

DRAFT: Qualified Health Plan Submission Guide v1.0

West Virginia Offices of the Insurance Commissioner
February 2013

Table of Contents

Section I. General Information and Background.....	3
1.1 Purpose	3
1.2 Context	3
1.3 General Exchange Participation Requirements	4
1.4 Timetable	4
1.5 Contact Information	5
Section II. Specifications for QHP Certification	6
2.1 Issuer Administrative Information.....	6
2.2 Licensure, Solvency, and Standing.....	7
2.3 Benefit Standards and Product Offerings	8
2.3.1 Essential Health Benefits	8
2.3.2 Annual Cost-Sharing Limitations	9
2.3.3 Actuarial Value	10
2.3.4 Non-Discrimination.....	11
2.3.5 Mental Health Parity and Addiction Equity Act	11
2.4 Rating Factors and Rate Increases	12
2.5 Accreditation Standards.....	13
2.6 Network Adequacy and Provider Data.....	14
2.6.1 General	14
2.6.2 Essential Community Providers	15
2.6.3 Mental Health and Substance Abuse Services	17
2.6.4 Service Area.....	17
2.6.5 Provider Directory	18
2.7 Marketing, Applications, and Notices.....	18
2.8 Quality Standards	18
2.9 Segregation of Funds for Abortion Services	19
2.10 Past Complaints/Compliance.....	20
2.11 Other Issuer and QHP Requirements	21
2.12 Summary of Required Attachments	21
Section III. Attestations.....	23
3.1 West Virginia Requirements	23
3.2 HHS Requirements.....	23
Section IV. Appendices	33

Appendix A. QHP Certification Checklist 33
Appendix B. Reference Table for Federal Requirements 48

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): CCIIO 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	<ul style="list-style-type: none"> <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	 45 CFR §155.410(b) 45 CFR §155.410(e) 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.	 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