

Certification of Qualified Health Plans (QHP) Cheat Sheet

Affordable Care Act (ACA) Requirements for QHPs:

- Meet criteria for certification
- Provide Essential Health Benefits (EHB) package
- Includes QHPs offered through CO-OPs and multi-state plans

ACA Requirements for Health Insurance Issuers Offering QHPs:

- Licensed and in good standing in each state where offering QHPs
- Agrees to offer at least one silver and one gold QHP
- Agrees to charge the same premium inside and outside the exchange
- Complies with federal regulations and applicable exchange requirements

Certification of QHPs (Proposed Rules, Part 155, Subpart K, 77 Fed Reg 19310, Mar 27, 2012)

- Certification standards. Only certified QHPs can be offered on an exchange. To be certified, QHPs must comply with minimum certification requirements (see below) and must be determined to be in the interest of qualified individuals and employers.
- Certification process. Prior to the beginning of the open enrollment period, the exchange must establish procedures and monitoring of issuers for ongoing compliance with certification requirements. CO-OPs and multi-state plans must be recognized as QHPs.
- Rate and benefit information. The exchange must receive justification for rate increases before implementing increases, and on an annual basis, receive rates, covered benefits, and cost-sharing requirements.
- Transparency. The exchange must collect information relating to coverage transparency (see below) and monitor whether an issuer has made cost-sharing information available upon request.
- Accreditation. The exchange must establish a uniform period in which an issuer must become accredited.
- Network adequacy standards must be established.
- Service area. The exchange must have a process to establish or evaluate service areas to ensure the service area meets minimum criteria.
- Stand-alone dental plans. The exchange must allow the offering of certain dental benefits.
- Recertification process. The exchange must establish a recertification process that includes general certification criteria, to be completed on or before Sept. 15 of the applicable calendar year. CO-OPs and multi-state plans are exempt from recertification.
- Decertification process. The exchange must establish a decertification (including appeal) process for issuers who are out of compliance with general certification criteria. Notice of decertification must be provided to the issuer, enrollees, HHS, and the state department of insurance. CO-OPs and multi-state plans cannot be decertified.

Minimum Certification Standards for QHPs (Proposed Rules, Part 156, Subpart C, 77 Fed Reg 18310, Mar 27, 2012)¹

- Issuer participation standards – comply with exchange processes, procedures and requirements; ensure QHP compliance with benefit design standards; licensed and in good standing to offer coverage; implement and report on quality improvement strategies; pay applicable fees; comply with risk adjustment standards.
- Rates and benefits – must be set for an entire benefit/plan year. Rate and benefit information must be submitted to the exchange, and rate increase justification must be submitted prior to the implementation of an increase.
- Transparency in coverage – plain language information/data on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights must be submitted to the exchange, HHS, and the state insurance commissioner.
 - Information about enrollee cost-sharing under an individual's plan or coverage must be made available upon request.
- Marketing and benefit design – QHP issuers must comply with state marketing laws and regulations. Marketing practices and benefit designs that discourage enrollment of individuals with significant health needs cannot be used.

¹ Additional SHOP standards (§156.285) are addressed in a separate summary.

- Network adequacy – include essential community providers, comply with standards established by the exchange and federal law, and make the provider directory available online (including providers that are not accepting new patients).
- Essential community providers – QHP issuer must have a sufficient number and geographic distribution of a broad range of essential community providers.
- Direct primary care medical homes – QHP issuers may provide coverage through direct primary care medical homes.
- Applications and notices – all applications and notices must meet readability and accessibility standards.
- Rating variations – premiums may be varied by the geographic rating area, but premium rates must be the same inside and outside the exchange.
 - Rating categories: individuals, two-adult families, one-adult families with child/children, all other families.
 - ACA: premium rate may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1)
- Enrollment periods – initial and annual open enrollment periods, as well as special open enrollment periods.

Notification of effective date of coverage is required.
- Enrollment process – enrollment information must be collected and transmitted to the exchange, and enrollment files must be reconciled with exchange enrollment files monthly.
- Termination of coverage – notice must be provided for termination of coverage. A standard policy for termination of coverage must be established and must include a grace period for certain enrollees and be applied uniformly. Notice of payment delinquency must be provided. Records of termination of coverage must be maintained.
- Accreditation – A QHP issuer must maintain accreditation so long as it offers QHPs.

Categories for accreditation include clinical quality measures, patient experience rating, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.
- Segregation of funds – QHP issuers must comply with state law that prohibits abortion coverage. Federal funds cannot be used for abortion services except in certain cases.
- Non-renewal – If a QHP issuer does not seek recertification, it must notify the exchange, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice.
- Decertification – If a QHP is decertified by the exchange, the QHP issuer must terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage.
- Prescription drugs – distribution and cost-reporting required for prescription drugs.