



Date: [date]

From: [name, title], Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

Title: Affordable Exchanges Guidance 2013-[#]

Subject: Annual Letter to States and Issuers on 2014 Market Reforms; Federally-facilitated and State Partnership Exchanges

The Centers for Medicare & Medicaid Services (CMS) is issuing the first Annual Letter to states and issuers (Annual Letter). This year's Annual Letter serves two primary purposes. First, the Annual Letter provides additional guidance to states and issuers of individual and small group market plans regarding 2014 market reforms – in particular, coverage of essential health benefits (EHB) and actuarial value (AV). Second, the Annual Letter provides Qualified Health Plan (QHP) issuers in Federally-facilitated Exchanges (FFE) and Federally-facilitated SHOPS (FF-SHOP), including State Partnership Exchanges, with operational and technical guidance to help them successfully participate in Exchanges.

As indicated in previous guidance, states where a State Partnership Exchange is operating have flexibility to apply certification standards and adjust processes. Throughout the Annual Letter we identify the areas in which states participating in a State Partnership Exchange have some flexibility to follow a different approach from the approach articulated in this guidance, and direct issuers to the appropriate source for information and guidance (e.g., CMS or the state). We note that the policies articulated in this Annual Letter apply to the 2014 coverage year. In future years, CMS will use the Annual Letter to communicate pertinent policy developments related to market-wide standards and provide operational updates to QHP issuers.

CMS has previously provided guidance on market-wide and QHP certification standards, eligibility and enrollment functions, and other Exchange-related topics in several phases. A list of the most relevant regulations and guidance documents is included in Appendix B. These materials provide the basis for much of the operational guidance included in this Annual Letter.

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Issuers are advised to consult these materials in conjunction with the Annual Letter to ensure full compliance with the requirements of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (together referred to as the Affordable Care Act), as implemented. These and other regulatory and guidance materials are available at <http://cciio.cms.gov/resources/regulations/index.html>.

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Table of Contents

| | |
|--|------------------|
| <u>Chapter 1: 2014 Market Reforms for Individual and Small Group Plans.....</u> | <u>3</u> |
| SECTION 1. MARKET REFORMS | 3 |
| SECTION 2. ESSENTIAL HEALTH BENEFITS..... | 3 |
| SECTION 3. EHB PRESCRIPTION DRUG COVERAGE..... | 5 |
| SECTION 4. ACTUARIAL VALUE | 6 |
| SECTION 5. CALCULATING THE ACTUARIAL VALUE OF UNIQUE PLAN DESIGNS..... | 6 |
| SECTION 6. ANNUAL LIMITATIONS ON DEDUCTIBLES FOR EMPLOYER-SPONSORED HEALTH PLANS IN THE SMALL GROUP MARKET..... | 7 |
| SECTION 7. ANNUAL LIMITATION ON COST SHARING | 8 |
| SECTION 1. NETWORK ADEQUACY AND INCLUSION OF ESSENTIAL COMMUNITY PROVIDERS..... | 8 |
| SECTION 2. ACCREDITATION..... | 11 |
| SECTION 3. NON-DISCRIMINATION BY QHPs | 11 |
| SECTION 4. CONSIDERATION OF RATE INCREASES | 12 |
| SECTION 5. REVIEWS UNDER THE “INTEREST TEST”..... | 12 |
| REVIEW OF RATES | 13 |
| REVIEW FOR MEANINGFUL DIFFERENCE | 13 |
| <u>Chapter 3: Qualified Health Plan Certification Process in FFEs, including State Partnership Exchanges.....</u> | <u>15</u> |
| SECTION 1. QHP APPLICATION AND CERTIFICATION PROCESS IN NON-PARTNERSHIP FFEs..... | 15 |
| SECTION 2. QHP CERTIFICATION PROCESS IN A PLAN MANAGEMENT STATE PARTNERSHIP EXCHANGE | 16 |
| SECTION 3. QHP AGREEMENT..... | 17 |
| SECTION 4. FFE QHP ANNUAL REVIEW AND RECERTIFICATION..... | 17 |
| SECTION 5. CERTIFICATION OF STAND-ALONE DENTAL PLANS..... | 18 |
| SECTION 6. CERTIFICATION OF CO-OPS FOR ALL EXCHANGES..... | 18 |
| SECTION 7. OPM MULTI-STATE PLANS | 18 |
| <u>Chapter 4: Qualified Health Plan Performance and Oversight.....</u> | <u>20</u> |
| SECTION 1. ACCOUNT MANAGEMENT..... | 20 |
| SECTION 2. QHP ISSUER COMPLIANCE AND OVERSIGHT..... | 20 |
| SECTION 3. QHP MARKETING | 20 |
| <u>Chapter 7: Consumer Support.....</u> | <u>30</u> |

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| | |
|---|------------------|
| <u>SECTION 1. CALL CENTER AND WEBSITE.....</u> | <u>30</u> |
| <u>SECTION 2. CONSUMER EDUCATION.....</u> | <u>30</u> |
| <u>SECTION 3. PROVIDER DIRECTORY</u> | <u>30</u> |
| <u>SECTION 4. COMPLAINTS TRACKING AND RESOLUTION.....</u> | <u>30</u> |
| <u>SECTION 5. COVERAGE APPEALS.....</u> | <u>31</u> |
| <u>Chapter 8: Tribal Relations and Support.....</u> | <u>34</u> |
| <u>SECTION 1. MODEL CONTRACT ADDENDUM FOR TRIBAL ISSUERS WORKING WITH INDIAN PROVIDERS.....</u> | <u>34</u> |
| <u>SECTION 2. TRIBAL SPONSORSHIP OF PREMIUMS.....</u> | <u>34</u> |

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Chapter 1: 2014 Market Reforms for Individual and Small Group Plans

Beginning in the plan or policy year 2014, all non-grandfathered¹ individual and small group market plans will become subject to additional market reforms, including reforms related to rating and availability of coverage, and will be required to cover EHB and meet AV levels specified in the Affordable Care Act. The following sections provide additional guidance to states and issuers on provisions of CMS's Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule ("EHB/Accreditation Final Rule"). In addition, these sections outline how CMS will review plans for compliance with EHB and AV standards if a state notifies CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" these provisions, or if CMS determines that a state is not substantially enforcing these requirements.

States are the primary regulators of health insurers and are responsible for enforcing the market reform provisions in title XXVII of the Public Health Service (PHS) Act both inside and outside the Exchanges. Issuers should follow state guidance and processes for review that a state conducts. States may adopt CMS's planned approach, but are not required to do so. To assist states that wish to use CMS's approach, CMS will provide several analytic tools that states may use, including an automated drug count service, benefit templates, and detailed guidance on reviewing any benefit substitutions for actuarial equivalence.

Under §§ 2723 and 2761 of the Public Health Services (PHS) Act and existing regulations, 45 C.F.R. Part 150. CMS is responsible for enforcing the provisions of Parts A and B of title XXVII of the PHS Act in a state if a state notifies CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the provisions, or if CMS determines that the state is not substantially enforcing the requirements. Although this enforcement scheme remains the same for the new 2014 requirements as it was under the Health Insurance Portability and Accountability Act (HIPAA), the market will be much different. Therefore, there will be an increased need for consistent market-wide state enforcement to ensure a level playing field and minimize or eliminate opportunities for adverse selection.

States can use their existing framework and tools to monitor compliance with the market reform requirements. Examples of such tools include policy form review, market conduct examinations, market analysis, as well as CMS-developed analytic tools such as the AV calculator and plans and benefits template for EHB review.

¹ "Grandfathered" and "non-grandfathered" health plans are defined in Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (published at 75 FR 34538 – 34570; June 17, 2010).

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If a state notifies CMS that it has “not enacted legislation to enforce or that it is not otherwise enforcing” one or more of the provisions, or if CMS determines that the state is not substantially enforcing the requirements, CMS is responsible for enforcing the requirements of Parts A and B of title XXVII of the PHS Act. If CMS is the primary enforcer for these requirements in a state, CMS will seek to accomplish its direct enforcement of the group and individual market reforms through a collaborative arrangement with the state. To the extent that CMS and a state agree on a collaborative approach, issuers would continue working directly with the state to ensure compliance with these requirements. Under a collaborative arrangement, if the state were not able to achieve compliance with the market reform requirements, the state would notify CMS, and CMS would notify issuers of the concern. If CMS is enforcing these requirements in a state without an agreed upon CMS/state collaborative enforcement arrangement, CMS will notify issuers in the respective state that issuers must submit policy forms to CMS for review. CMS will collect policy forms from issuers in such state, and review those policy forms for compliance with the respective market reform provision(s) and will notify issuers of any concerns. CMS will also conduct targeted market conduct examinations, as necessary, to ensure compliance.

Where states are enforcing EHB and AV standards, FFEs will not duplicate these reviews as part of QHP certification provided that a state can and does share its findings with CMS. For more information on the QHP certification process, please see Chapter 3.

SECTION 1. MARKET REFORMS

This section describes how CMS will interpret and apply health insurance market reforms that apply to all issuers of non-grandfathered individual and small group market plans.

The market reforms (sections 2701, 2702 and 2703 of the PHS Act, as added and amended by the Affordable Care Act, and sections 1302(e) and 1312 (c) of the Affordable Care Act) provide new rating parameters for health insurance premiums, extend guaranteed availability (also known as guaranteed issue) protections to the individual market; continue current guaranteed renewability protections; prohibit issuers from dividing their insurance risk pools; clarify the approach used to enforce the applicable requirements of the Affordable Care Act with respect to health insurance issuers and group health plans that are non-federal governmental plans; and provide coverage and enrollment guidelines for catastrophic plans.

i. *Interaction with State Law*

Pursuant to PHS Act section 2724(a)(1), a state law is preempted only if it prevents the application of a provision of the Affordable Care Act. State laws that provide more consumer

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protections are not preempted. For example, 45 C.F.R. §147.102(a)(1)(iv) provides that health insurance issuers in the individual and small group markets cannot vary rates based on tobacco use by more than 1.5:1. A state law that prescribes a wider ratio (for example, 3:1) would be preempted. However, a state law that prescribes a narrower ratio (for example, 1.25:1) or prohibits varying rates for tobacco use altogether would not be preempted, because such state law would not prevent the application of PHS Act section 2701.

ii. *Transition of Enrollees in State High Risk Pools*

Many states currently have high risk pools to provide insurance coverage for individuals that meet certain enrollment criteria and do not otherwise have access to health insurance. Because state high risk pool coverage is not insurance and is not group health plan coverage, state high risk pool coverage is not subject to the provisions of the PHS Act. If a state, however, requires guaranteed issue of certain individual market products by issuers or issuers of last resort as their state alternative mechanism, that coverage may be subject to the provisions of the PHS Act. PHS Act section 2704 prohibits group health plans and health insurance issuers from offering group or individual health insurance coverage that imposes preexisting condition exclusions with respect to such plan coverage after January 1, 2014. All individuals, including those enrolled in state high risk pools, will have a right to guaranteed issue for any products offered inside and outside of Exchanges. Each state will continue to have the discretion to determine whether it will continue to operate a high risk pool. States may not prevent individuals, however, from purchasing other products offered inside or outside the Exchange. CMS will provide additional guidance on the transition of Pre-Existing Condition Insurance Program (PCIP) enrollees in the future.

SECTION 2. ESSENTIAL HEALTH BENEFITS

This section provides additional guidance on EHB standards and describes how CMS will evaluate plans for compliance. States that are enforcing EHB standards may use a similar approach.

i. *Benefit Design*

Section 1301(a)(1)(B) of the Affordable Care Act, section 2707(a) of the PHS Act, and 45 C.F.R. Part 156, Subpart B require non-grandfathered health plans offered in the individual and small group markets, both inside and outside of Exchanges, to cover a core package of items and services, known as EHB. In the EHB/Accreditation Final Rule, CMS describes its approach to defining EHB by reference to a state-specific benchmark plan. Specifically, 45 C.F.R. §156.115 defines the EHB standard that the covered benefits and limits in all non-grandfathered individual and small group market plans be “substantially equal” to the covered benefits and limits in the applicable state-specific benchmark plan. The substantially equal standard gives issuers

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flexibility to offer slightly different benefits from those offered by the benchmark while still meeting the requirement to offer EHB. This flexibility should increase consumer choice and prevent market disruption.

In addition to the flexibility afforded issuers under the substantially equal standard, 45 C.F.R. § 156.115(b) sets forth a policy allowing substitution of a benefit or set of benefits subject to certain constraints and if not otherwise prohibited by a state. Specifically, a substituted benefit or set of benefits must be actuarially equivalent to the benefits being replaced. Further, substitution can only occur within benefit categories, not between different benefit categories. For example, prescription drug benefits cannot be substituted; however, drugs within categories may be substituted. Among other substitution requirements, an issuer that substitutes a benefit or set of benefits must provide an actuarial certification to the state attesting that the substituted benefits are actuarially equivalent to the benefits being replaced. Section 156.115(b) requires evidence of actuarial certification. This means that an actuary certified by the American Academy of Actuaries must confirm that the covered benefit is actuarially equivalent to the substituted benefit based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

An issuer seeking certification in an FFE will use the plans and benefits template embedded in the QHP Issuer Application to indicate where it has determined that its benefits are substantially equal to those offered by the benchmark or has substituted a benefit within a statutory category. In the case of a substituted benefit, the issuer will be prompted to upload a certification demonstrating actuarial equivalence.

ii. Non-discrimination in the Provision of Essential Health Benefits

45 C.F.R. § 156.125, which codifies section 1302(b)(4) of the Affordable Care Act, prohibits issuers providing EHB from employing or implementing benefit designs that have the effect of discriminating against individuals based on age, expected length of life, present or predicted disability, quality of life, or other health conditions. Similar to other EHB standards, the non-discrimination requirements are subject to state enforcement. QHPs seeking Exchange certification must meet additional non-discrimination standards generally related to plan cost sharing. Chapter 2, Section 3 provides more information on non-discrimination standards for QHPs.

Consistent with the general framework outlined at the beginning of this Chapter, CMS will only conduct a non-discrimination analysis on EHB where a state is not enforcing these standards. Each Exchange will be responsible for enforcing non-discrimination standards for QHPs. Where CMS is reviewing EHB coverage for non-discrimination, CMS will compare benefit designs for outliers on the limits and restrictions, such as visit limits and prior authorization requirements,

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associated with specific benefits, including those listed below. CMS will also review language contained in the “explanations” and “exclusions” portions of the plans and benefits template with the objective of identifying anomalies or wording. For example, discriminatory language could involve reduction in the generosity of a benefit in some manner or structural barriers to access or coverage for subsets of individuals that are not based on clinically indicated common medical management techniques. States may consider adopting this or a similar approach.

Where CMS is reviewing EHB coverage for non-discrimination, CMS’ analysis will focus on specific benefits including:

- i. Inpatient hospital stays,
- ii. Inpatient mental/behavioral health stays,
- iii. Specialist visits,
- iv. Pregnancy and newborn care,
- v. Specific conditions including behavioral health conditions such as mental health disorders and substance abuse, and.
- vi. Prescription drugs.

CMS will allow issuers to address any benefits flagged as potentially discriminatory during CMS’s review by providing an opportunity to modify any flagged benefit field(s) or submitting justifications.

CMS or a state may pursue complaints or allegations of benefits-related discrimination under available state or federal processes, even if an issuer’s benefit design or implementation is not flagged as potentially discriminatory as part of this review.

SECTION 3. EHB PRESCRIPTION DRUG COVERAGE

This section provides additional guidance on EHB standards and describes how CMS will evaluate plans for compliance. States that are enforcing EHB standards may use a similar approach.

i. Drug Count Service

45 C.F.R. § 156.122 requires a health plan providing essential health benefits to cover at least the greater of 1) one drug in every United States Pharmacopeial Convention (USP) Model category and class, or 2) the same number of prescription drugs in each category and class as the EHB-benchmark plan. A drug is considered covered if the health plan pays for all or part of the drug regardless of tiers and cost sharing. The specific drugs covered on each health plan’s formulary may vary as long as the minimum number in each category and class is met. For example, if a

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benchmark plan covers Clarinex (desloratadine) but not Patanase (olopatadine), a plan providing EHB could cover Patanase (olopatadine) but not Clarinex (desloratadine) because both of those drugs are in the same category. Similarly, if a benchmark plan covers five drugs in the antihistamines class and a plan providing EHB covers five different drugs in the Antihistamines class, this plan would also meet the standard.

CMS computed the number of chemically distinct drugs covered by each EHB benchmark by category and class by cross-walking NDC codes to categories and classes using the USP Model Guidelines version 5.0. Consistent with the Medicare Part D requirement that formularies include at least two chemically distinct drugs in each category and class, different dosages of the same drug, different concentrations of the same active ingredient, brands and their generic equivalents, extended release and non-extended release formulations, and different delivery methods of the same drug (e.g., injectable versus oral) were counted as one drug.

Table 1.1 Examples of Chemically Distinct and Not Chemically Distinct Drugs

| Chemically Distinct (counted as two drugs) | Not Chemically Distinct (counted as one drug) |
|---|---|
| <ul style="list-style-type: none"> Ⓟ Ibuprofen oral tablet and naproxen oral tablet Ⓟ Epivir (lamivudine) oral tablet and Epzicom (abacavir and lamivudine) oral tablet | <ul style="list-style-type: none"> Ⓟ Brand name Aricept (donepezil hydrochloride) and generic donepezil hydrochloride Ⓟ Ritalin LA (methylphenidate hydrochloride) 20 mg extended release capsule and Ritalin 20 mg oral tablet Ⓟ Penicillin oral solution, Penicillin oral tablet |

CMS is developing a count service that will compute the number of drugs per category and class offered by an EHB-compliant formulary. States may elect to use CMS's drug count service to review plan formularies, if desired. CMS notes that formularies that include more than the minimum number of required drugs would not be considered to provide benefits in excess of EHB, because this scenario is similar to offering more generous coverage of the same benefit or a more robust provider network.

ii. Prescription Drug Exceptions Process

Some enrollees will likely require a prescription drug that is not on the plan's covered drug list. Therefore, 45 C.F.R. § 156.122(c) establishes that a health plan providing EHB must have procedures in place that allow an enrollee to request and access clinically appropriate drugs not covered by the health plan. The exceptions process outlined below is distinct from the exceptions process described in PHS Act section 2719, which is described further in Chapter 7.

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CMS realizes that most commercial health plans already have an exceptions process in place. Those plans may continue to use their current processes, so long as the existing processes allow an enrollee to request both an internal and an independent review of the exception request. CMS encourages issuers to utilize the following process:

- ⌚ Step 1 – Internal review: The issuer would consider an exception request (made verbally or in writing within 60 calendar days following notification of the denial, by an enrollee, enrollee’s representative, or prescriber on behalf of an enrollee) and provide verbal notification of its determination as expeditiously as an enrollee’s health condition requires, but no later than 72 hours (“standard decision”), or 24 hours (“expedited decision”) after the request is received if the enrollee is suffering from a serious health condition. The issuer would provide its decision in writing no later than 48 hours after verbal notice has been given. The issuer would also advise the consumer about his or her ability to request an independent review.
- ⌚ Step 2 – Independent review: If the issuer denies the exception request in Step 1, the enrollee (or enrollee’s representative or prescriber) may request, orally or in writing, a second review, within 60 calendar days of the internal review decision. The independent review entity (IRE) contracted by the issuer to review the exception request denial would make a decision within the same timeframes described in Step 1. The IRE’s decision would be provided in writing no later than 48 hours after verbal notice has been given.

Consistent with the Medicare Part D program, CMS suggests that a drug is clinically appropriate, and should be covered, if an oral or written supporting statement is submitted from a prescriber, and establishes that the requested prescription drug is clinically appropriate to treat the enrollee's disease or medical condition, based on one or more of the following criteria:

- i. All of the covered drugs on any tier of the plan’s covered drug list for treatment for the same condition would not be as effective for the enrollee as the requested drug, and/or would have adverse effects for the enrollee, or
- ii. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition or,
 - b. Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

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- iii. The prescription drug alternative(s) listed on the covered drug list or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
 - b. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

As part of the required exceptions process, CMS strongly encourages plans offering EHB to allow the enrollee to have the medication in dispute during the entire review process and, if the exception request is granted, to allow the enrollee to have access to the non-covered drug in subsequent plan/policy years should enrollment continue without interruption.

SECTION 4. ACTUARIAL VALUE

This section provides additional guidance on AV standards.

The Affordable Care Act requires issuers offering non-grandfathered health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered plan meets a distinct level of coverage, or AV, specified in section 1302—bronze, silver, gold, or platinum (also known as “metal tiers”). Issuers may also offer catastrophic-only coverage to certain eligible individuals.

45 C.F.R. § 156.135 sets forth regulations for issuers to meet these AV standards. Specifically, §156.135(a) requires that all issuers of non-grandfathered plans in the individual and small group market use an AV Calculator² developed by CMS to determine the AV and corresponding metal tier of all plans.³ Section 156.140(c) establishes a de minimis variation of +/- 2 percentage points (+/-1 percentage points for certain silver level plans) from the AV established metal tier levels (i.e., 60 percent, 70 percent, 80 percent, and 90 percent). CMS is providing the AV Calculator in two formats, as described below: a formal, integrated format for use by state

² The AV Calculator is available at: <http://cciio.cms.gov/resources/regulations/index.html#hie>.

³ The AV Calculator and more information on its development including a detailed methodology document available at <http://cciio.cms.gov/resources/regulations/index.html>.

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regulators and CMS in evaluating plans for compliance with AV standards, and a stand-alone format for issuers to use in product development and design.

i. Integrated AV Calculator for Formal Submission and Review

The AV Calculator will be integrated into both the Health Insurance Oversight System (HIOS) and the System for Electronic Rate and Form Filing (SERFF) so that states and CMS can evaluate plans for compliance with AV standards on an automated basis. Issuers will first complete the plans and benefits template and submit the information through HIOS or SERFF; the plans and benefits template will directly populate the AV Calculator to determine a plan's AV and corresponding metal tier. A plan's results from the AV Calculator will be displayed automatically in SERFF or HIOS.

States that do not use SERFF or HIOS will determine their own processes for issuers to use the AV Calculator.

ii. Stand-alone Tool for Product Development

To assist issuers in designing plans and preparing to submit data for formal evaluation by states or CMS, CMS has made available a stand-alone version of the AV Calculator. The stand-alone format of the calculator will return the same results as the integrated format for the same plan data. AV results derived from the stand-alone tool will not be collected by CMS.

SECTION 5. CALCULATING THE ACTUARIAL VALUE OF UNIQUE PLAN DESIGNS

This section provides additional guidance on AV standards and describes how CMS will evaluate plans for compliance. States that are enforcing AV standards may use a similar approach.

Although the AV Calculator has been designed to accommodate the vast majority of plan designs, there is the possibility that the Calculator will not be able to accommodate a small percentage of plan designs. Under 45 C.F.R. § 156.135(b), issuers with unique plan designs will need to use an alternate method to calculate AV, as described below.

For example, the following types of plan designs could be considered "unique," for purposes of determining AV:

Example 1: A plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10 percent coinsurance for the first \$1,000 in consumer spending after the deductible, 20 percent coinsurance for the next \$1,000 in consumer spending, and 40 percent coinsurance up to a \$6,400 out-of-pocket maximum. This plan design would be considered "unique" because the current AV Calculator can accommodate only a single coinsurance rate for each benefit.

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Example 2: A plan with a multi-tiered provider or hospital network with substantial amounts of utilization expected in tiers other than the two lowest-priced tiers. This plan design would be considered “unique” because the current AV Calculator does not take into account utilization beyond the second network tier when computing AV.

Generally, a plan design that includes different cost sharing for services not included in the AV Calculator would not be considered to be unique. For example, advanced imaging is a single cost-sharing input in the Calculator; a plan design would not be considered unique because it assigns different copayment amounts to different types of imaging (e.g., MRI versus CT). Similarly, because the AV Calculator does not consider quantitative or qualitative limits for any benefit, the application of limits to a particular benefit would generally not necessitate one of the alternative methods for AV calculation.

To account for these “unique plan designs” and ensure that requiring the use of the AV Calculator allows for plan innovation, 45 C.F.R. § 156.135(b) provides two alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AV Calculator. Issuers of such plans must:

- ⌚ Make adjustments to certain key plan design features to input a modified plan design that fits into the parameters of the AV Calculator, and have an actuary certify that the plan design was appropriately fit into the parameters of the AV Calculator; or
- ⌚ Use the AV Calculator to determine the AV for plan provisions that do fit within its parameters, and then have an actuary calculate appropriate adjustments to the Calculator-generated AV to account for remaining plan features. For example, a plan with reference pricing for prescription drugs could use the Calculator to determine the AV for the medical benefits in its plan and then make adjustments to reflect its prescription drug benefits.

Both of the AV calculation methods for evaluating “unique plan designs” must be certified by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies.

i. Review of Unique Plan Designs

If an issuer uses either of the two alternate methods for calculating AV just described, the issuer must submit an actuarial certification to the reviewing entity. Where CMS is reviewing plans for compliance with AV standards, CMS will conduct a two-part review of this actuarial certification. First, CMS will evaluate the plan design to verify that it is unique for purposes of the AV calculation. Second, CMS will verify that the actuarial certification was completed by a member of the American Academy of Actuaries and conduct a review to ensure that the

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calculation was made in accordance with generally accepted actuarial principles and methodologies.

Both SERFF and HIOS will allow an issuer to upload an actuarial certification, if necessary. States that do not use SERFF or HIOS will determine an alternate process for collecting any required certifications.

i. *Family Plan Design*

The AV Calculator standard population and claims data were developed using claims data that did not include any family cost-sharing information. Issuers of plans with deductibles and/or out-of-pocket maximum costs that accumulate at the family rather than the individual level may use one of three approaches to calculate AV, as described below.

First, in the case of a plan with a deductible and/or out-of-pocket maximum that accumulates at the family rather than the individual level, the plan may enter the individual deductible and out-of-pocket maximum into the AV Calculator to determine the family plan design AV. Because the probability of reaching the deductible or out-of-pocket maximum is higher when spending for multiple members of a family is included, the AV Calculator's result for such a plan may be slightly lower than expected if the underlying data included family claims. However, we expect the differential will be within the de minimis variation of +/- 2 percentage points.

Second, as a safe harbor, plans with a deductible and/or out-of-pocket maximum that accumulate at the family rather than the individual level may have the same AV as the corresponding individual plan so long as the deductible and/or out-of-pocket maximum does not go beyond the range of the mathematical product of the individual level cost sharing and a family multiplier of 1.8-3.5. By way of example, if the individual plan has a deductible of \$1,000 and an out-of-pocket maximum of \$3,000, the family version of the plan could not be outside the range of a deductible of \$3,500 and an out-of-pocket maximum of \$10,500. We note that the overall out-of-pocket maximum is still constrained by statutory and regulatory limitations regardless of the family multiplier safe harbor.

Third, if the issuer believes that the family nature of the plan's cost-sharing features will make a material difference in the AV produced by the calculator, the issuer may submit the plan as a unique plan design and include plan-specific data on how the family-specific cost sharing is adjusted.

SECTION 6. ANNUAL LIMITATIONS ON DEDUCTIBLES FOR EMPLOYER-SPONSORED HEALTH PLANS IN THE SMALL GROUP MARKET

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This section provides additional guidance on AV standards for the annual limitation on deductibles for health plans offered in the small group market.

Section 1302(c)(2) of the Affordable Care Act places limits on the deductibles for health plans offered in the small group market as part of the EHB package that must be offered by issuers in the individual and small group markets and qualified health plans. As provided in 45 C.F.R. § 156.130(b)(3), a health plan may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (i.e. metal level) without doing so. For example, if the only way that an issuer can offer a bronze plan and a \$2,000 deductible is by offering all other services at a 90 percent cost-sharing rate, the plan may exceed the deductible because this would be considered an ‘unreasonable’ plan design. The health plan could instead be offered at the bronze level of coverage with a \$3,000 deductible and a 40 percent cost-sharing rate, which is consistent with what is commonly offered in the small group market today. When designing a bronze level plan with a deductible that exceeds the maximum, an issuer should increase the deductible by the smallest amount that achieves a reasonable plan design.

CMS recommends that states collect general compliance information through market-wide targeted audits or an alternative state-based enforcement of this provision. Where CMS is reviewing plans for compliance with AV standards, CMS will be reviewing plans that exceed the deductible to determine if the plan reasonably meets the desired metal tier. To facilitate the design of small group market plans to be offered in 2014, CMS reviews will recognize the following safe harbor for plan designs: plans that exceed the deductible limits in Section 1302(c)(2) will be considered to meet the reasonableness exception in Section 1302(c)(3) if the plan design results in an expected average cost sharing of at least 20 percent after reaching the deductible but before reaching the out-of-pocket maximum. Acceptable evidence would include either a coinsurance of at least 20 percent for all major classes of services or an actuary’s statement that the plan design meets the safe harbor provision.

SECTION 7. ANNUAL LIMITATION ON COST SHARING

This section provides additional guidance on the annual limitation on enrollee cost sharing and how CMS will evaluate plans for compliance. States that are enforcing this standard may use a similar approach.

Section 1302(c)(1) of the Affordable Care Act sets an annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) as part of the EHB package that a non-grandfathered policies sold in the individual and small group markets must offer. As provided in 45 C.F.R. § 156.130(c), cost sharing for benefits provided outside of a health plan’s network do not count towards the annual limitation on cost sharing when the health plan uses a provider network. For 2014, this limit will be the out-of-pocket limit for high deductible health

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plans (HDHP), adjusted by the Consumer Price Index (CPI-U), and set by the Internal Revenue Service (IRS) pursuant to section 223(c)(2)(A)(ii) of the Internal Revenue Code.⁴ Issuers of stand-alone dental plans should consult Chapter 5 of this Letter for more information on stand-alone dental plans.

CMS anticipates that the IRS will publish the HDHP limit for 2014 in the spring of 2013. IRS's publication of these limits cannot occur earlier because of the statutorily required method for computing and adjusting the HDHP limit. To assist issuers in designing health plans for the 2014 plan year, CMS has estimated that the annual limitation on cost sharing for the 2014 plan year will be approximately \$6,400 for self-only coverage and \$12,800 for family coverage.⁵ These are estimates only.

In the FFE, if IRS-published limits are below \$6,400/\$12,800, CMS will flag QHP applications with out-of-pocket maximums above the allowed amount for deficiency. Affected issuers will be permitted to revise their out-of-pocket maximums during the resubmission window built into the QHP certification process. CMS will allow issuers to adjust other associated data elements for affected plans if necessary. For example, issuers will be permitted to modify other cost-sharing parameters in order to maintain an AV consistent with the standards of 45 C.F.R. § 156.140.

CMS encourages states, particularly those participating in a State Partnership Exchange, to use this approach to allow updates during the revision window. However, states may instruct issuers to follow an alternate process to address deficiencies of this type so long as an opportunity to create the deficiency is provided.

Chapter 2: Additional Standards for Qualified Health Plans

The following sections describe CMS's approach to reviewing plans against standards that apply only to QHPs seeking certification from an Exchange. The reviews described in these sections

⁴ Beginning in 2015, a different methodology set by CMS will be used as set forth in section 1302(c)(1)(B) of the Affordable Care Act. This methodology will be discussed in the Notice of Benefit and Payment Parameters for 2015. 45 C.F.R. § 156.130(a)(2).

⁵ For reference, the limit set by the IRS for the 2013 calendar year is \$6,250 for self-only coverage or \$12,500 for family coverage. IRS Rev. Proc. 2012-26, available at <http://www.irs.gov/pub/irs-drop/rp-12-26.pdf>. This \$6,400/\$12,800 estimate is approximately a 2 percent increase from the limit set by IRS for the 2013 benefit year (\$6,250). By way of comparison, a 0 percent increase in the limit would result in an annual limit for 2014 of \$6,250, and a 6 percent increase would result in an annual limit of \$6,650. Over the past 20 years, CPI has always been below 6 percent.

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will be conducted either by a state participating in a State Partnership Exchange in plan management as a part of the state recommendation to CMS or by CMS as a part of the process of certifying a QHP in the applicable FFE.

Each section describes CMS's planned approach to evaluating QHPs against a certification standard in a non-Partnership FFE. As noted in previously released guidance, State Partnership Exchanges have some flexibility in their application of QHP certification standards, provided that the state's application is consistent with the parameters outlined in CMS regulation and guidance. States where a State Partnership Exchange is operating may use CMS's planned approach to conduct QHP certification reviews and arrive at certification recommendations, or adopt another approach that is consistent with the federal regulatory standards in consultation with CMS. Issuers seeking certification in State Partnership Exchanges should refer to state guidelines.

SECTION 1. NETWORK ADEQUACY AND INCLUSION OF ESSENTIAL COMMUNITY PROVIDERS

This section addresses how CMS will review QHPs for compliance with network adequacy and essential community provider standards. States participating in a State Partnership Exchange may use a similar approach.

In collaboration with states, CMS will monitor QHPs network adequacy and Essential Community Provider (ECP) sufficiency. QHPs are encouraged to view the network adequacy and ECP standards set forth in 45 C.F.R. §§156.230 and 156.235 and explained in this Annual Letter as the minimum requirements; in particular, CMS urges issuers to offer provider networks with robust ECP participation.

i. Network Adequacy

45 C.F.R. §156.230(a)(2) requires a QHP issuer to maintain a network that is sufficient in number and types of providers, including specialists in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay. CMS recognizes that many states conduct network adequacy reviews as part of the licensure process under their existing authority. As a result, for the 2014 coverage year, when CMS is evaluating applications for QHP certification, CMS will rely on state analyses and recommendation when the state has the authority and means to assess issuer network adequacy. CMS' approach to reviewing network adequacy will vary based on whether the state assesses network adequacy in a sufficient manner and using the standards at least as stringent as to that identified in 45 C.F.R. § 156.230(a).

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- ⌚ In states with sufficient network adequacy reviews, CMS will use a state's findings as part of its evaluation.
- ⌚ In states without sufficient network adequacy review, CMS will consider reviews of issuer network access standards and processes performed by accrediting entities. Unaccredited issuers will be required to submit an access plan, based upon access plan requirements in the NAIC Model Act to demonstrate compliance with the certification standard.⁶ The access plan document that an issuer has standards and procedures in place to maintain an adequate network consistent with § 156.235(a).

CMS will monitor network adequacy, for example via complaint tracking or gathering network data from any QHP issuer at any time to determine whether the QHP's network(s) continue to meet these certification standards.

ii. Essential Community Providers

45 C.F.R. § 156.235 establishes standards for inclusion of ECPs in provider networks and provides an alternate standard for issuers that provide a majority of covered services through employed physicians or a single contracted medical group.

As defined in the statute and regulation, ECPs include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Because the number and types of ECPs available varies significantly by location, CMS will use the following approach to evaluate QHP issuer applications for inclusion of ECPs for the 2014 coverage year. CMS notes that contracted ECPs are subject to applicable issuer credentialing standards.

- ⌚ **Safe Harbor Standard:** An issuer application that demonstrates compliance with the standards outlined in this paragraph will be determined to meet the regulatory standard established by 45 C.F.R. § 156.235(a) without further documentation. First, the issuer application demonstrates that at least 20 percent of available ECPs in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation of available ECPs, the issuer offers contracts before the start of the coverage year to:
 - All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and

⁶ Available at: <http://www.naic.org/>.

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- At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.

CMS may verify the offering of contracts after certification.

- ⌚ **Minimum Expectation:** An issuer application that demonstrates that at least 10 percent of available ECPs in the plan's service area participate in the issuer's provider network(s) will be determined to meet the regulatory standard, provided that the issuer includes as part of its application a narrative justification describing how the issuer's provider networks, as currently designed and after taking into account new 2014 enrollment, provide an adequate level of service for low-income and medically underserved enrollees.

- ⌚ **Examples:**

- Issuer A proposes a service area in which 80 ECPs are available. Issuer A's network includes 16 ECPs, and attests in its narrative justification that it has offered contracts to available Indian providers and one ECP in each major ECP category. Issuer A meets the safe harbor standard; no additional documentation is required.
- Issuer B also proposes a service area in which 80 ECPs are available. Issuer B's network includes 8 ECPs. Issuer B meets the minimum expectation by providing a narrative justification explaining why its network includes only 8 ECPs and how it will ensure service for low-income and medically underserved enrollees.

For an issuer that fails to achieve either the safe harbor standard or the minimum expectation CMS will expect as part of the application a narrative justification describing why the issuer was not able to achieve either standard and how the issuer's provider networks will provide an adequate level of service for low-income and medically underserved enrollees consistent with the regulatory standard. CMS anticipates that it will be difficult for issuers that do not meet the minimum expectation to demonstrate an adequate level of service for such enrollees to meet the regulatory standard. Failure to achieve compliance with the regulatory standard will be a basis for not certifying a plan as a QHP.

To assist issuers in identifying these providers, CMS is publishing a non-exhaustive list of available ECPs based on data maintained by the CMS and other federal agencies. The list is available at <http://cciio.cms.gov/resources/regulations/index.html#pm> and includes identifying and contact information for each provider.

Issuers will indicate which ECPs are included in their provider network(s) by populating a template as part of the QHP Application. CMS will provide detailed instructions to support

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issuers in completing the template. Issuers that submit a narrative justification will do so as part of the issuer application for QHP certification.

Issuers will be permitted to write in ECPs not on the CMS-developed list for consideration as part of CMS's certification review (that is, allowable write-ins will count toward the satisfaction of the minimum expectation or safe harbor standard). For example, issuers may write in any providers that are currently eligible to participate in 340B programs that are not included on the CMS-developed list, or not-for-profit or state-owned providers that qualify for 340B program participation but do not receive federal funding under the relevant section of law referred to in section 340B. Such providers include non-profit or governmental family planning service sites that furnish contraceptive and STD-related services to low-income and uninsured women, men, and adolescents but do not receive a grant under Title X of the Public Health Service Act.

Table 2.1: ECP Categories and Types in FFEs

| Major ECP Category | ECP Provider Types |
|--|--|
| Federally Qualified Health Center (FQHC) | FQHC and FQHC "Look-Alike" Clinics |
| Ryan White Provider | Ryan White HIV/AIDS Providers |
| Family Planning Provider | Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics |
| Indian Providers | Tribal and Urban Indian Organization Providers |
| Hospitals | DSH and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals |
| Other ECP Providers | STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, etc. |

iii. Alternate ECP Standard for Integrated Issuers

Issuers that qualify for the alternate ECP standard articulated in 45 C.F.R. §156.235(a)(2) and (b)⁷ must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. CMS interprets this standard as being met by the safe harbor described in this paragraph. Specifically, CMS will review whether the issuer has demonstrated that it has providers located in or contiguous to

⁷ To qualify for the alternate standard, an issuer must provide a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group.

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Health Professional Shortage Areas (HPSA) and zip codes in which 30 percent or more of the population falls below 200 percent of the federal poverty level (FPL). CMS will apply the safe harbor threshold and minimum expectation, described above, to these providers. For example, if an issuer's service area includes 50 available ECPs, the issuer would have five providers in the service area that are also in a HPSA or low-income zip code to meet the minimum expectation, and 10 providers in the service area that are in a HPSA or low-income zip code to meet this safe harbor standard.

As with the general safe harbor, an application that fails to meet the safe harbor standard must include a narrative justification. To be considered complete, an issuer's explanation would need to address how the issuer intends to ensure coverage in HPSA or low-income zip codes where the issuer does not already have provider coverage. For example, an issuer could describe plans to contract with available ECPs, or establish or acquire additional "in-house" providers in the applicable zip codes, or otherwise provide additional access to low-income and underserved populations in such areas. Finally, the explanation should describe the extent to which the issuer's provider sites are accessible to, and have services that meet the needs of, specific underserved populations, including:

- ⌚ Individuals with HIV/AIDS (including those with co-morbid behavioral health conditions);
- ⌚ American Indians/Alaska Natives (AI/AN); and
- ⌚ Low-income and underserved individuals seeking women's health and reproductive health services.

CMS is providing issuers with a database of zip codes listed as HPSAs or where more than 30 percent of the population falls below 200 percent of the federal poverty level. The database is available at <http://cciio.cms.gov/resources/regulations/index.html#pm>. Issuers that qualify for the alternate standard will use the same data template as other issuers to complete this section of the application.

SECTION 2. ACCREDITATION

This section provides additional guidance on accreditation requirements for QHP issuers seeking certification in an FFE, including a State Partnership Exchange.

45 C.F.R. §155.1045 establishes the timeline by which QHP issuers offering coverage in an FFE must be accredited. An issuer's accreditation status will be displayed to consumers on the

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Exchange website.⁸ As stated in the preamble to the EHB/Accreditation Final Rule, CMS is implementing a phased approach to accreditation for QHP issuers in FFEs.

As part of the application for QHP certification, issuers will be asked to provide some information about their accreditation status to determine if the standard in § 155.1045(b) is met. Issuers will be asked if they have any existing health plan accreditation in the commercial, Medicaid, or Exchange markets (i.e., accredited on products under the same legal entity as the one that is offering products in the Exchange). If so, they will be asked to provide information about that accreditation and identify the recognized accrediting entity that issued the accreditation. For certification in 2013 for the 2014 plan year, the National Committee for Quality Assurance (NCQA) and URAC have been recognized as accrediting entities.⁹ The issuer will be asked to enter information for accredited products within the commercial, Medicaid, or Exchange markets, such as accredited product type(s), expiration date(s), and accrediting entity-specific identification information numbers, such as the NCQA Organization Identification Number and Sub-Identification Number(s), and/or the URAC application number(s). Issuers should verify with the applicable accrediting entity before completing the application if they are unsure about their identification numbers. This is important for displaying the appropriate accreditation-related data for the issuer. For certification in future years, the timeline in § 155.1045(b) will be applied by looking at the issuer's accreditation status 90 days prior to open enrollment.

To verify the accreditation information, issuers will also be asked to upload their current and relevant accreditation certificates issued by either NCQA or URAC, or both of these recognized accrediting entities, if applicable. Only data that can be validated will be displayed. All issuers will be required to complete attestations about the accreditation data that will be displayed on the Exchange website in order to demonstrate how the issuer and health plan meet the applicable certification requirements. In addition, information about the issuer's Consumer Assessment of Healthcare Providers and Systems (CAHPS)¹⁰ surveys and other data will be requested for CMS to use in determining whether it is in the interest of qualified individuals and qualified employers to certify the health plan as a QHP. Consistent with 45 C.F.R. § 156.275(a)(2), issuers will be

⁸ CMS will be responsible for the Exchange website in FFEs, including State Partnership Exchanges.

⁹ NCQA and URAC were established as recognized as accrediting entities on an interim basis in a final rule published on July 20, 2012 (77 FR 42658) and formally recognized in a final notice published on November 23, 2012 (77 FR 70163). CMS may recognize additional accrediting entities in the future. *See* 45 C.F.R. § 156.275(a).

¹⁰ CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) of HHS.

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asked as part of the application to authorize the release of their accreditation survey data from the recognized accrediting entity to the Exchange, if available.

For open enrollment beginning on October 1, 2013, an Exchange website will display selected CAHPS survey results from an issuer's accredited commercial product lines when these existing CAHPS data are available for the same QHP product types and adult/child populations. CMS will display the two CAHPS Global Ratings for the health plan¹¹ and health care,¹² and results from one access to care measure.¹³

If CAHPS commercial data are not available through existing accreditation for an issuer's same QHP product types (e.g., HMO, PPO) and adult/child populations, CMS will display CAHPS survey results available from an issuer's accredited Medicaid product lines if these data are available for the same QHP product types and adult/child populations. If applicable CAHPS data are not available through existing accreditation, the Exchange website will display a neutral statement such as "No data available." For issuers with relevant Medicaid CAHPS data to be displayed, the Exchange website will display Medicaid CAHPS 2012 data at the beginning of open enrollment until Medicaid CAHPS 2013 data are available (anticipated in mid-November 2013).

For the 2014 coverage year, the Exchange website will also display the accreditation status of a QHP issuer ("Accredited by NCQA," "Accredited by URAC," "Accredited by NCQA and URAC," or "Not yet accredited") if an issuer is accredited on *any* of its existing products (e.g., HMO, PPO) in the commercial, Medicaid, or Exchange markets by one of the currently recognized accrediting entities. If the QHP issuer is accredited by NCQA with "Excellent," "Commendable," "Accredited," and /or "Interim" status, then the exchange website will display the issuer as accredited. If the QHP issuer is accredited by URAC with "Full," "Provisional," and/ or "Conditional," status, then the Exchange website will display the issuer as accredited." An issuer will not be displayed as accredited if the accreditation review is scheduled or in

11 Using any number from 0 to 10 where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

12 Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care (excluding dental and hospital) in the last 12 months?

13 In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?
[Never/Sometimes/Usually/Always]

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process. If the issuer does not have this existing accreditation from a currently recognized accrediting entity, neutral language such as “Not yet accredited” will be displayed.

In addition to displaying CAHPS data attained through accreditation and accreditation status as explained above, all states participating in an FFE (including a State Partnership Exchange) have the option of requesting that the Exchange website display a link to existing quality data available for the commercial and/or Medicaid market in that state. We interpret 45 C.F.R. § 155.205(c) to apply to such linked websites and materials when the linked sites are provided as part of the FFE provision of comparable data about QHPs and QHP issuers.¹⁴

SECTION 3. NON-DISCRIMINATION BY QHPs

This section addresses how CMS will review QHPs for compliance with non-discrimination standards that apply to QHPs. States participating in a State Partnership Exchange may use a similar approach.

In addition to the standards described in Chapter 1, Section 2 of this Annual Letter, QHPs must not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs (see 45 C.F.R. § 156.225). To ensure non-discrimination in benefit design, CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) as part of QHP certification. QHPs identified as outliers may be requested to modify certain benefits if the outlier benefits have the effect of discouraging the enrollment of individuals with significant health needs.

CMS’s outlier analysis will compare benefit packages with comparable cost-sharing structures for outliers with specific benefits such as:

- i. Inpatient hospital stays,
- ii. Inpatient mental/behavioral health stays,
- iii. Specialist visits,
- iv. Pregnancy and newborn care, and
- v. Specific conditions including behavioral health conditions such as mental health disorders and substance abuse.

¹⁴ 45 C.F.R. §155.205(c).

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In addition to conducting outlier analyses, CMS will collect attestations that issuers' QHPs will not discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation, consistent with 45 C.F.R. § 156.200(e).

CMS will also review information contained in the "explanations" and "exclusions" sections of the plans and benefits template with the objective of identifying clearly discriminatory anomalies or wording. Discriminatory cost-sharing language would typically involve reduction in the generosity of a benefit in some manner for subsets of individuals not based on clinically indicated common medical management practices.

SECTION 4. CONSIDERATION OF RATE INCREASES

This section addresses how CMS will review rate increases for QHPs. States participating in a State Partnership Exchange may use a similar approach.

45 C.F.R. § 155.1020 requires an Exchange to consider all rate increases when certifying plans as QHPs. For the 2014 plan year, CMS will take into consideration issuers' data and actuarial justifications provided in the Unified Rate Template; other information submitted as part of the Effective Rate Review program; and any recommendations provided to CMS by the applicable state's rate review grantee about patterns or practices of excessive or unjustified rate increases and whether or not particular issuers should be excluded from participation in the Exchange. In future years, CMS may also take into account other factors such as rate growth inside and outside the Exchange market.

As discussed above and in the State Partnership Exchange Guidance, CMS does not plan to duplicate reviews that a state is already conducting as a matter of state law, and will take into consideration reviews conducted on behalf of a state under the Effective Rate Review program as described in the Final Market Rules. CMS anticipates integrating state and other CMS rate reviews into its QHP certification processes, provided that states provide information to CMS consistent with federal standards and agreed-upon timelines.

For rate increases not being reviewed by an Effective Rate Review program or by CMS on behalf of a state:

- ① The QHP issuers' justification for all rate increases, including those under 10 percent, will be captured in the submission of Part I of the rate filing justification (Unified Rate Review Template).

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- ⌚ To ensure consumer transparency, issuers must publish information from Part I of the rate filing justification by either: (1) posting a link directly on the issuer’s website to the Exchange’s website (or HealthCare.gov), or (2) posting the information directly on the issuer’s website.¹⁵

SECTION 5. REVIEWS UNDER THE “INTEREST TEST”

This section addresses how CMS will review plans for QHP certification. States participating in a State Partnership Exchange may use a similar approach.

Under the “interest test” (45 C.F.R. §155.1000(c)(2)), an Exchange may certify a health plan as a QHP only if the Exchange determines that making the health plan available is in the interest of qualified individuals and qualified employers. An Exchange has discretion to choose among several different strategies for making this determination. For reasons highlighted below, we believe that reviewing rates and plan design for meaningful difference benefits consumers are key components of an evaluation under the interest test. FFEs, including State Partnership Exchanges, will consider rates and meaningful differences as part of determining whether certifying a QHP is in the interest of qualified individuals and qualified employers. CMS and states may consider other factors under the interest test. CMS is highlighting review of rates and meaningful difference so that issuers may take this guidance into account when applying for QHP certification.

REVIEW OF RATES

This section addresses how CMS will review plans for QHP certification in all FFEs, including where a State Partnership Exchange is operating.

CMS plans to conduct tests to ensure that QHP rates are in the interest of the qualified individuals who seek to purchase coverage through an FFE, including a State Partnership Exchange (see 45 C.F.R. §155.1000(c)(2)). For example, we would identify plans with proposed premiums that are statistical outliers.

i. *Non-Partnership FFEs*

CMS anticipates conducting the tests on the rate data submitted by issuers for each rating area in each state, standardized by age and tobacco status as part of the QHP certification application.

CMS plans to use standard statistical methods for identifying outliers and to adjust the methods

¹⁵ See section 1311(e)(2) of the Affordable Care Act, which directs issuers to “prominently post” justifications for any rate increases.

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depending on the number of plans offered in each rating area. CMS plans to conduct these tests on data submitted by issuers seeking to participate in a non-Partnership FFE after the submission window closes on 4/30/13. CMS will then notify the appropriate states and/or issuers of any outliers that have been identified. The state or entity reviewing rates may use this information as it completes its review of the issuer's rates under authority unrelated to QHP certification (e.g. PHS Act § 2794 rate review or state law providing for a review of rates). Where a non-Partnership FFE is operating, CMS will re-run rate tests on issuers' rate data shortly after states share the results of market-wide reviews to CMS on July 31, 2013.

ii. *State Partnership Exchanges*

In a State Partnership Exchange, CMS plans to conduct the second, EHB-focused analysis mentioned in the preceding paragraph after states submit the results of their rate reviews to CMS on July 31, 2013. CMS will then notify the appropriate entities of any outliers and provide them with the opportunity to respond or correct the outliers.

As stated above, CMS anticipates integrating state and other CMS rate reviews under other law (e.g. PHS Act § 2794 and separate state authority) into the QHP certification process. However, if an outlier is identified and not corrected or otherwise addressed, CMS may determine not to certify the plan as a qualified health plan based on an application of the consumer interest test. This approach should limit the burden on issuers, avoid duplication of state reviews, and ensure that certified QHPs will be in the best interest of consumers.

iii. *Non-Partnership FFEs*

CMS anticipates conducting the tests on the rate data submitted by issuers for each rating area in each state served by an FFE or FF-SHOP, as part of the QHP certification application process; however, CMS will broaden the test to the state level for states in which few plans are available in each rating area. CMS plans to use standard statistical methods for identifying outliers. CMS plans to conduct these tests on data submitted by issuers seeking to participate in a non-Partnership FFE after the submission window closes on April 30, 2013. CMS will notify the appropriate rate review entity of any outliers that have been identified. Where a non-Partnership FFE is operating, CMS will re-run rate tests on issuers' final rate data shortly after states share the results of market-wide reviews to CMS on July 31, 2013. CMS will again notify the appropriate state entity of any outliers and provide the state entity with the opportunity to respond. If an outlier is identified and not addressed, CMS will take this into account as part of its determination of whether making a given plan available is in the best interest of qualified individuals or qualified employers.

iv. *State Partnership Exchanges*

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In a State Partnership Exchange, CMS plans to conduct the tests mentioned in the preceding paragraph after states submit the results of their reviews to CMS on July 31, 2013. CMS will then notify the appropriate state entities of any outliers and provide them with the opportunity to respond. However, as noted above, if an outlier is identified and not addressed, CMS will take this into account as part of its determination of whether making a given plan available is in the best interest of qualified individuals or qualified employers.

As stated above, CMS anticipates integrating state and other CMS rate reviews under other law (e.g. PHS Act § 2794 and separate state authority) into the QHP certification process. This approach should limit the burden on issuers, avoid duplication of state reviews, and ensure that certified QHPs will be in the best interest of consumers.

REVIEW FOR MEANINGFUL DIFFERENCE

This section addresses how CMS will review plans for QHP certification. States participating in a State Partnership Exchange may use a similar approach.

Review for meaningful difference will be one of many factors that CMS will consider when deciding whether making a plan available is in the best interests of qualified individuals and qualified employers. Based on feedback from stakeholders and its experience administering the Medicare program, CMS believes that consumers will benefit from an Exchange with a manageable number of meaningfully different QHP choices for two primary reasons. First, we believe that too many plans from a given issuer without any meaningful difference between them would deteriorate a consumer's ability to choose a plan. Second, we are concerned that one issuer offering a number of plans without meaningful differences could take virtual "shelf space" from other competitors and stifle competition.

CMS believes that a meaningful difference review is an important component of the interest test. This review will help ensure that qualified individuals and qualified employers participating in the FFEs and the FF-SHOPS are able to make an informed selection among an ample but manageable number of choices of QHPs, while allowing for plan innovation.

With respect to the 2014 coverage year, CMS will look at the following as part of the broader interest test under § 155.1000(c)(2):

- ⌚ **Part One:** Whether the health plan's benefit package and plan costs are substantially different from other potential Exchange plan offerings in that state from that issuer. CMS will take into account the extent to which each potential QHP is substantially different

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from other QHPs of its plan type¹⁶ with respect to key characteristics such as metal level (that is, bronze, silver, gold or platinum), service areas covered, provider networks, premiums, cost sharing, benefits offered, or formulary structure; and

- ⌚ **Part Two:** Whether consumers would likely be able to distinguish the particular plan from other QHP offerings from the same issuer in a given service area.

CMS will use these factors as part of its application of the interest test to evaluate potential QHPs in an FFE and FF-SHOP. Given the unique focus of the stand-alone dental plan market, CMS will not perform a meaningful difference review of stand-alone dental plans.

Examples of health plans that might not be in the interest of qualified individuals and qualified employers to certify as QHPs, assuming that the plan submissions were from a single issuer for plans of the same type, metal level and overlapping service areas, include:

- ⌚ A \$50 difference in the annual deductible, when the two potential QHPs have otherwise identical cost sharing and nearly identical covered benefits.
- ⌚ A \$100 difference in annual maximum out-of-pocket limit (MOOP), when the two potential QHPs have otherwise identical cost sharing and nearly identical covered benefits.
- ⌚ A slight difference in covered benefits, when the two potential QHPs have nearly identical cost sharing. A slight difference would be for “immaterial benefits” that do not materially impact the monthly premium (e.g., coverage of hydrotherapy).

If CMS determines that a potential QHP is not meaningfully different, the issuer will be given the opportunity to amend or withdraw its submission for one of the identified health plans. Alternatively, the issuer may submit supporting documentation to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification. For example, an issuer may make the case that one QHP is an Accountable Care Organization. Such additional information will factor into the determination whether it is in the interest of the qualified individuals and qualified employers to certify the plan as a QHP.

CMS anticipates its approach related to meaningful difference and other factors to be considered in applying the interest test will evolve over time and may be updated in future years.

¹⁶ Plan types are defined as preferred provider organization (PPO), health maintenance organization (HMO), point of service (POS), or exclusive provider organization (EPO). QHPs with multiple in-network tiers will also be considered a different plan type for purposes of a meaningful difference review.

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Chapter 3: Qualified Health Plan Certification Process in FFEs, including State Partnership Exchanges

This Chapter provides an overview of the QHP certification process in FFEs, including State Partnership Exchanges, and describes the timing, data submission by issuers, and communication processes. High-level graphics summarizing the certification process in non-Partnership FFEs and State Partnership Exchanges are included in Appendix C.

SECTION 1. QHP APPLICATION AND CERTIFICATION PROCESS IN NON-PARTNERSHIP FFEs

This section describes how CMS will conduct QHP certification. States and issuers participating in a State Partnership Exchange should refer to Section 2.

In accordance with 45 C.F.R. part 155 subpart K, CMS will review and approve or deny applications from issuers that are applying to offer QHPs on the FFE. Table 3.1 presents a high-level overview of key dates in the certification process. Each major component of the process is described in greater detail in subsections (i) – (iv).

Table 3.1 Key Dates: QHP Certification in an FFE (Non-Partnership)

| Expected Date (all dates in 2013) | Activity |
|-----------------------------------|---|
| Beginning by March 1 | Issuers Submit Requests for Plan IDs (for plans intended for the Exchange) to the Health Insurance Oversight System (HIOS) |
| April 1 – April 30 | Issuers Submit QHP Applications in HIOS |
| May 1 – June 16 | CMS Reviews QHP Applications |
| June 17 | CMS Releases QHP Application Results to Issuers |
| June 17 – June 21 | Issuers Revise QHP Applications based on Deficiencies and Resubmit to HIOS |
| July 31 | As Applicable, HHS Receives final State Evaluation Findings in HIOS |
| August | CMS Review of State Evaluation Findings |
| August 22 – August 26 | Issuers Review Data During Plan Preview Period and Submit Data Corrections |
| September 4 | CMS Notifies all Issuers of QHP Certification Decisions for the FFEs |
| September 5 – September 9 | Issuers Sign Agreements with CMS |
| October 1 | Open Enrollment Begins |

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a.i. Registration and Application

To offer QHPs in non-Partnership FFEs for the 2014 plan year, health insurance issuers must complete QHP Applications electronically through HIOS. Before submitting an application, issuers must gain access to HIOS and define user roles (i.e. data submitter, data validator, and attester), and obtain HIOS user IDs.

We expect that between April 1 and April 30, 2013, the issuers will access the QHP Application in HIOS to submit all information necessary for certification of health plans as QHPs. The QHP Application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 C.F.R. parts 155 and 156 and other programmatic requirements necessary for the operational success of an Exchange, and provide requested supporting documentation. These attestations will also apply to vendors and contractors of the issuer or company.

a.ii. Issuer Data Collection and Coordination with States

As indicated in Chapter 1, CMS expects that states will review potential QHPs for compliance with EHB and AV standards under state regulatory authority in the PHS Act. CMS intends to utilize state results from reviews conducted under state authority, and will review and incorporate these data, to the extent permissible under the law, into its certification decisions; in addition, CMS will review and incorporate state results in other areas, including network adequacy. Regardless of which reviews a state conducts under its own authority, issuers will submit a complete copy of the QHP Application and any supporting data in HIOS. States will be able to access the Application information collected through HIOS to conduct their independent reviews.

We expect that states will establish the timeline, communication process, and resubmission window for any reviews under state authority, and will deliver findings to CMS via HIOS by July 31, 2013. Issuers should defer to any state-specific guidelines for review and resubmission of state-reviewed standards. CMS notes that issuers may be required to submit additional data to state regulators, if required by a state, and must comply with any requests for resubmissions from the state or from CMS in order to be certified. CMS will coordinate with states to ensure that any state-specific review guidelines and procedures are consistent with applicable federal law and operational deadlines. We note that all QHP issuers must be being licensed and in good standing to offer health insurance coverage in each state where the issuer offers health insurance coverage.

a.iii. FFE review of QHP Applications

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Between May 1 and June 16, 2013, CMS will review QHP applications for any market-wide standards (e.g., EHB) that are not substantially enforced by a state and QHP certification standards. On or around June 17, 2013 CMS expects to notify issuers of the results of all reviews conducted in this initial period by CMS, including any deficiencies or requests for additional documentation. Issuers will submit corrections or clarifications in response to CMS's notification into HIOS during a single resubmission window. During this period, issuers may also receive requests for resubmission or other communications from states conducting reviews under state authority. Issuers will only be able to alter data explicitly identified as deficient in CMS' notice or by a state. CMS expects to review the revised data, verify and confirm findings and results submitted by a state, and inform issuers of its final certification determination by September 4, 2013.

Once CMS's QHP certification determinations are complete, HIOS will send all final QHP application data to SERFF for use as a final state record.

a.iv. Plan Preview

The Plan Preview period will allow issuers to review their QHP data before the data become public and to correct any discrepancies between the issuer's Application data and the data for display as appropriate. Plan Preview will occur concurrently with CMS's final certification reviews; therefore, display during Plan Preview is not a guarantee that a QHP will be certified. After receiving final QHP data from issuers, CMS will load QHP data into a plan preview portal for issuer review. Accreditation status and CAHPS survey data will also be part of Plan Preview, as applicable. Issuers will review revised plan data as the data will appear to consumers on the Exchange website, and will have an opportunity to submit corrections if necessary. Issuers will not have an opportunity to submit substantive changes to 2014 QHP Applications during the Plan Preview period. At a later date, issuers will also have the opportunity to review the updated Medicaid CAHPS 2013 data when these data become available and prior to posting on the website; CMS expects that the website will refresh these data in November 2013. More information about CAHPS data is included in Chapter 2, Section 2 of this Annual Letter.

SECTION 2. QHP CERTIFICATION PROCESS IN A PLAN MANAGEMENT STATE PARTNERSHIP EXCHANGE

This section describes how states participating in a State Partnership Exchange will conduct QHP certification. Issuers participating in a non-Partnership FFE should refer to Section 1.

In a State Partnership Exchange, issuers will work directly with the state to submit all QHP issuer application data in accordance with state guidance.¹⁷ CMS anticipates that states will

¹⁷ CMS will work with states participating in State Partnership Exchanges to ensure that such guidance is consistent with federal regulatory standards and operational timelines.

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choose to use the SERFF system to collect and review QHP data. The state will review issuer applications for QHP certification for compliance with the standards described above and will provide a certification recommendation for each QHP to CMS. CMS will review and confirm the state's recommendations, coordinate Plan Preview, make final certification decisions, and load certified QHP plans on the Exchange website for the relevant State Partnership Exchange. CMS will work closely with states in State Partnership Exchanges to coordinate this process.

As indicated in Table 3.2, the certification process in State Partnership Exchanges will align with the process for Non-Partnership FFEs, particularly after July 31, 2013. Each major component of the process is described in greater detail in subsections (iii) and (iv).

Table 3.2 Key Dates: QHP Certification in a State Partnership Exchange

| Expected Dates (all dates in 2013) | Activities |
|------------------------------------|---|
| Beginning by March 1 | Issuers Submit Requests for Plan IDs (for plans intended for the Exchange) to the Health Insurance Oversight System (HIOS) |
| Beginning approx. April 1 | Issuers Submit QHP Applications into State's Application system |
| July 31 | HHS Receives State Certification Recommendation and Final Reviewed QHP Data from Partner States |
| August | HHS Review of State Certification Recommendations |
| August 22 – August 26 | Issuers Review Data During Plan Preview Period and Submit Data Corrections |
| September 4 | HHS Notifies all Issuers of QHP Certification Decisions |

i. Registration, Application, and State Review

An issuer's HIOS user ID will be used to link the state and federal records for a given issuer or QHP. Therefore, an issuer applying in a State Partnership Exchange must also access HIOS between March 1, 2013 and the beginning of the state's QHP certification process to obtain a HIOS user ID, as described in Section 1 above.

Issuers are to submit QHP Applications to the state, typically in SERFF, according to the timeline laid out by the State Partnership Exchange. Each state will define the relevant submission window as well as dates and processes for deficiency notices, corrections, and resubmissions. Issuers are to refer to state guidance on this process.

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We expect that the state will review the QHP Applications and provide final data and recommendations for certification to CMS no later than July 31, 2013.

ii. Plan Preview

As described in Section 1 above, CMS will offer a plan preview period for issuers seeking certification in a State Partnership Exchange. The plan preview period will follow the process outlined in Section 1, except that issuers that submitted QHP Applications into SERFF will also submit any data corrections into SERFF.

SECTION 3. QHP AGREEMENT

This section describes how CMS will conclude QHP certification in all FFEs, including State Partnership Exchanges.

A signed QHP Agreement with CMS will complete the certification process in an FFE or State Partnership Exchange. The Agreement will highlight and memorialize many of the QHP issuer's statutory and regulatory requirements and will serve as an important reminder of the relationship between the QHP issuer and CMS. A single QHP Agreement will cover all of the QHPs offered by the issuer in a state. CMS will release a copy of the QHP Agreement in the spring of 2013. In order for QHPs to be displayed in the Exchange to potential enrollees during the initial open enrollment period, issuers must submit the signed agreement to CMS in early September. The agreement must be signed by a representative of the issuer who has the authority to commit the issuer to upholding all statutory and regulatory requirements.

SECTION 4. FFE QHP ANNUAL REVIEW AND RECERTIFICATION

This section describes how CMS will conduct QHP recertification. States participating in a State Partnership Exchange may use a similar approach.

QHP certification in an FFE is valid for one year. Issuers wishing to continue participating in FFEs will be required to re-apply for recertification. CMS is developing its annual review and certification process, which will be outlined in future guidance. Issues uncovered through issuer audits, monitoring, consumer complaints, and/or concerns raised by states during the 2014 coverage year will factor into CMS's future certification decisions.

Consistent with a state's role in State Partnership Exchange certification activities, CMS expects that states in State Partnership Exchanges will establish their own QHP recertification processes that are consistent with FFE policies and guidance. CMS will articulate a process for working with states to complete recertification in future guidance.

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SECTION 5. CERTIFICATION OF STAND-ALONE DENTAL PLANS

This section provides additional guidance for stand-alone dental plans seeking certification in FFEs, including State Partnership Exchanges.

CMS and states participating in a State Partnership Exchange will use the QHP certification process, with necessary adjustments, to certify stand-alone dental plans. As provided in the Exchange Final Rule, stand-alone dental plans seeking Exchange certification must meet all applicable QHP certification standards. Appendix A identifies which QHP Certification Requirements will apply to stand-alone dental plans seeking certification in FFEs, including State Partnership Exchanges, for the 2014 coverage year. CMS anticipates verifying compliance with those requirements by having dental issuers attest to meeting the applicable certification requirements as part of their QHP Applications.

SECTION 6. CERTIFICATION OF CO-OPs FOR ALL EXCHANGES

This section provides additional guidance for CO-OPs seeking certification in FFEs, including State Partnership Exchanges, and State-based Exchanges.

Section 1322 of the Affordable Care Act establishes the Consumer Operated and Oriented Plan (CO-OP) Program to provide additional health plan options for consumers in Exchanges. Consistent with this goal, QHPs offered by CO-OPs may be deemed certified to participate in the Exchanges by CMS pursuant to section 1301(a)(2) of the Affordable Care Act.

Under 45 C.F.R. 156.520(e) of the final rule “Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan Program,”¹⁸ to be deemed certified to participate in an Exchange, a CO-OP must meet the terms of the CO-OP Program, federal standards for Exchanges, and any state-specific Exchange standards.¹⁹ CO-OPs may be deemed certified to participate in the Exchanges for two years by CMS. CMS will work closely with State Based Exchanges (SBEs) and State Partnership Exchanges to assess whether QHPs offered by a CO-OP meet all certification standards. An SBE’s or state’s recommendation regarding whether a CO-OP QHP meets Exchange certification standards will be given consideration in CMS’s determination to deem a CO-OPs QHP to be certified to be offered through an Exchange.

¹⁸ Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan Program, 76 FR 77392 (Dec. 13, 2011) (to be codified at 45 C.F.R. 156).

¹⁹ CO-OPs are not required to meet state-specific Exchange standards that operate to exclude CO-OPs due to being new issuers or other characteristics inherent in the design of a CO-OP.

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To apply to be deemed certified to participate in FFEs, including State Partnership Exchanges, a CO-OP issuer must generally follow the same application process as other QHP issuers. When registering in HIOS, CO-OP issuers must select the CO-OP indicator on the QHP Application to be considered for deeming. CMS does not expect to collect information beyond the QHP Application from CO-OP issuers in order to complete the deeming process in FFEs, including State Partnership Exchanges.

SECTION 7. OPM MULTI-STATE PLANS

This section provides additional guidance for multi-State plans seeking certification in FFEs, including State Partnership Exchanges, and State-based Exchanges.

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan Program (MSPP) as required under section 1334 of the Affordable Care Act. Specifically, OPM is responsible for contracting with at least two health insurance issuers to offer individual and small group coverage through Multi-State Plans (MSP) made available on Exchanges. In accordance with section 1334(d) of the Affordable Care Act, MSPP issuers under contract with OPM are deemed to be certified by an Exchange.²⁰

Issuers seeking to offer MSPs must apply to participate via OPM's online application portal. OPM will evaluate issuer applications and determine which issuers are qualified to become MSPP issuers. OPM plans to work closely with states in reviewing benefits and rates to achieve a viable MSPP and a level playing field for all issuers within a state. In accordance with section 1334(d) of the Affordable Care Act, MSPP issuers under contract with OPM to offer an MSP in specific states will be deemed to be certified by the Exchanges operating in those states. In order to be deemed certified by an Exchange, an MSP must be offered in the relevant state under contract with OPM in the relevant state.

We expect OPM to issue guidance to MSPP issuers with further details on a number of issues, including data transmissions to Exchanges, reporting requirements, and MSPP user fees. In addition, OPM will release a draft of the MSPP standard contract, which sets forth performance requirements for MSPP issuers. MSPP plans operating under contract with OPM will be displayed on the FFE website and included in the display of QHPs made available through consumer tools. CMS plans to display accreditation status, CAHPS data (if applicable), and a

²⁰ For more information about the MSPP, please see the proposed rule issued by OPM, "Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges," 77 Fed. Reg. 72,582 (Dec. 5, 2012) (to be codified at 45 C.F.R. pt. 800), or visit <http://www.opm.gov/insure/mspp/index.asp> or email MSPP@opm.gov.

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link to existing quality data provided by OPM, though OPM will communicate quality requirements for MSPs. OPM will provide additional information via rulemaking and guidance.

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Chapter 4: Qualified Health Plan Performance and Oversight

Section 1311 of the Affordable Care Act establishes minimum requirements that health plans must meet in order to be certified as QHPs. CMS, in operation of FFEs, is responsible for the ongoing compliance of issuers offering QHPs in all states where FFEs, including State Partnership Exchanges, are operating.

SECTION 1. ACCOUNT MANAGEMENT

This section describes how CMS will monitor QHP performance during the coverage year in all FFEs, including State Partnership Exchanges.

As described in previously released guidance, all issuers participating in FFEs, including State Partnership Exchanges, will be assigned a federal Account Manager. Account Managers will serve as the QHP issuer's primary point of contact with the Exchange and will provide QHP issuers with clarification and other assistance related to issuers' responsibilities and requirements for participating in the Exchange. Particularly in State Partnership Exchanges, the Account Manager will focus on issues that are unique to Exchange participation, such as assisting issuers with questions regarding the Exchange website, enrollment transaction files, and other operational matters. CMS expects that states, regardless of Exchange type, will take the lead in addressing market-wide issues, such as complaints related to market conduct.

SECTION 2. QHP ISSUER COMPLIANCE AND OVERSIGHT

This section describes how CMS will monitor QHP performance during the coverage year in all FFEs, including State Partnership Exchanges.

QHP issuers will be asked to submit a Compliance Plan as part of the QHP Application. The Compliance Plan is largely intended as a means for each issuer to document its efforts to ensure that appropriate processes are in place to maintain adherence with applicable regulations and guidelines, as well as to prevent fraud, waste, and abuse. CMS believes that compliance plans are a key part of an issuer's overall performance. While submission of a compliance plan is not a requirement for QHP certification, we encourage issuers to submit a plan. We anticipate that the information provided in such a document will help CMS determine whether a certifying a particular QHP is in the interests of the qualified individuals and qualified employers who are served by the applicable FFE.

CMS will generally look to existing state compliance oversight and enforcement efforts for issues that fall under the state's regulatory and enforcement authority (e.g., standards that apply to all non-grandfathered individual and small-group market products). CMS will also investigate compliance concerns that are Exchange-specific in nature. CMS intends to use a risk-based

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approach to monitoring compliance, focusing first on issuers that show signs of potential performance issues or non-compliance. CMS may perform periodic compliance reviews to address evident or suspected performance issues or non-compliance.

SECTION 3. QHP MARKETING

This section describes how CMS will monitor QHP performance during the coverage year in all FFEs, including State Partnership Exchanges.

45 C.F.R. § 156.225 requires that in order to be certified, a QHP issuer must comply with all applicable state laws regarding health plan marketing. In addition, a QHP issuer must not employ marketing practices that could discourage the enrollment of individuals with significant health needs.

Because states already regulate health plan marketing materials and other documents under state law, CMS does not intend to review QHP marketing materials for compliance with state standards as directed by 45 C.F.R. § 156.225. However, to assist consumers in identifying plans that have been certified by an Exchange, all marketing materials distributed to enrollees and to potential enrollees should contain the following disclaimer: “[Insert plan’s legal or marketing name] is a Qualified Health Plan in the [insert name of Health Insurance Marketplace].” A logo for the Health Insurance Marketplace will also be made available and should be used on all marketing materials.

In addition to complying with state marketing standards that apply to all issuers, QHP issuers must ensure that all marketing products and materials meet the meaningful access standards described in Chapter 7, Section 6 of this Annual Letter to ensure access for individuals with limited English proficiency and individuals with disabilities (*See* 45 C.F.R. § 155.205, 155.230, and 156.250).

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Chapter 5: Stand-alone Dental Plans

Stand-alone dental plans are treated uniquely in the Affordable Care Act, particularly with respect to stand-alone dental plan participation in Exchanges. Thus, various statutory and regulatory standards apply differently to stand-alone dental plans from how they apply to QHPs. To provide states, issuers, and other stakeholders with additional clarity on this issue, the following sections cover a number of policy issues unique to stand-alone dental plans.

SECTION 1. REGULATION OF STAND-ALONE DENTAL PLANS

This section clarifies which statutory and regulatory standards apply to stand-alone dental plans participating in any Exchange.

i. *Affordable Care Act Provisions that Do Not Apply to Stand-alone Dental Plans*

Dental benefits are excepted benefits as defined by PHS Act section 2791 and thus exempt from the requirements of the PHS Act when provided under a separate policy or contract. This exemption includes the insurance market reform provisions of the Affordable Care Act that amend the PHS Act and generally apply to non-grandfathered health plans in the individual and small group markets inside and outside the Exchange, such as guaranteed availability and renewability of coverage.

There are other provisions of the Affordable Care Act that apply generally to QHPs offered in an Exchange that are not appropriate for stand-alone dental plans because of the unique nature of the limited benefits they provide. As stated in 45 C.F.R. § 155.1065, issuers of stand-alone dental plans and stand-alone dental plans must meet QHP certification standards, except for any certification requirement that cannot be met because the plan only covers dental benefits. Further, section 1402(c)(5) of the Affordable Care Act, as codified in 45 C.F.R. § 156.440(b), excludes stand-alone dental plans from the cost-sharing reduction requirements placed on medical QHP issuers. The provision states that any cost-sharing reductions that would be applied to the pediatric dental EHB in a comprehensive medical QHP will not be applied if the pediatric dental benefit is provided through a stand-alone plan.

ii. *Affordable Care Act Provisions that Apply to Stand-alone Dental Plans*

Some market-wide and Exchange-specific provisions in the Affordable Care Act do apply to stand-alone dental plans:

- ⌚ **Prohibition on Annual and Lifetime Dollar Limits:** The Affordable Care Act prohibits health insurance issuers in the individual and group markets from placing annual or lifetime limits on the dollar value of benefits for any beneficiary, beginning in 2014.

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Under 45 C.F.R. §155.1065(a)(2), the pediatric dental EHB offered by stand-alone dental plans must be offered without annual and lifetime limits.

- ④ **Annual Limits on Cost-Sharing:** Under 45 C.F.R. §156.150, rather than meeting the specific dollar limits that apply to comprehensive medical QHPs, stand-alone dental plans offered inside an Exchange will be required to demonstrate to the Exchange (FFE or otherwise) that they have a reasonable annual limitation on cost-sharing in place. The final rule also clarified that the Exchange is responsible for determining the level for “reasonable.”

SECTION 2. PRICING STAND-ALONE DENTAL PLANS

This section describes how stand-alone dental plans will be treated in FFEs, including State Partnership Exchanges.

i. Displaying Stand-alone Dental Plan Premium Rates

As articulated in 45 C.F.R. §155.205(b), the Exchange is required to collect and display premium rate information for all QHPs, including stand-alone dental plans, in a standardized and comparable way. In addition, 45 C.F.R. §156.210 requires QHP and stand-alone dental plan issuers to submit rate and benefit information to the Exchange as a condition of participation in the Exchange. Due to their excepted benefit status, stand-alone dental plans are not held to the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and business rules template. However, stand-alone dental plans will still need to complete these tables, and based on that information, CMS will display basic, comparable rate information for stand-alone dental plans on the Web portal. CMS will also calculate the advance payment of the premium tax credit for stand-alone dental plans using the pediatric dental EHB premium allocation.

When a consumer is directed to the stand-alone dental plan issuer to make the initial premium payment to effectuate enrollment, the stand-alone dental plan issuer would have the ability to make any premium adjustments beyond those accounted for in the Rating Tables and Rate Review table based on additional rating factors available to issuers of stand-alone dental plans.

In order to provide the maximum amount of information to consumers during plan selection, stand-alone dental plans will need to indicate whether they are committing to the rates reported in the Rating Tables or if they are reserving the option to charge additional premium amounts. Issuers of stand-alone dental plans would indicate in the templates included in the issuer application for QHP certification whether they are guaranteeing the rate that is completed in the templates. If the issuer indicates that the rates are guaranteed, then the issuer would not charge

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additional rates beyond what is reported in the rating templates. If the issuer indicates that the rates are not guaranteed, the issuer could charge additional premiums to the consumer. The plan compare function of the FFE website will inform consumers what the different indications mean.

The Unified Rate Review Template will not need to be completed for stand-alone dental plans in the FFE.

ii. *Separately Offering and Pricing Stand-alone Dental Plans*

In the discussion of stand-alone dental plans in the preamble to the Exchange final rule, it is noted that each Exchange can require as a condition of certification, comprehensive medical QHPs to offer and price the pediatric dental EHB (if covered) separately, if doing so would be in the best interest of consumers.

CMS will not require comprehensive medical QHP issuers that provide pediatric dental coverage to offer and price the pediatric dental EHB separately from the rest of the plan in connection with certification by an FFE.

Additionally, the FFE will not have the capacity to display dental benefits of a QHP as a separate or severable benefit, for example where an issuer offers both health plans and stand-alone dental plans and wishes to “bundle” them in the plan compare website. In order to be displayed on the Exchange website, dental benefits must either be embedded in a comprehensive medical QHP or offered separately through a stand-alone dental plan.

iii. *Annual limits on Cost-Sharing in the FFE for SADPs*

For the 2014 coverage year in the FFE, any annual limit on cost sharing that is \$1,000 or below for one child or \$2,000 or below for more than one child will be considered reasonable for the pediatric dental EHB. Any annual limits above these thresholds may receive additional review.

v. *SADP Voluntary Reporting Results*

In order to allow QHP issuers to exercise the statutory option to omit the pediatric dental EHB in an Exchange where a stand-alone dental plan is also offered, CMS established a voluntary reporting program in the EHB Data Collection Final Rule²¹ to determine in which Exchanges dental issuers are likely to offer stand-alone plans. The voluntary reporting encouraged dental

²¹ Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42,658 (Jul. 20, 2012) (to be codified at 45 C.F.R. pt. 156).

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issuers that intend to seek certification of one or more stand-alone plans in an Exchange to communicate their intent to CMS by state, service area, and market (individual or group). The data was published on February 11 on the CCIIO website for the FFE states.²² The data show that a stand-alone dental plan is expected to be offered throughout each state in which an FFE, including a State Partnership Exchange, will be operating; therefore, QHP issuers participating in FFEs, including State Partnership Exchanges, can expect to have the option to omit the pediatric dental EHB.

²²Results of Voluntary Reporting for the FFE: <http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf>.

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Chapter 6: Consumer Enrollment and Premium Payment

In the General Guidance on Federally-facilitated Exchanges, CMS outlined a high-level approach for implementation of the enrollment process in FFEs. This Chapter provides updated policy, operational, and technical information to assist issuers in their preparations to offer health insurance coverage through the federal Exchange. Specifically, this Chapter addresses the enrollment process, the enrollment transaction and accompanying Companion Guide for issuers, related transactions, enrollment periods, effective dates, changes, terminations, and enrollment reconciliation. Because eligibility and enrollment functions will be conducted by CMS in State Partnership Exchanges, all processes related to eligibility and enrollment described in this Chapter will apply in all State Partnership Exchanges and Federally-facilitated Exchanges. Some of the standards and practices outlined in this Chapter will also apply to State-based Exchanges. However, given the complexity of state laws in this area and additional flexibility authorized for State-based Exchanges, CMS intends to provide similarly detailed guidance to State-based Exchanges and participating issuers in those Exchanges in the future.

Sections 1 – 3 provide a high-level overview of the enrollment process, including premium payment. The policies and procedures outlined in these sections are consistent with the Exchange Final Rule, and are intended to promote issuer readiness to receive and transmit necessary data and process premium payments.

SECTION 1. OVERVIEW OF THE ENROLLMENT PROCESS FOR QUALIFIED INDIVIDUALS

This section describes the enrollment process for qualified individuals applying online for coverage through an FFE, including a State Partnership Exchange. If deemed necessary, CMS will publish future guidance addressing nuances associated with applying for coverage via a paper application.

When a qualified individual wishes to purchase health insurance in a qualified health plan or stand-alone dental plan through the FFE, the individual will:

1. Complete the eligibility application for coverage and insurance affordability programs through the Exchange, if desired,
2. Evaluate available QHPs to compare the options,
3. Make a plan selection,
4. Select the desired amount of advance premium tax credit (APTC), if eligible, and
5. After being re-directed by the Exchange to the appropriate issuer's website, follow instructions provided by the issuer to determine how to make the first premium payment (unless the APTC are greater than the premium) and provide any additional information required by the QHP issuer to process the enrollment, such as a selection of primary care

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provider. More information about the initial premium payment is provided later in this document.

At least once daily, the Exchange and QHP issuers will exchange electronic files containing new enrollments, updates for existing enrollees (e.g., address changes), cancellations, and terminations. The enrollment transactions will also include the APTC and cost-sharing reduction (CSR) amounts for those who are eligible for that assistance. QHP issuers are expected to update their internal records promptly to match the Exchange's records.

SECTION 2. PAYMENT OF PREMIUMS

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

i. Initial Premium Payments

Enrollees in all FFEs (including State Partnership Exchanges) will make premium payments directly to the QHP issuer; the Exchange will not accept premium payment on behalf of issuers. The mechanism of payment must comply with the issuer's payment policies. When a qualified individual makes a QHP selection online, the Exchange will direct the individual to the issuer's website. If the issuer accepts payment electronically, we anticipate that the individual will be able to make the first premium payment on-line using that link to the issuer's website. We expect that QHP issuers will also provide a telephone number that individuals can call to make payment or ask questions. If payment must be made by other means, instructions should be provided on the issuer's website.

CMS interprets premium payment to mean confirmation by the issuer's financial institution that funds can be processed by the issuer. In the event that the payment information submitted by the individual does not clear the issuer's financial institution, QHP Issuers are permitted to follow their standard cancellation procedures (for initial premium payments) or termination procedures (for existing enrollees), subject to applicable federal law and regulations. For existing enrollees, coverage may be terminated in accordance with the allowable grace periods set forth at 45 C.F.R. 155.430(b) and §156.270(c). Issuers must develop a process for notifying an enrollee of the termination, communicating the reason for the termination. CMS believes that also providing an explanation of any associated liability for medical claims that may have been incurred would be a best practice for QHP Issuers.

ii. Initial Premium Payment Cut-off Dates and Cancellations

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CMS recommends that issuers establish the following best practices regarding payment cut-off dates and coverage cancellations. The cut-off date set by issuers for premium payment by the enrollee should be no later than the day before the effective date of coverage and cannot be earlier than the last possible date of plan selection. For example, if a qualified individual selects a QHP on December 14, 2013, for coverage on January 1, 2014, the premium payment cut-off date should be no earlier than December 15, 2013, and no later than December 31, 2013. Issuers may choose to *cancel* coverage of any qualified individual who does not make timely payment of initial premium. Requiring initial premium payment before the effective date of coverage prevents an individual from using the insurance benefit of covered services without first having made a premium payment. If the qualified individual is still in an enrollment period at the time the coverage is cancelled, he or she may go through the plan selection process again and may select the same or another QHP.

If a qualified individual makes a QHP selection but subsequently selects a new QHP before the coverage effective date, the initial QHP selection could be automatically cancelled by the Exchange as part of the transmission of updated enrollment information to QHP issuers. If any premiums were paid to the initial QHP, the issuer would be responsible for refunding the premium. In some instances, such as when cancellation requests are received immediately before the coverage effective date, the process may result in a retroactive cancellation and issuers should ensure their systems can accommodate such transactions.

iii. *Advance Payments of the Premium Tax Credit and Premium Payments from Qualified Individuals and Enrollees*

In order for the Exchange to appropriately administer APTCs, the QHP issuer must report current and accurate information on the status of qualified individual and enrollee premium payments. QHP Issuers will provide up-to-date information on the last premium payment date for every enrollee. In accordance with 45 C.F.R.155.270, QHP Issuers will use Version 5010 Technical Report Type 3 Benefit Enrollment and Maintenance Transaction (ASC X12 834), adopted by the Secretary of Health and Human Services on January 23, 2009, and required for use on January 1, 2012 by HIPAA covered entities – such as health plans and issuers.

SECTION 3. EFFECTIVE DATE OF COVERAGE

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

When a qualified individual enrolls in a QHP, enrollment effective dates follow the dates established by 45 C.F.R. §§155.410(c)(1) and 155.420(b)(1)–(2); CMS will not attempt to negotiate alternative (earlier) effective dates for FFEs. Although most coverage effective dates are either the first of the following month or the first of the second following month, there are

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exceptions for certain special enrollments (such as those for birth, adoption, placement of adoption, marriage and loss of minimum essential coverage), which allow a qualified individual or enrollee to make a plan selection outside of the initial or annual open enrollment period.

Special enrollment period coverage effective dates depend on the type of event, the date of request for a special enrollment period, and the date of plan selection. CMS will determine enrollee eligibility for all special enrollment periods. Table 5.1 depicts certain triggering events and their corresponding effective enrollment dates, assuming the individual selects a plan and makes a timely premium payment.

Table 6.1: Examples of Effective Dates of Coverage

| Triggering Event | Triggering Event Date | Eligibility Determination Date | Enrollment Period | | Plan Selection Date Examples | Enrollment Effective Dates (first available date depending on the plan selection date) | |
|---|-----------------------|--------------------------------|-------------------|---------|------------------------------|--|--|
| | | | Start | End | | | |
| Initial Open Enrollment Period | | 10/1/13 | 10/1/13 | 3/31/14 | 10/1/13 | 1/1/2014 | |
| | | | | | 3/16/14 | 5/1/2014 | |
| Annual Open Enrollment Period (example for years subsequent to 1/1/2015) | | 9/10/15 | 10/15/15 | 12/7/15 | 12/7/15 | 1/1/16 | |
| Special Enrollment Periods last 60 days from the triggering event per 45 C.F.R. § 155.420(c). Enrollment Period start dates below indicate the earliest date an individual could select a plan. | | | | | | | |
| Relocation | 4/1 | 4/10 | 4/10 | 5/30 | 4/15 | 5/1 | |
| | 4/10 | | | 6/10 | 4/16 | 6/1 | |
| | 3/20 | | | 5/20 | 5/16 | 7/1 | |
| Birth | 6/1 | 7/20 | 7/20 | 7/30 | 7/29 | 6/1 | |
| Loss of Minimum Essential Coverage | 4/28 | 4/28 | 4/28 | 6/28 | 4/29 | 5/1 | |
| | 4/15 | | | 6/15 | 5/2 | 6/1 | |
| Marriage | 4/12 | 5/28 | 5/28 | 6/12 | 5/28 | 5/1 | |
| Loss of | 8/30 | 8/5 | 8/5 | 10/30 | 8/5 | 9/1 | |

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| Triggering Event | Triggering Event Date | Eligibility Determination Date | Enrollment Period | Plan Selection Date Examples | Enrollment Effective Dates (first available date depending on the plan selection date) |
|------------------------------|-----------------------|--------------------------------|-------------------|------------------------------|--|
| employer-sponsored insurance | | | | | |

SECTION 4. TRANSMISSION OF ENROLLMENT INFORMATION BETWEEN THE FFE AND QUALIFIED HEALTH PLANS

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

45 C.F.R. § 155.270 requires Exchanges to use standards, implementation specifications, operating rules, and code sets adopted by the Secretary under the HIPAA and the Affordable Care Act when conducting certain electronic transactions with a covered entity such as an issuer.

The transaction standard CMS and issuers will use to exchange electronic enrollment files will be the ASC X12 834, adopted by the Secretary of CMS on January 23, 2009, and required for use by HIPAA covered entities – like issuers and health plans - on January 1, 2012. CMS has released a Companion Guide²³ for certain fields and data elements for use by Exchanges and issuers to include data elements not otherwise provided in the ASC C 12 834 standard transaction, such as APTCs. Most issuers currently use Companion Guides to provide direction to their trading partners when conducting any type of HIPAA-compliant data exchange such as enrollment, claims processing, eligibility inquiries, and claim status inquiries. Issuers offering QHPs through an FFE, including a State Partnership Exchange, must use ASC X12 834 with the CMS Companion Guide for purposes of QHP enrollment transactions. The CMS Companion Guide is available for use by issuers and Exchanges to begin programming and internal testing.

In some situations, it may be necessary to accept an enrollment file in a non- EDI format (e.g. natural disaster, or serious technical problems). CMS will work with QHP issuers to evaluate and determine appropriate alternate paths to transmit enrollment data as necessary under those circumstances, which may include CD, tapes, or online processes.

The ASC X12 Version 5010 834 Benefit Enrollment and Maintenance Transaction TR3 may be purchased from ASC X12, at <http://store.x12.org/store/>.

²³ Centers for Medicare & Medicaid Services, Standard Companion Guide Transaction Information Companion Guide Version Number: 1.0 (January 1, 2013). Available at: <http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf>.

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i. *Enrollment Transaction Acknowledgement Files (ASC X12 999)*

When the issuer receives the daily enrollment file, in accordance with 45 C.F.R. §155.400(b)(2), it must acknowledge receipt of information to the FFE by transmitting an ASC X12 Version 5010 999 Implementation Acknowledgement for Health Care Insurance transaction (ASC X12 999 Acknowledgement). This transaction informs the submitter that the file (the ASC X12 Version 5010 834 Benefit Enrollment and Maintenance Transaction TR3) arrived at the destination and can be processed. The ASC X12 999 Acknowledgement may include the number of transactions received, the number of transactions processed, and any errors detected. CMS will provide future guidance as to the other content required in the ASC X12 999 Acknowledgement.

ii. *Enrollment Confirmation Transaction*

Issuers will use the ASC X12 834 as a confirmation transaction for certain enrollment actions. For example, when a qualified individual submits full payment to the issuer for any applicable initial premium due, the issuer will send the Exchange a full ASC X12 834 “confirmation” record. Additionally, in response to the Exchange sending a file to an issuer containing changes for multiple enrollees, once the issuer has made those changes or effectuated an enrollment, the issuer will send the Exchange a full ASC X12 834 “confirmation” record for each individual affected. The confirmation file provides CMS, in operation of the FFEs, assurance that the issuer has effectuated enrollment, terminations, cancellations, and updates (e.g., a name change) consistent with the information received from the Exchange and also provides the Exchange with the data necessary to reconcile any pending transactions.

iii. *Identifiers within the Enrollment Transaction*

Both CMS and issuers will utilize several identifiers in the enrollment transaction, including unique identifiers designating the subscriber, enrollee, issuer, and Exchange. Some of these identifiers will be created and provided to the issuer by the Exchange, and some will be created by the issuer and sent to the Exchange. The identifiers, their sources, and definitions will be included in the CMS Companion Guide to include information about the qualifiers that will be used with each identifier, where they will be found in the transaction, and how they will be defined. The key identifiers for the enrollment transaction are the subscriber identifier, which is the identifier for the person with the primary coverage, and the member identifier, which is associated with the other individuals who are insured with the subscriber.

iv. *Unique Identifiers for the Subscriber*

Issuers use unique numbers to identify subscribers and members, and these numbers are often associated with the individual for as long as such individual maintains coverage through a group or health plan with that issuer. The ASC X12 834 standard requires the use of an individual

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identifier in each transaction to ensure the accuracy of an exchange of data between two trading partners, and the consistency of that information over time.

CMS will assign a unique identifier to each individual enrolled in a QHP. The unique identifier will be associated with the specific issuer and will not “travel” with the qualified individual if the individual changes QHPs.. If the qualified individual changes to a QHP with another issuer, he or she will receive a new identifier. However, if the qualified individual returns to a QHP issuer from whom he or she previously held coverage through the Exchange, the same identifier will be reassigned to that person.

Because CMS will be redirecting qualified individuals to QHP issuers to make initial premium payments rather than aggregating premiums in the FFEs serving the individual market, there will be a unique application ID to aid issuers in matching initial premium payments made by qualified individuals to the ASC X12 834 transactions sent by the Exchange. In addition, there will be an associated bar code when individuals decide to print in PDF. Qualified individuals will be able to refer to the unique application ID in communications with issuers if there are issues with the premium payment process.

SECTION 5. TERMINATION OF COVERAGE AND CANCELLATION OPTIONS

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

CMS will initiate all enrollee terminations of coverage and enrollment through an FFE, except that the QHP issuer may initiate terminations in cases of non-payment of premium to the issuer by the enrollee and situations covered by 45 C.F.R. § 147.128 (e.g. fraudulent activity by the enrollee). When enrollees wish to terminate coverage, they should do so through the Exchange, and should provide reasonable notice. Issuers will receive termination information from the Exchange through an ASC X12 834 transaction, and guidance on the data elements to be used in the transaction will be provided in the Companion Guide.

SECTION 6. GRACE PERIODS FOR NON-PAYMENT OF PREMIUMS

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

In accordance with the Exchange Final Rule, issuers will be permitted to terminate coverage for enrollees who fail to pay premiums. However, 45 C.F.R. §156.270(d) requires issuers to observe a three month grace period before terminating coverage for those enrollees who are receiving APTCs. The grace period only applies to enrollees who have already paid their share of one month’s premium in full; for enrollees who meet this initial requirement, the grace period is triggered once the enrollee subsequently misses a premium payment. The Exchange Final Rule

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outlines a process for addressing such instances of non-payment, including issuer responsibilities with respect to provider notification and claims payment.

If an enrollee makes all outstanding premium payments before the end of the grace period, the enrollee's enrollment with the same QHP remains intact. However, if an enrollee exhausts the grace period without making all outstanding premium payments, the issuer must terminate coverage with notice to the enrollee. An enrollee may not extend the grace period by paying only a portion of the outstanding premium (e.g., by paying the first outstanding month's premium). Only complete payment of all outstanding premiums will bring the qualified individuals into good standing. If coverage is terminated for non-payment of premiums, the last day of coverage may be the last day of the first month of the grace period; thus, coverage may be terminated retroactively. If an enrollee exhausts the grace period, the issuer must return APTCs for the second and third months to the Treasury Department. CMS will provide information about this process in the future.

If an enrollee's coverage in a QHP is terminated for non-payment of premiums, as indicated on the 834 transaction via the disenrollment code, he or she may not enroll in another QHP with any issuer through a special enrollment period. 45 C.F.R. § 155.420(d)(1) and (e). We anticipate that all Exchanges will have access to this information as part of the enrollment information sent by QHP issuers in the ASC X12 834 standard. If a QHP issuer terminates the enrollee's coverage for non-payment, all individuals on the policy also lose coverage. Applicable state law will govern grace periods for enrollees not receiving APTCs within the Exchange.

SECTION 7 NOTICE REQUIREMENTS

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

i. *Notice of Premium Non-payment— to Enrollees*

Issuers must notify enrollees who are receiving APTCs and who have failed to make a premium payment that they are delinquent in such payment, as described in 45 C.F.R. §156.270(f). The notice should be written in plain language and comply with the standards provided herein under Chapter 7, Section 6 with regard to the provision of notice to people with limited English proficiency or to people with disabilities. Issuers should include the following information:

- ⌚ Purpose of the notice,
- ⌚ An identification/reference number unique to the notice,
- ⌚ The name of the QHP and affiliated issuer,
- ⌚ Primary subscriber and relevant contact information,

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- ⌚ Names of all enrollees affected by the unpaid premium,;
- ⌚ Explanation about the three-month grace period, including applicable dates,
- ⌚ The telephone number for the QHP customer service, and
- ⌚ Consequences of losing coverage, including:
 - Repayment of premium tax credits provided for months of coverage that is retro-actively terminated,
 - Inability to participate in a special enrollment period, and
 - Individual responsibility for paying any medical claims incurred during the period of the retro-actively terminated coverage.

ii. *Notice of Pending Claims—to Providers*

In accordance with 45 C.F.R. § 1 56.270(d)(3), issuers must notify all providers that may be impacted (including at least providers that submit claims for services rendered during the grace period) that an enrollee has lapsed in his or her payment of premiums. Issuers may utilize automated electronic processes to convey such notices. The notice must indicate there is a possibility that the issuer may deny payment of claims incurred during the second and third months of the grace period if the enrollee exhausts the grace period without paying the premiums in full. Issuers should notify all potentially impacted providers as soon as is practicable when an enrollee enters the grace period, since the risk and burden are greatest on the provider. Issuers should include the following information in the provider notification:

- ⌚ Purpose of the notice,
- ⌚ A notice-unique identification number,
- ⌚ The name of the QHP and affiliated issuer,
- ⌚ Names of all individuals affected under the policy and possibly under the care of this provider,
- ⌚ An explanation of the three month grace period, including applicable dates, including:
 - Whether the enrollee is in the second or third month of the grace period,
 - Consequences of grace period exhaustion for the enrollee and provider, and

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- Options for the provider, and
- ⌚ The QHP customer service telephone number specifically for use by providers, if available.

iii. *Notice of Premium Non-payment— to the Exchange*

Issuers should report to the Exchange electronically about enrollees who have entered into the three month grace period on an ASC X12 834 transaction at the end of each month. Reporting instructions for this transaction are provided in the Companion Guide and include the use of the last payment date field. CMS will use the data in the transaction to track delinquent enrollees and may conduct outreach to such enrollees, though any outreach would not negate the issuer's notice responsibilities.

SECTION 8. ENROLLMENT RECONCILIATION

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

On at least a monthly basis, as determined by CMS, the Exchange and issuers will exchange full enrollment files to identify and resolve discrepancies between the enrollment records and to ensure information in each system (Exchange and issuer) is consistent.

i. *Reconciliation Process*

To operationalize the requirement in 45 C.F.R. § 155.400(d), CMS will conduct a reconciliation process electronically and in a bi-directional flow between the Exchange and the issuer, meaning that each party will send the other a full file of data for comparison. At a scheduled time each month, each issuer will compile an ASC X12 834 audit file comprised of all enrollments for a specified period of time (e.g., one quarter), and will transmit this through the Data Services Hub (Hub). CMS will compare the issuer records with the internal enrollment records for the Exchange for that same period of time. The files will be transmitted through the Hub and will be processed based on evaluation criteria to be established for the reconciliation processes. At the same time CMS is comparing its files to those of the issuers, CMS will compile and send an ASC X12 834 audit file to each issuer for the same time period, comprised of all individuals enrolled in that issuer's QHPs. Each QHP issuer will use this file for its own comparison and analysis.

The data exchange will allow the issuers and the Exchange to identify discrepancies using key data elements including name, date of birth, issuer ID numbers, plan/level, effective and

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termination dates, cancellations, and APTC and CSR amounts. CMS will create a discrepancy report for each issuer, and each issuer will create a similar discrepancy report for the Exchange. CMS will publish information regarding the content and format for the discrepancy report in future guidance, and will include it in future versions of the Companion Guide.

CMS will analyze the discrepancy reports and conduct appropriate research to understand and resolve discrepancies so that ultimately the issuer and CMS will have the same enrollment data. This may involve some manual effort and discussions on the part of both CMS and/or issuers to obtain correct information from the enrollee.

ii. *Enrollment and Mid-year Changes*

Issuers will receive enrollment changes and updates due to enrollees reporting changes in circumstances throughout the benefit year and as part of the eligibility redetermination process. The transactions will be sent in sequential order and should be applied sequentially in order to ensure that issuers have the most up-to-date mid-year change data. Issuers will also periodically receive an update from the Exchange with retroactive changes. The most common instances in which this will occur include birth, death, errors, QHP material provision violations, and exceptional circumstances. The process for how APTC and CSR will be handled is outlined in the Final Payment Notice.

SECTION 9. DIRECT ENROLLMENT WITH THE QHP ISSUER

This section describes the enrollment process for qualified individuals enrolling in coverage through an FFE, including a State Partnership Exchange.

As provided in 45 C.F.R. § 156.265(b), a QHP issuer may treat an enrollee as enrolled in the QHP through the Exchange if certain conditions are met and procedures followed. In order to facilitate enrollment of qualified individuals in a QHP through the Exchange when such individuals approach an issuer directly, CMS will provide an Application Programming Interface (API) for issuers, which will allow individuals accessing an issuer's website to receive an eligibility determination from the Exchange and use the issuer's website to select a QHP offered by the issuer, as detailed below. CMS plans to have issuers intending to use the API sign an attestation describing CMS' expectations regarding its use. In order to use the API, issuers will sign an agreement with CMS and participate in a pre-established web-based training program. The API will allow an individual to access the Exchange portal via a link to the Exchange. Once the individual is determined eligible for coverage through the Exchange, the Exchange will provide the results of the eligibility determination process via the API so that the qualified individual may select a QHP. Following this interaction:

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- (1) The individual compares plans on the issuer's website and selects a QHP and APTC amount (if applicable),
- (2) The issuer's website redirects the individual to the Exchange website to confirm the QHP selection and make APTC attestations,
- (3) The Exchange redirects the individual to the issuer's website to make initial premium payment, and
- (4) The issuer confirms the payment to the Exchange via an 834 enrollment confirmation transaction.

Issuers that access the API will display a message to the consumer indicating that the issuer's website is not the Exchange, and that the consumer may visit the Exchange if desired. Enrollees will also be able to use the API to submit changes that impact eligibility. An enrollee in a QHP can go to the issuer website to report a change in circumstance, such as a change in income or residence. The following steps reflect how an individual will report changes through issuers:

- (1) The issuer website will redirect the enrollee to the Exchange to report the change,
- (2) Based on the change, the enrollee may receive a new eligibility determination, and
- (3) If the enrollee is eligible for a special enrollment period, the enrollee will be returned to the issuer's website to select a new plan and APTC amount, if applicable, and follow the same process as direct enrollment outlined above.

The individual's information entered via the redirect to the Exchange will be stored with the Exchange and will not be stored with the issuer.

SECTION 10. AGENTS AND BROKERS

This section describes how agents and brokers can assist qualified individuals with the enrollment process for coverage through an FFE, including a State Partnership Exchange.

Section 1312(e) of the Affordable Care Act and 45 C.F.R. §155.220 permit states to allow agents and brokers to enroll qualified individuals, employers, and employees in QHPs through an Exchange. Where permitted by the state, agents and brokers may assist with the eligibility application and enrollment processes, including plan selection, as well as in applying for insurance affordability programs, including APTCs and CSRs, subject to the standards outlined in 45 C.F.R. §155.220.

All agents and brokers, including web-brokers, seeking to enroll individuals through an FFE or FF-SHOP must be licensed as producers by the state and adhere to all applicable state laws. States will maintain their current roles of overseeing agents and brokers in their insurance markets, including licensure requirements, appointments with carriers, and any compensation standards.

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CMS will work with agents and brokers to facilitate enrollment in an FFE or FF-SHOP, including a State Partnership Exchange, to the extent permitted by state law. Specifically, CMS will grant agents and brokers access to a web portal to complete a registration process which will include an Exchange-specific training course. As described in the Exchange Final Rule, CMS will enter into agreements with registered agents and brokers seeking access to the web portal to ensure compliance with federal regulation and Exchange privacy and security requirements. Upon signing the Agent/Broker Agreement, the web portal will allow an agent or broker to assist clients electronically and manage client accounts, among other functions.

This Exchange-specific agreement will govern agents' and brokers' access to the Exchange website. CMS will conduct monitoring and oversight of agents and brokers to confirm ongoing compliance with the terms of the Agreement. CMS anticipates that this monitoring and oversight will be limited to terms of the Agreement not covered by state law, such as the Exchange's privacy and security requirements and standards for obtaining consumer consent. If an agent or broker violates their Agreement with the FFE, CMS may terminate agent or broker access to the Exchange portal.

CMS will notify the state when an agent's or broker's Exchange access has been terminated. CMS will also refer any identified market conduct issues (for example, failure to act in the best interest of the consumer) to states for follow-up and remediation.

Issuers must ensure that marketing actions taken on their behalf by agents, brokers, and web-brokers participating in FFEs and FF-SHOPS comply with applicable federal and state requirements. Any marketing materials related to an issuer's QHPs and used by an agent, broker, or web-broker have to conform to requirements in the QHP issuer's Agreement with the Exchange.

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Chapter 7: Consumer Support

SECTION 1. CALL CENTER AND WEBSITE

This section describes how CMS will provide support to consumers and employers in FFEs and FF-SHOPs, including State Partnership Exchanges, through the operation of a Call Center and website.

CMS is responsible for the operation of the FFE Call Center, to support consumers in states that do not have an SBE, including states where a State Partnership Exchange is operating. The Call Center will provide an unbiased central point of contact for consumers and employees.

The Call Center will handle calls in English and Spanish and use a language line to support 150 additional languages. As one of the primary channels for communication with the consumer, the Call Center will be available twenty four hours a day, seven days a week. Where possible, the customer service representatives at the call center will be able to provide referrals to the appropriate state or federal agencies or assistance programs (e.g., Navigators, in-person assistors), or issuers.

The Call Center will be established so that all customer service representatives are able to address requests for general information, consumer eligibility, plan comparisons, and enrollment. Complex topics may be transferred to specialized customer service representatives within the Call Center.

CMS will also operate a website to support consumers in states that do not have a State-based Exchange. The website supporting FFEs and State Partnership Exchanges will be 508 compliant, designed to accommodate people with disabilities according to federal requirements, and will support the following key program topics in both English and Spanish:

- ⌚ Exchange, Medicaid and CHIP program support (e.g., eligibility determinations, enabling successful plan selection, and enrollments),
- ⌚ Customer self-service,
- ⌚ Online support for third parties (customer service representatives, Assisters, Navigators, Agents, etc.), and
- ⌚ Consumer education.

Additionally, the website will be designed to support seamless handoffs (or redirections) to more appropriate websites. For example, if a consumer indicates he or she resides in a state with an SBE where a website for that SBE is available, the consumer will be re-directed to the appropriate website and where possible, his or her account information will be transferred with the consumer's consent. A common API will be available for SBE websites to use, to ensure consistency of information across websites to the greatest extent possible.

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Mobile support is also a strong focus for the Exchange. At a minimum, the website will be provided in a mobile-friendly format using responsive design techniques.

CMS is also funding Navigators in each FFE that will provide assistance to consumers as directed in 45 C.F.R. §155.210. The duties of Navigators include maintaining expertise in eligibility, enrollment, and program specifications; conducting public outreach; providing information in a fair, impartial and accurate manner; facilitating selection of a QHP; making referrals to consumer assistance entities when appropriate; and providing information in a manner that is culturally and linguistically appropriate and that is accessible by individuals with disabilities.

SECTION 2. CONSUMER EDUCATION

This section addresses consumer education efforts by QHP issuers participating in FFEs and FF-SHOPs, including State Partnership Exchanges, and related requirements.

CMS encourages QHPs to engage in consumer education efforts. Educational, marketing, and plan materials should comply with the requirements for meaningful access for limited English proficient individuals and for people with disabilities as set forth in, Section 6 of this chapter. In addition, CMS notes that QHPs are required to provide a Summary of Benefits and Coverage (SBC) and uniform glossary to current enrollees as well as to individuals and small employers seeking insurance in accordance with the rules set forth at 45 C.F.R. §147.200.

SECTION 3. PROVIDER DIRECTORY

This section describes how QHP issuers participating in FFEs and FF-SHOPs, including State Partnership Exchanges, should make network provider information available.

Pursuant to 45 C.F.R. § 156.230, CMS will require QHPs to make their provider directories available to the Exchange for publication online by providing the URL link to their network directory. CMS expects the directory to include location, contact information, specialty and medical group, and any institutional affiliations for each provider. CMS encourages issuers to include information such as whether the provider is accepting new patients, languages spoken, provider credentials, and whether the provider is an Indian provider.

SECTION 4. COMPLAINTS TRACKING AND RESOLUTION

This section describes how QHP issuers will investigate and resolve complaints received from consumers enrolled in QHPs through FFEs and FF-SHOPs, including State Partnership Exchanges, and also describes how CMS will track such complaints.

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CMS expects QHP issuers to investigate and resolve consumer complaints received directly from members or forwarded to the issuer by the state and/or CMS. Complaints may be forwarded within a CMS complaint tracking system developed by CMS or by other means as determined by CMS and states. CMS expects issuers to resolve complaints in a timely and accurate manner to ensure consumers receive the highest level of service and to meet QHP issuer participation standards as outlined in 45 C.F.R. §156.200.

In addition, issuers are expected to comply with all applicable state and federal laws related to consumer complaints, including advising consumers of their appeal rights. CMS intends to track complaints and use aggregated complaints information as a tool for directing oversight activities in FFEs and State Partnership Exchanges. To the greatest degree possible, CMS will collaborate with states in tracking complaints and sharing information suggestive of issuer performance problems.

SECTION 5. COVERAGE APPEALS

This section describes how QHP issuers participating in FFEs and FF-SHOPs, including State Partnership Exchanges, are expected to handle consumer complaints.

QHPs are required to meet the standards for internal claims and appeals and external review established in 45 C.F.R. § 147.136, which codifies section 2719 of the PHS Act, as amended by the Affordable Care Act. Section 2719 of the PHS Act requires that all non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage implement an effective process for internal claims appeals and external review. QHPs must fully comply with the requirements of 45 C.F.R. § 147.136 and any applicable guidance documents. CMS will monitor the effectiveness of QHP issuers' internal and external appeals processes in order to ensure compliance with applicable law and regulation, including by monitoring complaints.

SECTION 6. MEANINGFUL ACCESS

This section describes how QHP issuers in FFEs and FF-SHOPs, including State Partnership Exchanges, can ensure meaningful access by limited-English proficient speakers and by individuals with disabilities.

In order to ensure meaningful access by limited-English proficient speakers and by people with disabilities, the Exchange Final Rule requires that QHP issuers provide all applications, forms, and notices to enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and individuals with limited English proficiency. (See 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250). Additionally, 45 C.F.R. § 156.200(e) prohibits

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QHP issuers, with respect to QHPs, from discriminating on the basis of race, color, national origin, or disability.

Certain Federal civil rights laws also apply to QHPs. Title VI of the Civil Rights Act of 1964²⁴ prohibits discrimination on the basis of race, color, or national origin (including primary language) by entities that receive Federal financial assistance. Section 504 of the Rehabilitation Act of 1973²⁵ includes an obligation to provide individuals with disabilities an equal and effective opportunity to benefit from or participate in a program receiving Federal financial assistance or under any program or activity conducted by a Federal Executive Agency.

To assist QHP issuers in complying with the standards established in 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, we outline a safe harbor approach for issuers. QHP issuers can satisfy meaningful access standards by implementing the measures described in the following paragraphs.

- ⌚ **Safe Harbor Measures:** The measures outlined in this paragraph are evidence of compliance with the regulatory requirements established by 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250.
 - *Language Access*
 - Applications and notices, as described in the list below, produced or used by QHP issuers should be available in the languages spoken by the state's top ten largest LEP groups or spoken by 10,000 persons or greater, whichever yields the greater number of languages. Said documents should also include taglines in the top 30 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer's call center.
 - QHP issuers should offer oral interpretation, such as through telephonic interpreter services via a call center, in 150 languages, for notices and applications.
 - QHP issuer Websites that contain information about QHPs, including applications and notices, should have taglines in the top 15 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer's call center. Websites with

²⁴ 42 U.S.C § 200d et seq.

²⁵ 29 U.S.C. §794d.

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content in English should be translated into Spanish, and applications and notices appearing on issuer Websites should meet the standards above.

○ *Access for Individuals with Disabilities*

- Applications and notices, as described in the list below, must be provided, as requested, in alternate formats, including Braille, large print, or another effective method of making visually delivered materials available to individuals with disabilities, including individuals who are blind and who have low vision.
- Applications and notices, as described in the list below, should be in plain language and presented at or below the 6th grade proficiency and comprehension level.
- Call centers operated by QHP issuers must include telecommunications relay services to effectively serve persons who are deaf and hard of hearing.
- QHPs are required to inform consumers of the availability of auxiliary aids and services such as qualified interpreters, note-takers, and materials in alternate formats.
- QHPs must provide auxiliary aids and services at no cost to the consumer.
- Websites and electronic documents must be compatible with screen reader software.

- Websites and electronic documents must meet Section 508 standards or standards that provide greater accessibility to persons with disabilities.

A QHP issuer that does not implement the safe harbor measures may demonstrate compliance with meaningful access standards by developing and submitting a plan or strategy to provide meaningful access for persons with limited English proficiency and persons with disabilities. QHP issuers that implement the safe harbor measures are also encouraged to develop and submit such a plan. The plan or strategy should include at least the following:

- ⌚ How to identify persons with limited English proficiency or with disabilities;
- ⌚ The types and extent of assistance services available;
- ⌚ How to provide notice to persons with limited English proficiency or with disabilities of the availability of appropriate assistance services;
- ⌚ How to communicate with persons with limited English proficiency or with disabilities on the phone, in writing, and in person;
- ⌚ A schedule and process for monitoring and updating the plan; and

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- ⌚ Training of new and existing staff in providing appropriate assistance services to persons with limited English proficiency.

CMS remains open to other explanations of how issuers plan to meet the regulatory meaningful access requirements.

CMS expects that QHP issuers will ensure meaningful access to at least the following essential documents:

- ⌚ Applications (including the single streamlined application),
- ⌚ Consent, grievance, and complaint forms, and any documents requiring a signature,
- ⌚ Correspondence containing information about eligibility and participation criteria,
- ⌚ Notices pertaining to the denial, reduction, modification, or termination of services, benefits, non-payment, and/or coverage,
- ⌚ A plan's explanation of benefits or similar claim processing information,
- ⌚ QHP ratings information,
- ⌚ Rebate notices, and
- ⌚ Any other document that contains information that is critical for obtaining health insurance coverage or access to care through the QHP.

Documents related to appeals and SBC are not included in this list because they have their own regulatory standards with which issuers must comply.

We intend to further address and clarify the standards for ensuring meaningful access by limited-English proficient speakers and by people with disabilities in future rulemaking. QHP issuers will be held to whatever standards will ultimately apply as a result of that rulemaking.

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Chapter 8: Tribal Relations and Support

SECTION 1. MODEL CONTRACT ADDENDUM FOR TRIBAL ISSUERS WORKING WITH INDIAN PROVIDERS

This section provides additional information on how issuers participating in FFEs, including State Partnership Exchanges, and State-based Exchanges can contract with Indian health care providers.

The federal government has a historic and unique relationship with Indian tribes. In adhering to QHP certification standards, CMS encourages QHPs to engage with Indian health care providers, through which a significant portion of American Indians and Alaska Natives (AI/AN) access care. To promote contracting between issuers and Indian health care providers, CMS developed a Model QHP Addendum (“Addendum”) to facilitate the inclusion of Indian Health Service, Tribal Organization, and Urban Indian Organization providers (“Indian health care providers”) in QHP provider networks. The Addendum is a model standardized document for QHP issuers to use in contracting with Indian health care providers; the Addendum is also intended to help QHP issuers comply with the QHP certification standards set forth in part 156 of the Exchange Final Rule.

Although the Addendum is not required, it can assist QHP issuers in including Indian health care providers in their networks and provides an efficient way to establish contract relationships with such providers, while also helping to ensure that AI/ANs can continue to be served by their Indian provider of choice. CMS will publish the model QHP Addendum along with a database of Indian health care providers compiled by the Indian Health Service.

SECTION 2. TRIBAL SPONSORSHIP OF PREMIUMS

This section provides additional information about how CMS will work with Tribes in FFEs, including State Partnership Exchanges.

45 C.F.R. § 155.240(b) provides Exchanges with flexibility to permit Indian Tribes, Tribal organizations, and urban Indian organizations to pay QHP premiums—including aggregated payment—on behalf of members who are qualified individuals, subject to terms and conditions determined by the Exchange. Feedback provided during consultation with Tribal governments indicates that American Indians and Alaska Natives may be reluctant to enroll in QHPs if Tribes are not able to pay premiums on their behalf, in part due to the large number of American Indians and Alaska Natives who may have not previously paid premiums for health insurance. As a result, CMS is considering options for supporting the payment of QHP premiums by Tribes on behalf of their members in FFEs. There are a number of logistical challenges that must be addressed to support an effective Tribal premium payment program for 2014 or future plan years, and CMS intends to issue further guidance on this issue. CMS also expects that Tribes and issuers will work together to explore possibilities for Tribal payment of premiums.

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Appendix A: Market-wide and QHP Certification Standards and CMS Approach

| | Regulatory Standard | CMS approach |
|---------------------------------|---|---|
| Market-wide Standards | | |
| EHB Standards | <p>Issuer offers coverage that is substantially equal to the coverage offered by the EHB benchmark plan.</p> <p>Note: also applies to stand-alone dental plans with respect to the pediatric dental EHB.^</p> | <ul style="list-style-type: none"> ⌚ Confirm that issuer offers coverage that is substantially equal to EHB benchmark plan**; ⌚ If the issuer is substituting benefits, confirm that the issuer has demonstrated actuarial equivalence of substituted benefits**; and ⌚ Collect issuer attestation of compliance with all EHB standards. |
| EHB Formulary Standards | <p>Issuer’s plan covers at least the greater of:</p> <ol style="list-style-type: none"> 1. One drug in every USP category and class; OR 2. The same number of prescription drugs in each category and class as benchmark plan. | <ul style="list-style-type: none"> ⌚ Use drug count service to determine number of drugs per category and class**; ⌚ Conduct outlier test to identify potentially discriminatory formularies**; and ⌚ Collect issuer attestation of compliance with EHB and non-discrimination standards. |
| AV Standards | <p>Offers plans at metal levels specified in statute.</p> <p>Note: also applies to stand-alone dental plans who must high/low AV levels of 85% or 75% within a <i>de minimis</i> variation of +/-2 percentage points.</p> | <p>Confirm that the AV for each plan meets specified levels (or falls within allowable variation):</p> <ul style="list-style-type: none"> ⌚ Bronze plan: 60% (58 to 62%) ⌚ Silver plan: 70% (68 to 72%) ⌚ Gold plan: 80% (78 to 82%) ⌚ Platinum plan: 90% (88 to 92%) <p>Review for unique plan designs, if applicable, and use of permissible methodologies under 45 C.F.R. §156.135(b).</p> |
| Out-of-Pocket Maximum Standards | <p>For plan year 2014: Cost sharing may not exceed the dollar amount specified by the IRS for high deductible health plans (HDHPs).</p> <p>For plan year 2015: CMS will specify these standards based on a premium adjustment percentage in the Fall 2013 Notice of Payment Parameters.</p> | <p>Confirm that the maximum out-of-pocket limit meets requirements.</p> |

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| | Note: as applied to stand-alone dental plans, maximum out-of-pocket limit must be reasonable. | |
| Standards that Apply to QHPs Seeking Exchange Certification | | |
| Licensure and solvency | <p>Licensed by and in good standing with the state.</p> <p>Note: also applies to stand-alone dental plans.</p> | <ul style="list-style-type: none"> ⌚ Confirm that state has licensed the issuer and determined that the issuer is in good standing; or ⌚ Collect issuer attestation to meeting state licensure and solvency requirements. |
| Network adequacy | <p>Network includes sufficient number and types of providers (including providers that treat substance abuse and mental health conditions) to assure that all services are available without unreasonable delay.</p> <p>Note: also applies to stand-alone dental plans.</p> | <p>Collect attestation that issuer meets standard plus one of the following:</p> <ul style="list-style-type: none"> ⌚ If CMS determines that state has an effective network adequacy review***, CMS will confirm that the state has approved the issuer’s network; ⌚ If CMS determines that a state does not have an effective network adequacy review, CMS will accept the issuer's attestation alone if the issuer is accredited for an existing line of business (commercial or Medicaid) by an CMS-recognized accrediting entity; or ⌚ If CMS determines that a state does not have an effective network adequacy review and the issuer is not accredited, CMS will collect an access plan for the QHP. CMS will also collect provider network data from a sampling of selected issuers following certification, and will also monitor accessibility complaints. |
| Inclusion of ECPs | <p>Network includes sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of ECPs.</p> <p>Note: also applies to stand-alone dental plans.</p> | <p>Confirm one of the following:</p> <ul style="list-style-type: none"> ⌚ Issuer achieves 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****; |

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| | | <ul style="list-style-type: none"> ⌚ Issuer achieves 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or ⌚ Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application. Justifications submitted by issuers that fail to achieve either standard will undergo stricter review by CMS. |
| | <p>Issuer that provides a majority of covered services through employed physicians or a single contracted medical group complies with the alternate standard established by the Exchange (see 45 C.F.R. § 156.235(b)).</p> <p>Note: also applies to stand-alone dental plans.</p> | <p>Confirm one of the following:</p> <ul style="list-style-type: none"> ⌚ Issuer has at least the same number of providers located in designated low-income areas²⁶ as the equivalent of 20% of available ECPs in the service area; ⌚ Issuer has at least the same number of providers located in designated low-income areas as the equivalent of 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or ⌚ Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application. |
| Marketing | <p>Complies with state marketing laws and regulations.</p> <p>Note: also applies to stand-alone dental plans.</p> | <ul style="list-style-type: none"> ⌚ Collect issuer attestation to meeting state marketing standards. ⌚ Obtain link to issuer’s provider directory for display on the Exchange website. |
| Accreditation | <p>Achieves accreditation based on local performance by an entity recognized by HHS on the timeline established by the Exchange. Issuers must authorize the release of their accreditation survey data.</p> | <ul style="list-style-type: none"> ⌚ Confirm that issuer meets FFE accreditation timeline requirements. ⌚ Confirm that issuer has authorized release of accreditation data. ⌚ Collect and verify information on issuers’ existing accreditation (if |

²⁶ CMS will consider a low-income area a Health Professional Shortage Area (HPSA) or a zip code in which at least 30 percent of the population have incomes below 200 percent of the federal poverty limit.

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| | | applicable), including accreditation data. |
| Service area | <p>The service area of a QHP must be at minimum an entire county, or a group of counties, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and was established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.</p> <p>Note: also applies to stand-alone dental plans.</p> | <p>Conduct automated check to identify partial-county requests. If a partial county request is identified, conduct case-by-case manual review of justification.**</p> |
| Non-discrimination | <p>Issuer does not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.</p> <p>Note: also applies to stand-alone dental plans</p> | <p>⌚ Collect issuer attestation to meeting regulatory standards.</p> |
| Non-discrimination : Medical and drug benefits | <p>Issuer does not employ benefit designs that will discourage the enrollment of individuals with significant health needs.</p> <p>Note: also applies to stand-alone dental plans</p> | <p>⌚ Conduct outlier analysis or other automated test to identify possible discriminatory benefit designs.**</p> <p>⌚ Review identified outliers and/or results of automated test.</p> <p>⌚ Collect issuer attestation to meeting regulatory standards.</p> |
| Consumer Interest Requirement | <p>The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, subject to the constraints outlined in 45 C.F.R. § 155.1000(c).</p> | <p>One factor CMS will take into account when determining whether certifying a QHP is in the consumer interest is whether and the extent to which each QHP is meaningfully different from other QHPs offered by the same issuer: 1. QHP application is "substantially different" from issuer's other applications; and</p> |

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| | | <p>2. Consumers are not likely to have difficulty distinguishing between offerings. CMS will identify possible issues and perform manual review based on key features such as plan type, metal level, service area, premiums, cost sharing, benefits offered, or formulary structure.**</p> <p>In addition, CMS will conduct an outlier analysis on QHP rates to ensure that rates are relatively consistent across QHPs. FFEs will not impose price controls.</p> |
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*CMS will make available an analytic tool, analytic parameters, or other resources (e.g., scenarios) to support states in implementing the good faith approach.

** CMS would determine whether a state has an effective network adequacy review based upon whether the state has statutory authority to review issuers' networks, and whether the authority allows the state to determine whether the state maintains a network sufficient in number and type of providers to ensure that all services will be accessible without unreasonable delay.

***Contracts offered must comply reflect the generally applicable payment rates of the issuer, and must account for the payments to FQHCs under 1902(bb), unless the FQHC and issuer mutually agree on other rates. Contracts offered to Indian providers must include the QHP Addendum for Indian providers.

^The Exchange Final Rule establishes that all “applicable” QHP certification standards also apply to stand-alone dental plans seeking to be certified on an Exchange, as noted in this table. CMS anticipates that dental issuers will submit attestations of meeting the applicable certification requirements with their QHP Applications. These requirements will be reviewed in the FFE and State Partnership Exchange certification processes. At this time, accreditation regulations established for QHP issuers do not apply to stand-alone dental plans.

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Appendix B: Authorities Cited

Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, 124 Stat. 119 (2010)
(codified as amended in scattered sections of 26 & 42 U.S.C.)

Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936
(codified as amended in scattered sections of 29 & 42 U.S.C.)

Internal Revenue Code, 26 U.S.C. §1, *et seq.*

Public Health Service Act, 42 U.S.C. §201, *et seq.*

Rehabilitation Act of 1973, 29 U.S.C. §701 *et seq.*

Social Security Act, 42 U.S.C. §301, *et seq.*

Workforce Investment Act of 1998, 29 U.S.C. §2801, *et seq.*

Patient Protection and Affordable Care Act; Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections Final Rule, 75 Fed. Reg. 37,188 (Jun. 28, 2010) (to be codified at 45 C.F.R. pts. 144, 146, & 147)

Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan Program, 76 Fed. Reg. 77,392 (Dec. 13, 2011) (to be codified at 45 C.F.R. pt. 156)

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156, & 157)

Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42,658 (Jul. 20, 2012) (to be codified at 45 C.F.R. pt. 156)

Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges, 77 Fed. Reg. 72,582 (Dec. 5, 2012) (to be codified at 45 C.F.R. pt. 800)

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Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicaid & Medicare Serv., General Guidance on Federally-facilitated Exchanges (May 16, 2012), *available at* <http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf>

Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicaid & Medicare Serv., Guide to Reviewing Proposed State EHB Benchmark Plans (November 26, 2012), *available at* <http://cciio.cms.gov/resources/EHBBenchmark/ehb-benchmark-review-guide.pdf>

Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicaid & Medicare Serv., Guidance on State Partnership Exchange Options in the Federally-facilitated Exchange (January 3, 2013), *available at* <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>.

Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicaid & Medicare Serv., Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Exchange (FFE) (January 31, 2013), *available at:* <http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf>.

Dept. of Health & Human Serv., Office of Inspector Gen., Notice of Publication of the OIG's Compliance Program Guidance for Medicare+Choice Organizations Offering Coordinated Care Plans, 64 Fed. Reg. 61,893 (Nov. 15, 1999), *available at* <https://oig.CMS.gov/fraud/docs/complianceguidance/111599.pdf>

Dept. Health & Human Serv., Office for Civil Rights, Prohibition Against Discrimination on the Basis of Disability in the Administration of Temporary Assistance to Needy Families (TANF) (2001), *available at* www.CMS.gov/ocr/prohibition.html

Internal Revenue Serv., Rev. Proc. 2012-26, 26 C.F.R. §601.602, *available at* <http://www.irs.gov/pub/irs-drop/rp-12-26.pdf>

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