicized*) indicating whether or not the information required for the certification area must be provided once per issuer or for each QHP, and whether or not the section applies to stand-alone dental plans (SADP's)
 - Statutory/Regulatory Standard
 - OIC/HHS Certification Approach
 - Primary Data Submission Method from Issuer

Layout

- **Section III. Attestations**
 - WV-specific list
 - HHS-required list
- **Section IV. Appendices**
 - QHP Certification Checklist
 - Reference Table for Federal Requirements

QHP SUBMISSION AND CERTIFICATION REQUIREMENTS

Data Submission Methods

- Built-in Onscreen SERFF Data Entry Fields
 - E.g., Plan Binder Name, Plan Year, Market Type
- Standard MS Excel Data Templates (as attachments)
 - E.g., Administrative Data, Plan and Benefit Data, Rate Data, Formulary Data
- Supporting Documents (as attachments)
 - E.g., Certification of Compliance, Actuarial Memorandum, Certificate of Readability
- Attestations (as a PDF attachment)
 - E.g., “Issuer will adhere to all requirements contained in 45 CFR 156, applicable law and applicable guidance”
- At the time of drafting the Guide, the CClIO MS Excel Data Templates are in proposed form and can be found at the following location under “Documentation –Business”: <http://www.serff.com/hix.htm>

General Exchange Participation Requirements

- To be certified for participation in the Exchange, a QHP must:
 - Meet the legal requirements of offering health insurance in West Virginia;
 - Satisfy the certification criteria as established by the State;
 - Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts §155 and §156; and
 - Receive a recommendation for certification by the OIC, have the recommendation ratified by HHS, and enter into a Certification Agreement with HHS.
- In addition, to participate in the Exchange an issuer must:
 - Submit at least one (1) silver plan and one (1) gold plan (45 CFR 156.200(c)(1));
 - Provide a child-only option for each metal tier for which the issuer offers a QHP (45 CFR 156.200(c)(2); and
 - Submit three variations to each silver plan reflecting reduced cost sharing on the essential health benefits (45 CFR 156.420(a).

QHP Certification Requirements

- 2.1: Issuer Administrative Information
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- 2.10: Past Complaints/Compliance
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QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Issuer Administrative Information (508 Appendices A1 and A4 of PRA package, CMS Form Number CMS-10433)	Basic information required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers; data elements may include issuer contact information and banking information	N/A

Primary data submission method(s): *CCIIO Excel Data Template*

Is information issuer- or QHP-specific?	<i>Issuer</i>
Does it apply to SADP's?	<i>Yes</i>



QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Licensure, Solvency, and Standing (45 CFR 156.200 (b)(4))	Issuer must be licensed, meet WV solvency requirements, and have unrestricted authority to write its authorized lines of business in West Virginia; issuer must have no outstanding sanctions imposed by the OIC	Review and confirm issuers meet these standards, leveraging existing information and data sources; issuers licensed in WV will not be required to submit supporting documentation for this standard initially unless concerns are identified and additional review is required Issuers not currently licensed will be required to complete the WV licensing process

Primary data submission method(s): *Attestation*

Is information issuer- or QHP-specific?	<i>Issuer</i>
Does it apply to SADP's?	<i>Yes</i>

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Essential Health Benefits (45 CFR 156.115; 45 CFR 156.120) *	<p>Offers coverage that is substantially equal to the coverage offered by the benchmark plan</p> <p>Covers at least the greater of one drug in every USP category and class or the same number of drugs in each category and class as benchmark</p> <p>WV benchmark is Highmark Blue Cross Blue Shield WV Super Blue Plus 2000 1000 Ded supplemented by WV CHIP for pediatric dental and FEDVIP for pediatric vision</p>	<p>Confirm issuer offers coverage that is substantially equal to the benchmark plan; has demonstrated actuarial equivalence of substituted benefits if the issuer is substituting benefits; and provides required number of drugs per category and class</p> <p>EHB substitutions will require an actuarial certification</p>

Primary data submission method(s): *CCIIO Excel Data Template; Attestation; Supporting Documents (e.g. actuarial certification)*

Is information issuer- or QHP-specific?

QHP

Does it apply to SADP's?

Yes

* Standards are contained in proposed Federal rules expected to be final in early 2013.

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
<p>Annual Cost-Sharing Limitations (45 CFR 156.130; 45 CFR 156.150) *</p>	<p>Out-of-Pocket Limits: cost-sharing for self or family coverage will not exceed the dollar amounts in section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self and family coverage beginning in 2014</p> <p>Deductibles: Employer-sponsored plans may not have a deductible >\$2,000 for a plan covering a single individual or \$4,000 for other coverage; deductible limit may be increased by the maximum amount of reimbursement reasonably available to an employee under a flexible spending arrangement</p> <p>Cost-sharing for SADPs will be considered separately from other QHPs; plan must demonstrate the annual limitation on cost-sharing for the SADP is “reasonable” for coverage of the pediatric dental EHB</p>	<p>Review plan data for compliance with ACA cost-sharing limitations</p>

Primary data submission method(s): *CCIIO Excel Data Template; Attestation*

Is information issuer- or QHP-specific?	QHP
Does it apply to SADP’s?	Yes

*Standards are contained in proposed rules that should be final in early 2013

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
<p>Actuarial Value (45 CFR 156.135; 156.140; 156.150) *</p>	<p>Except for the impact of cost-sharing reduction subsidies and <i>de minimis</i> variation of +/- 2 percent, plan must meet specified AV based on the cost-sharing features of the plan</p> <ul style="list-style-type: none"> • Bronze plan – AV of 60 percent • Silver plan – AV of 70 percent • Gold plan – AV of 80 percent • Platinum plan – AV of 90 percent • Catastrophic plan –N/A <p>Issuer <i>must</i> use AV calculator for plan submittal to OIC and <i>may</i> use informally when designing plans; an exception is made for unique plan design, for which an actuarial certification from the issuer indicating compliance with use of an approved alternative calculation method is required</p> <p>SADP’s certified to meet a 75 percent AV (+/- 2 percent) will be considered a “low” plan and anything with an AV of 85 percent (+/- 2 percent), will be considered a “high” plan; SADP’s may <u>not</u> use AV calculator</p>	<p>Review and confirm that the AV for each QHP meets specified levels; review unique plan designs and accompanying actuarial certification, if applicable</p>

Primary data submission method(s): *CCIIO Excel Data Template; Attestation; Supporting Documents (e.g., actuarial certification for unique plan designs)*

Is information issuer- or QHP-specific?

QHP

Does it apply to SADP’s?

Yes

*Standards are contained in proposed rules that should be final in early 2013

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Non-Discrimination (45 CFR 156.125; 156.200(e); 156.225(b))*	Issuer must not discriminate based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation (45 CFR 156.200(e)); and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs	Conduct outlier tests to identify potentially discriminatory benefit designs; issuer will also attest to non-discrimination

Primary data submission method(s): *CCIIO Excel Data Template; Attestation*

Is information issuer- or QHP-specific?

QHP

Does it apply to SADP’s?

Yes

*Standards are contained in proposed rules that should be final in early 2013

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Mental Health and Substance Abuse Parity (ACA § 1311(j))	Section 2726 of the Public Health Service Act applies to QHP’s in the same manner and to the same extent as such section applies to health insurance issuers and group health plans	Review benefits and cost-sharing for compliance with standard, including ensuring that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits

Primary data submission method(s): *CCIIO Excel Data Template; Attestation*

Is information issuer- or QHP-specific?	<i>QHP</i>
Does it apply to SADP’s?	<i>No</i>

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
<p>Rating Factors and Rate Increases (45 CFR 147.102; 156.255; 156.210)</p>	<p>Issuer may only vary premiums based on age (within a 3:1 ratio for adults), tobacco use (within a 1.5:1 ratio and subject to wellness program requirements in the small group market), family size, and geography</p> <p>Issuer must set rates for an entire benefit year, or for the SHOP, plan year; must charge the same premium rate without regard to whether the plan is offered through the FFE or directly from the issuer through an agent and is sold inside or outside of the Exchange; must submit rate information to the Exchange at least annually; must submit a justification for a rate increase prior to the implementation of the increase; and must prominently post the justification on its Web site</p> <p>Rate increases for QHPs are subject to the reporting and review requirements in 45 CFR 154.215 related to the submission of a Rate Filing Justification</p>	<p>Review rates for compliance with the standards and issuer attestations; review Rate Filing Justification, including actuarial memorandum, for rate increases</p>

Primary data submission method(s): *CCIIO Excel Data Template; Attestation; Supporting Documents*

Is information issuer- or QHP-specific?

QHP

Does it apply to SADP's?

*No***

*Standards are contained in proposed rules that should be final in early 2013; review and analysis of WV-specific factors is underway and will be defined within 30 days of the publication of the final Federal rules

**At this time, HHS has not further defined specific information related to dental plan rating factors.

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Accreditation (45 CFR 155.1045; 45 CFR 156.275)	<p>During initial year of certification (e.g., 2013 for the 2014 coverage year), issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in WV granted by a HHS recognized accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with a recognized accrediting entity*</p> <p>Issuers meeting accreditation standards in initial year must authorize the release of accreditation survey data to the OIC and Exchange; issuers must provide attestations including acknowledgment that, prior to 2016, CAHPS® data may be used on the Exchange Internet web site</p>	<p>Verify accreditation status based on data received from NCQA and URAC in SERFF and that issuer meets FFE accreditation timeline requirements</p>

Primary data submission method(s): *Built-in SERFF fields; Attestation*

Is information issuer- or QHP-specific?

Issuer

Does it apply to SADP's?

No

*Per proposed 45 CFR 155.1045, prior to the 2nd and 3rd year of certification, issuer must be accredited on the policies and procedures that are applicable to their HIX products or must have commercial or Medicaid plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is offering Exchange coverage and 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. Prior to a QHP issuer's fourth year of QHP, issuer must be accredited in accordance with 45 CFR 156.275.

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Network Adequacy – General (45 CFR 156.230(a)(2); WV Informational Letter No. 112)	Network includes sufficient number and types of providers (including providers that treat substance abuse and mental health conditions) to ensure that all services are available without unreasonable delay	Verify issuer is accredited with respect to network adequacy by an HHS-recognized accrediting entity and attests to complying with Federal standards and WV standards, as outlined in WV Informational Letter No. 112 <u>or</u> issuer submits access plan based on the NAIC Model Act #47 requirements

Primary data submission method(s): *Attestation; Supporting Documents*

Is information issuer- or QHP-specific?

Issuer- or QHP-specific

Does it apply to SADP’s?

Yes

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
<p>Network Adequacy – Essential Community Providers (ECP’s) (45 CFR 156.235)</p>	<p>Network has a sufficient number and geographic distribution of ECP’s, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area</p>	<p>Based on an HHS-developed ECP list, verify one of the following:</p> <ul style="list-style-type: none"> • Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers; • Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission <p>Issuer will provide a list of ECP’s with which it has contracts by service area using a data template and provide attestation of meeting standard and/or narrative justification</p>

Primary data submission method(s): *Attestation; CCIIO Excel Data Template; Supporting Documents (e.g., narrative justification)*

Is information issuer- or QHP-specific?

Issuer- or QHP-specific

Does it apply to SADP’s?

Yes

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Network Adequacy – Essential Community Providers, <i>continued</i> (45 CFR 156.235(b))	Issuer that provides a majority of covered services through employed physicians or a single contracted medical group complies with the alternate standard established by the Exchange	Based on an HHS-developed ECP list, verify one of the following: <ul style="list-style-type: none"> • Issuer has at least the same number of providers located in designated low-income areas; • Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission. <p>Issuer will provide a list of ECP’s with which it has contracts by service area using a data template and provide attestation of meeting standard and/or narrative justification</p>

Primary data submission method(s): *Attestation; CCIIO Excel Data Template; Supporting Documents (e.g., narrative justification)*

Is information issuer- or QHP-specific?

Issuer- or QHP-specific

Does it apply to SADP’s?

Yes

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Network Adequacy – Mental Health and Substance Abuse Services (45 CFR 156.230(a)(2))	Network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay	Verify issuer has established a standard to assure the QHP network complies with the Federal standard; issuer must attach a copy of this standard and certify that the provider network for this QHP meets this standard

Primary data submission method(s): *Attestation; Supporting Documents*

Is information issuer- or QHP-specific?	<i>Issuer- or QHP-specific</i>
Does it apply to SADP's?	<i>Yes</i>

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Network Adequacy – Service Area (45 CFR 155.1055)	<p>Must be at minimum an entire county, or a group of counties, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and was established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations</p> <p>WV standard is a minimum of an entire county</p>	<p>Review service areas to determine compliance with standards</p>

Primary data submission method(s): *Attestation; CCIIO Excel Data Template*

Is information issuer- or QHP-specific?	<i>Issuer- or QHP-specific</i>
Does it apply to SADP’s?	Yes

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Network Adequacy – Provider Directory (45 CFR 156.230(b))	Issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request	Issuer will provide network names, IDs, and URL in a Network Template (included as part of the “Plans and Benefits Data Templates”)

Primary data submission method(s): <i>CCIIO Excel Data Template</i>	
Is information issuer- or QHP-specific?	<i>Issuer- or QHP-specific</i>
Does it apply to SADP’s?	Yes

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
<p>Marketing, Applications, and Notices (45 CFR 156.225; 45 CFR 155.230; 45 CFR 156.250; WV Legislative Rules Title 114 Series 10)</p>	<p>Issuer must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP Enrollee applications and notices must comply with Federal standards in 45 CFR 155.230 and 156.250, including being provided in plain language and language that is accessible to people with Limited English Proficiency and disabilities</p> <p>Issuer must comply with existing standards related to advertising and marketing in WV based on the NAIC Model Act for Advertisement of Accident and Sickness Insurance</p>	<p>Review materials for compliance with Federal and WV standards</p> <p>Issuer will submit a copy of all marketing materials, application, and notices for approval and provide a Certificate of Readability per WV 33-29-5</p> <p>Issuer will attest to compliance with the ACA requirements related to non-discrimination in marketing practices</p>

Primary data submission method(s): *Attestation; Supporting Documents*

Is information issuer- or QHP-specific?

Issuer- or QHP-specific

Does it apply to SADP's?

Yes

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Quality Standards (ACA §1311(c)(1)(E); §1311(c)(3); §1311(c)(4); §1311(g)(1); §1311(h))	<p>By 2016:</p> <ul style="list-style-type: none"> HHS will develop a rating system that will rate QHPs offered through an Exchange in each benefits level on the basis of the relative quality and price (ACA § 1311(c)(3)) and an enrollee satisfaction survey system (ACA § 1311(c)(4)) Issuer must implement a Quality Improvement Strategy (QIS) that complies with the description in ACA § 1311(g)(1), i.e., uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, and implement wellness programs 	<p>Issuer will attest to compliance with future Federal quality and quality improvement standards developed for 2016</p>

Primary data submission method(s): <i>Attestation</i>	
Is information issuer- or QHP-specific?	<i>Issuer- or QHP-specific</i>
Does it apply to SADP's?	<i>Yes</i>

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
<p>Segregation of Funds for Abortion Services (ACA Section 1303(b)(2)(C), (D), and (E); 45 CFR 156.280; Pre-Regulatory Model Guidelines from OMB and HHS)</p>	<p>ACA bars the use of federal funds "attributable" to either the advance refundable tax credit or cost-sharing reduction for non-excepted abortions</p> <p>Issuer must create allocation accounts separating the portion of premiums/tax credits/cost-sharing subsidies for covered services <i>other</i> than non-excepted abortions from the premium amount equal to the actuarial value of the coverage of abortion services and exclusively use funds from these separate accounts to pay for the services for which the funds were allocated</p> <p>Issuer must submit a segregation plan detailing its process and methodology for meeting the ACA requirements describing the health plan’s financial accounting systems, including appropriate accounting documentation and internal controls, which would ensure the segregation of funds</p>	<p>Perform periodic financial audits of each QHP to assure compliance with Section 1303 of the ACA</p> <p>Issuer will annually attest to compliance comply with law and provide a segregation plan</p>

Primary data submission method(s): *Attestation; Supporting Documents (e.g., segregation plan)*

Is information issuer- or QHP-specific?

QHP-specific

Does it apply to SADP’s?

No

QHP Certification Requirements

Standard	Summary of Standard	Certification Approach
Past Complaints and Compliance (45 CFR 155.1000 (c)(2))	Exchange may certify a health plan as a QHP if it determines it is in the interest of qualified individuals and qualified employers in the State to do so	As part of the “interest” standard, perform an analysis of past compliance and complaints for existing insurers Existing data sources will be used for this analysis; issuers are not required to complete or upload any specific data for this standard

Primary data submission method(s): <i>None</i>	
Is information issuer- or QHP-specific?	<i>Issuer- or QHP-specific</i>
Does it apply to SADP’s?	Yes

Other Issuer and QHP Requirements

- In addition to the initial QHP certification requirements listed in the preceding sections, issuers must comply with several other requirements in the ACA and associated Federal rules initially and on an ongoing basis as a condition of participation in the Exchange.
 - Transparency requirements (45 CFR 155.1040; 45 CFR 156.220);
 - Enrollment period (45 CFR 155.410; 45 CFR 155.410);
 - Enrollment process for qualified individuals (45 CFR 156.265; 45 CFR 156.400 (d));
 - Termination of coverage of qualified individuals (45 CFR 155.430; 45 CFR 156.270);
 - SHOP-specific requirements (45 CFR 156.285);
 - Recertification and decertification (45 CFR 156.290); and
 - Other substantive and reporting requirements (45 CFR 156.200(b); 45 CFR 156.200(e); 45 CFR 155.1000(c)(2); 45 CFR 147.136; 45 CFR 156.245; 45 CFR 156.295)

Next Steps and Questions

- OIC to hold Issuer QHP Forum on March 5, 2013
- Issuers begin QHP submissions on Monday, April 1, 2013
- Additional questions?

WV OIC Qualified Health Plan Certification Checklist

Section	Criteria	Standard	OIC Reviewing Entity	Notes
§ 156.200	Silver/Gold Plans	Issuer must provide at least one silver and one gold plan in the HIX	Rates and Forms	Manual review
§ 156.200	Child-Only Plans	Any QHP issuer offering a non-catastrophic health plan in the Exchange must offer the identical plan as a child-only health plan	Rates and Forms	Manual review
§ 156.200	Licensed, Solvent, and in Good Standing	Existing OIC standards (e.g., issuer must be licensed, meet State solvency requirements, and have unrestricted authority to write its authorized lines of business in West Virginia State in order to be considered “in good standing” and to offer a QHP through the Exchange. Good standing means that the issuer has no outstanding sanctions imposed by the OIC (45 CFR 156.200(b)(4))	Financial Conditions	Financial Conditions will continue to review these requirements; insurers use their NAIC “co” code to access and submit filings in SERFF and cannot receive this code –and therefore submit a QHP filing in SERFF- unless Financial Conditions has licensed them; existing; Rates and Forms current protocol is to remain in constant communication with Financial Conditions regarding the solvency and good standing of companies and therefore will be aware of any potential concerns related to issuers submitting QHP applications
§ 156.200	Benefit Design Standards			
§ 156.110; 156.115; 156.120	<i>Essential Health Benefits</i>	Plan provides essential health benefits package and in accordance with ACA Section 1302(c)	Rates and Forms	Proposed EHB in WV is largest small group plan in WV, with modification to pediatric oral to reflect CHIP plan and FEDVIP OIC will confirm the following: <ul style="list-style-type: none"> • Issuer offers coverage that is substantially equal to the benchmark plan • Issuer has demonstrated actuarial equivalence of substituted benefits if the issuer is substituting benefits • Issuer provides required number of drugs per category and class EHB substitutions will require an actuarial certification to support that the substitutions are compliant and actuarially equivalent substitutions (45 CFR 156.115(b)(2))
§ 156.140; 156.135(b)(2); 156.150	<i>Actuarial Value Standards (including Silver Plan Variations)</i>	Meets specified AV requirements based on the cost-sharing features of the plan (+/- 2 percentage points): <ul style="list-style-type: none"> • Bronze plan – AV of 60 percent 	Rates and Forms	Issuer must submit the actuarial value calculation based on the Federal AV calculator (w/exception of unique plan designs and SADP’s) and indicate the plan metal level; OIC will confirm the actuarial value of the plan is submitted, complies with ACA

WV OIC Qualified Health Plan Certification Checklist

Section	Criteria	Standard	OIC Reviewing Entity	Notes
		<ul style="list-style-type: none"> • Silver plan – AV of 70 percent • Gold plan – AV of 80 percent • Platinum plan – AV of 90 percent • Catastrophic plan – NA <p>Unique plan designs have an actuarial certification indicating compliance with one of the calculation methods described in 45 CFR 156.135(b)(2)</p> <p>Standalone dental plans certified to meet a 75 percent AV are considered a “low” plan and anything with an AV of 85 percent is a “high” plan</p>		<p>requirements, and has been signed off by an actuary; the OIC will leverage additional support from UHA actuaries as needed</p>
<p>§ 156.130; 156.150</p>	<p><i>Annual Cost-Sharing Limitations</i></p>	<ul style="list-style-type: none"> • Out-of-Pocket Limits: The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014. • Deductibles: Employer-sponsored plans may not have a deductible in excess of \$2,000 for a plan covering a single individual or \$4,000 for other coverage. The deductible limit may be increased by the maximum amount of reimbursement reasonably available to an employee under a flexible spending arrangement. • Annual limitation on cost-sharing for a stand-alone dental plan considered separately; must demonstrate the annual limitation on cost-sharing for the stand-alone dental plan is 	<p>Rates and Forms</p>	<p>OIC will review plan data for compliance with ACA cost-sharing limitations</p>

WV OIC Qualified Health Plan Certification Checklist

Section	Criteria	Standard	OIC Reviewing Entity	Notes
		"reasonable" for coverage of the pediatric dental EHB		
§ 156.225; 156.200(e)	<i>Non-Discrimination</i>	Issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125) or on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR 156.200(e)) and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs (45 CFR 156.225(b))	Rates and Forms	Issuers will attest to non-discrimination Additional State standards for evaluation of compliance with non-discriminatory benefit design are still under development; OIC may conduct outlier tests to identify potentially discriminatory benefit designs when a Federal analytic tool becomes available
ACA § 1311(j))	<i>Mental Health Parity and Addiction Equity</i>	Must comply with the Mental Health Parity and Addiction Equity Act	Rates and Forms	OIC will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits
§ 147.102; 156.255; 156.210; 154.215; 155.1020	Rates	Issuers must limit variation in plan premiums to age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography Rates must remain the same for benefit year (individual) or plan year (SHOP); HIX must review the justification of a rate increase prior to the implementation of the increase, assure that increase is posted on the issuer website, and consider any excess rate growth outside the Exchange as compared to the rate of growth inside the HIX	Rates and Forms	The OIC will review rates for compliance with rating standards, as well as issuer attestations. For rate increases, a review of the Rate Filing Justification, including actuarial memorandum, will be performed Existing Rates and Forms processes using SERFF and existing staff resources will be leveraged for analysis of QHP rate data; the OIC will leverage additional support from UHA actuaries hired with Federal Rate Review Grant funds as needed

WV OIC Qualified Health Plan Certification Checklist

Section	Criteria	Standard	OIC Reviewing Entity	Notes
§ 156.275	Accreditation	HHS standards -in first year of certification, QHP issuers <u>without</u> existing accreditation must schedule accreditation and be accredited on QHP policies and procedures by the second year of certification; by the fourth year of certification, all QHP issuers must be accredited on the QHP product type; in the first	Rates and Forms	<p>Accreditation status will be confirmed by Rates and Forms via SERFF</p> <p>If not currently accredited, will require proof that they are seeking accreditation</p> <p>Issuers meeting accreditation standards in the initial year must authorize the release of accreditation survey data to the OIC and Exchange; issuers, regardless of accreditation status, must provide attestations including acknowledgment that, prior to 2016, CAHPS[®] data may be used on the Exchange Internet website and the website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid or Exchange product lines</p>
§ 156.230	Network Adequacy - General	A QHP's provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay	Financial Conditions	<p>An issuer must be accredited with respect to network adequacy by an HHS-recognized accrediting entity and attest to complying with the following standards to demonstrate it has an adequate range of providers for the intended service areas:</p> <ol style="list-style-type: none"> 1. Issuer will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2) 2. Issuer's network meets applicable WV network adequacy requirements as defined in West Virginia Informational Letter No. 112 3. Issuer's network reflects executed contracts for the year in which the issuer is applying <p>If the issuer is not accredited or is accredited but cannot respond affirmatively to each of the attestations, a network access plan must be submitted. In general, the access plan may include, but is not limited to, the information based on the NAIC Model Act #47 requirements</p>
§ 156.235	<i>Essential Community</i>	QHP issuers must include in their provider networks a sufficient number of essential community	Financial	Issuers must denote the ECP's with which they have contracts for each network for each service area

WV OIC Qualified Health Plan Certification Checklist				
Section	Criteria	Standard	OIC Reviewing Entity	Notes
	<i>Providers</i>	providers, where available, that serve low-income, medically-underserved individuals	Conditions	<p>Based on an HHS-developed ECP list, the OIC will verify one of the following:</p> <ul style="list-style-type: none"> • Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers • Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission. <p>Justifications submitted by issuers that fail to achieve either standard will undergo stricter review by the OIC.</p> <p>Issuers that provide a majority of covered services through employed physicians or a single contracted medical group must comply with the alternate standard established by the Exchange (45 CFR 156.235(b)), as follows:</p> <ul style="list-style-type: none"> • Issuer has at least the same number of providers located in designated low-income areas¹ • Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission
§ 155.1055	<i>Service Area</i>	<p>Minimum service area is set by county in WV</p> <p>Federal law requires the HIX ensure that the service area of a QHP covers at least a county, or a group of counties if the HIX designates such a group, unless</p>	Financial Conditions	Consistent with standards outside of the Exchange such as Medicaid managed care, HMO, and Workers' Comp. which are adequate to protect consumer interests and is a familiar standard with carriers

¹HHS will consider a low-income area a Health Professional Shortage Area (HPSA) or a zip code in which at least 30 percent of the population have incomes below 200 percent of the federal poverty limit.

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		the QHP issuer demonstrates that serving a partial county is necessary, nondiscriminatory, and in the interest of qualified individuals and employers		
§ 156.230 (a)(2))	<i>Mental Health and Substance Abuse Services</i>	Issuers must ensure that the provider network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay	Rates and Forms	Issuers must establish a standard to assure that the QHP network complies with the Federal standard and must include a copy of this standard in application; issuer must attest that the provider network for this QHP meets this standard
§ 156.230 (b))	<i>Provider Directory</i>	A QHP issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request	Rates and Forms	Issuers must provide their network names, IDs, and URL in a Network Template
§ 156.225; 156.200; 155.230; 156.250	Marketing, Applications, and Notices	<p>Issuers must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP; all QHP enrollee applications and notices must comply with Federal standards in 45 CFR 155.230 and 156.250, including being provided in plain language and language that is accessible to people with Limited English Proficiency and disabilities</p> <p>Issuers must also comply with existing standards related to advertising and marketing in WV based on the NAIC Model Act for Advertisement of Accident and Sickness Insurance (“WV Legislative Rules Title 114 Series 10”)</p>	Rates and Forms	<p>Rates and Forms will perform the evaluation of marketing/advertising standards after a carrier initially files a plan; OIC believes existing standards provide adequate protections to consumers while maintaining the same standards inside and outside of the Exchange ensures a level playing field</p> <p>Issuers must attest to compliance with the ACA requirements related to non-discrimination in marketing practices. Issuers must also submit a copy of all marketing materials, application, and notices for approval and provide a Certificate of Readability per WV 33-29-5</p>
§ 156.200	Quality/Quality Improvement	By 2016, HHS will develop a rating system that will rate QHPs offered through an Exchange in each benefits level on the basis of the relative quality and price (ACA § 1311(c)(3)) and an enrollee satisfaction survey system (ACA § 1311(c)(4)). In addition, issuers must implement a Quality Improvement Strategy (QIS) that complies with the description in ACA § 1311(g)(1), i.e., uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient	TBD	HHS intends to propose in future rulemaking that quality reporting requirements related to all QHP issuers (other than accreditation reporting) become a condition of QHP certification, beginning in 2016, based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act § 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h); the OIC will implement in accordance with forthcoming Federal guidance

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		safety, and implement wellness programs		
§ 156.280	Segregation of Funds for Abortion Services	<p>Issuers must segregate premiums for which public funding is prohibited into a separate account that consists solely of such payments and that is used exclusively to pay for those services</p> <p>Segregation plan must detail process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) and comply with generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget and guidance on accounting of the GAO</p>	Rates and Forms	Attestation of compliance from issuer plus issuer must submit segregation plan
§ 155.1000 (c)(2)	Past Compliance and Complaints	<p>The Exchange may certify a health plan as a QHP if it determines it is in the interest of qualified individuals and qualified employers in the State to do so</p> <p>As part of the “interest” standard, the OIC may perform an analysis of past compliance and complaints for existing insurers. Level 1 Market Analysis includes 15 standard questions related to complaints, regulatory activities, etc.</p>	Market Conduct and Consumer Services	<p>Analysis will include review of past compliance and complaints for existing insurers (even if previously licensed in other states only); OIC feels this additional layer of analysis is in the best interest of WV consumers</p> <p>When QHP application is received by Rates and Forms, the analyst notifies Market Conduct and Consumer Services that an application has been received and Market Conduct has 30 days to perform the analysis and notify Rates and Forms of results</p>
<i>Items in the following section will be reviewed as attestations from the issuer. The list is not exhaustive and additional attestations may be required by the OIC or HHS.</i>				
§ 156.200	Applicable User Fees	Issuer must pay all applicable user fees	Rates and Forms	Attestation of compliance from issuer
§ 156.200	Risk Adjustment	Agrees to comply with participation requirements as described in 45 CFR part 153	Rates and Forms	Attestation of compliance from issuer
§ 156.200	Premium Equivalence	Premium rate charged is the same whether the plan is offered through the HIX, directly from the issuer or through an agent	Rates and Forms	Attestation of compliance from issuer
§ 156.220	Transparency in Coverage	Issuers must make available to the public and submit to the HIX, HHS, and the State insurance commissioner the following disclosures: (1) Claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment; (4) data on disenrollment; (5) data on the number of	TBD	The OIC is awaiting Federal guidance on standards for QHP collection and ongoing reporting of transparency

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Section	Criteria	Standard	OIC Reviewing Entity	Notes
		claims that are denied; (6) data on rating practices; (7) information on cost-sharing and payments with respect to any out-of-network coverage; and (8) information on enrollee rights under title I of the ACA		
§156.260, §156.265	Enrollment Period and Process	Issuers must accept and enroll individuals during the initial open enrollment period, during the annual open enrollment period, and during special enrollment periods; must adhere to the effective dates of coverage established in §155.410; must provide enrollees with notice of effective dates of coverage Issuers must adhere to the HIX process for enrollment, use and accept the HIX application, abide by the HIX premium payment process, etc.	Rates and Forms	Attestation of compliance from issuer
§156.270	Termination of Coverage	Issuer may terminate coverage for non-payment of premium, fraud and abuse, and relocation outside of the service area; must provide the enrollee with a notice of termination of coverage at least 30 days prior to termination; must provide for a grace period, etc.	Rates and Forms	Attestation of compliance from issuer
§ 156.285	SHOP-Specific Criteria	Issuer must accept aggregated premiums, abide by the rate setting timeline established by the SHOP and charge the same contract rate for a plan year; abide by small group enrollment periods and processes and termination processes	Rates and Forms	Attestation of compliance from issuer
§ 156.290	Non-Renewal and Decertification	Issuer must notify HIX of non-renewal prior to beginning of recertification process; continue providing the HIX with reporting information for the benefit or plan year even after withdrawing its QHP; for decertification, provide written notice to each enrollee; terminate coverage for enrollees only after the HIX has notified the QHP's enrollees and enrollees have had the opportunity to enroll in other coverage	Rates and Forms	Attestation of compliance from issuer
§ 156.295	Prescription Drug Distribution and Cost	Provide to HHS information on the distribution of prescription drugs, pharmacy benefit management activities, the collection of rebates	Rates and Forms	Attestation of compliance from issuer

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Section	Criteria	Standard	OIC Reviewing Entity	Notes
	Reporting	and other monies in conducting these activities, and costs incurred to provide those drugs		

WV OIC Exchange Complaint Resolution Process

Draft October 18, 2012



Exchange customer submits a complaint about the Exchange;
a QHP; or a Navigator, Agent, or Marketplace Assister (MA)

