Illinois Department of Insurance

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TO: ALL COMPANIES WRITING HEALTH AND ACCIDENT INSURANCE IN ILLINOIS

FROM: ANNE MELISSA DOWLING, ACTING DIRECTOR OF INSURANCE

DATE: March 25, 2016

RE: COMPANY BULLETIN # 2016-04 ILLINOIS QUALIFIED HEALTH PLANS 2017

Section I: Purpose and Scope

The purpose of this Bulletin is to provide instructions to Issuers seeking to have Illinois Qualified Health Plans ("QHP") recertified or certified for the 2017 Plan Year.

The submission time line for the Qualified Health Plans is provided below. Please note all dates listed in the time line may be subject to change.

Activity		Dates (Approximate)
QHP Application Submission and Review Process	Issuers Submit Plan Data to States and States Review	3/28/2016 – 4/18/2016
	First SERFF Data Transfer Deadline for States	5/11/2016
	Review Initial Plan Data	5/12/2016 – 6/10/2016
	First Correction Notice Sent to Issuers	6/15/2016 – 6/16/2016
	Issuers Resubmit Plan Data into SERFF	Varied
	Second SERFF Data Transfer Deadline for States	6/30/2016
	Conduct Re-review of Plan Data	7/1/2016 – 8/2/2016
	Notify States of any Needed Corrections to QHP Data	8/8/2016 – 8/9/2016
	Issuers Resubmit Plan Data into SERFF	Varied

	Final Deadline for Submission of QHP Data and Certification Recommendations; Deadline for All Risk Pools with QHPs to Be in "Final" Status in the URR System; Data Locked Down	8/23/2016
	Conduct Final Review of QHP Application Data received as of August 23	8/24/2016 – 9/9/2016
QHP Agreement/Final Certification	Certification Notices and QHP Agreements Sent to Issuers, Agreements Signed by Issuers, Agreements Countersigned by CCIIO, QHP Data Finalized	9/15/2016 – 10/4/2016
Open Enrollment		11/1/2016 – 1/31/2017

Section II: Illinois Qualified Health Plan Application Guidelines

As part of the recertification/certification process under the ACA, the Illinois Department of Insurance ("Department") prepared the Qualified Health Plan Guidelines and the Illinois QHP Application Checklist.

The QHP Guidelines specify the criteria that Issuer Plans, including Stand-Alone Dental Plans, must meet to be recertified/certified as a QHP in the individual Marketplace and/or the Small Business Health Options Program (SHOP) Marketplace. The Guidelines note alternative standards for Stand-Alone Dental Plans when appropriate.

Issuers that opt not to renew participation of any QHPs offered in the Marketplace should have already notified the Department as required by Company Bulletin CB 2016-01. The Issuer must follow all applicable laws, regulations and contractual requirements in terminating the respective QHP from the Marketplace, including appropriate notification to enrollees.

To apply to be recertified/certified as a QHP, Issuers must submit all required documentation listed in the Application Checklist, including rate and form filings, through the System for Electronic Rate and Form Filing (SERFF) between Monday, March 28, 2016, and Monday, April 18, 2016, at 11:59 p.m. (CST).

As noted, the Illinois QHP Application Checklist is included with this Bulletin. Additional checklists related to the recertification/certification process under the ACA can be found on the Department's website.

Section III. Background

The Affordable Care Act (ACA) requires all health plans offered in a Marketplace[1] to be certified as a Qualified Health Plan (QHP). As a Plan Management partner in plan year 2017, the Department, with the assistance of the Illinois Department of Public Health (DPH), will review QHP applications and recommend applicants that meet the application standards to CCIIO for QHP recertification/certification.

All Marketplace health plans and stand-alone dental plans need to be recertified/certified as a Qualified Health Plan. The review for recertification/certification must include, but is not limited to, consideration of general

[1] Marketplace is used in this document to reference Get Covered Illinois, Healthcare.gov, or any other entity that meets ACA standards and makes QHPs available to Illinois residents.

certification criteria as outlined in the Code of Federal Regulations, § 45 CFR 155.1000(c) as follows: Compliance with issuer licensure; Solvency requirements; Accreditation data; Network adequacy; Plan-level rate and benefit data; Consideration of changes to service areas; and Changes in ownership, mergers, or acquisitions.

In addition, the submission of any existing QHP for which an Issuer seeks recertification must include a review of the Issuer's performance over the last plan year. Concerns that emerge through issuer audits, monitoring, consumer complaints, and/or concerns raised by states or consumers during the 2016 coverage year will be factored into recertification decisions.

To be recertified/certified as a QHP, a plan must:

1. Be submitted to the Department through SERFF for review no later than 11:59 p.m. CST on April 18, 2016;
2. Meet all minimum federal and state requirements;
3. Be recommended by the Department to CCIIO; and
4. Be certified by CCIIO, which includes having a signed Issuer agreement.

Section IV. General Guidance

These Guidelines specify the criteria that Issuers must meet to have a health insurance plan, including a Stand-Alone Dental Plan, certified as a QHP in the Individual Marketplace and/or Small Business Health Options Program (SHOP) Marketplace.

All checklists, templates and supporting documentation must be submitted in a SERFF QHP binder. All appropriate rate and form filings will need to be properly associated to the QHP application in SERFF or the QHP binder must returned. Issuers will need to submit HIOS approved and validated templates which may be downloaded from SERFF http://www.serff.com/hix.htm**.** The QHP application will be considered incomplete unless the Issuer verifies use of the Data Integrity Tool and makes all corrections. **It should be noted that rate filings for Off Marketplace plans must be filed in the same timeframe as QHP Plans. CCIIO has been given the preemption provision in Section 2724 of the Public Health Service Act (along with their broad authority) to establish a process for monitoring and reviewing rate increases under Section 2794.**

The ACA and relevant HHS regulations and guidance provide the regulatory framework for QHP recertification/certification application requirements. Issuers are required to submit issuer-completed application templates, including benefit and service area data and rating tables, for review by the Department. Issuers must also agree to provide additional detail to CCIIO, such as reinsurance, enrollment and quality data. Because Illinois is a Plan Management partner, Issuers must use federal Plan Management Templates. Before uploading the completed application to SERFF, Issuers need to download the federal Excel templates from the SERFF website, complete the templates, validate them and attach them in the application. These templates will adjust standards for Stand-Alone Dental Plans accordingly. Issuers must use the Department's recertification/certification checklist to assist in the completion of the QHP recertification/certification application. This checklist is attached to the Guidelines and may be found at the Department website. In addition, there are checklists for the completion of the individual and SHOP requirements contained within the application. All of the checklists must be downloaded from the Department website, completed and attached to the QHP recertification application before the application is submitted in SERFF. If the QHP application is submitted without the appropriate completed checklist, the application will be returned.

All form filings must be submitted in the format of a complete insurance policy. Matrix insert page filings, riders, variable language and brackets will not be accepted. The rate and form filings must be submitted separately and the rate filings must properly identify which policy forms are associated with the specific rate filing.

All fees related to the submission and review of each QHP application must be submitted with the application. As outlined in Company Bulletin CB 2013-04, each QHP plan submission in SERFF must be accompanied by a fee of $3,000 and any QHP plan submission which is considered a renewal of an existing certified plan on the Marketplace must be accompanied by a fee of $1,500.

Each form filing submitted for recertification should provide a red-lined version identifying the variations in plan benefit design from the plans submitted for the previous plan year. Both the red-lined version and final form policy must be submitted in the Form Schedule tab in SERFF. The Department will not accept riders which outline the changes in the previous year's policy form.

To ensure that each QHP recertification/certification application is complete, the issuer should review the attached Application Checklist. The Application Checklist provides a list of documents which must be attached to complete the QHP application. Any outstanding fines, fees or other amounts owed by the Issuer to the Department must be paid or otherwise resolved before a QHP application will be recommended for recertification/certification.

Section V. Meaningful Difference

In order for its plans to be recommended for recertification/certification as QHPs, Issuers are required to offer plans in at least the silver and gold coverage level as defined by 2707(c) of ACA. The Department will review the plans to determine if there are meaningful differences between plan offerings. Plan offerings in the same metal level must meet at least one of the three criteria listed below to achieve meaningful difference:

1. Deductible, Maximum Out-of-Pocket, or Cost Sharing Difference:
    - Medical deductible difference of $250 or more; or
    - Pharmacy deductible difference of $100 or more; or
    - Integrated medical and drug deductible of $350, or
    - Maximum out of pocket difference greater than $1000 ;or
    - Inpatient/Outpatient Visit difference of at least 10%; or
    - PCP/Specialist Visit difference of at least $10 or 10%; or
    - Generic Drugs difference of at least a $5 average difference or if applicability of deductible is changed; or
    - Brand Drugs difference of at least a $10 average.

2. Network: Plan design has different networks identified by different provider network IDs listed in the template. Each network must independently meet the network adequacy/service area requirements.

3. Covered Benefits: the plans within the subgroup must differ in the coverage of one or more benefits that display to consumers on the HealthCare.gov website including Skilled Nursing Facility; Chiropractic Care; Habilitation Services; Routine Eye Exam (Adult); Routine Dental Services (Adult); Basic Dental Care – Adult; Major Dental Care – Adult; Orthodontia – Adult; Dental Check-Up for Children; Basic Dental Care – Child; Major Dental Care – Child; Orthodontia – Child; Hearing Aids; Infertility Treatment; Private-Duty Nursing; Bariatric Surgery; or Acupuncture. (Note that QHPs must cover benefits required to provide EHB based on the applicable benchmark in Illinois.)

Section VI. Catastrophic Plans

Catastrophic plans may be sold only on the individual Marketplace, not in the SHOP. Catastrophic plans are available for adults under age 30 and consumers without other affordable insurance options. Catastrophic plans

must offer:

1. Coverage that is not in the bronze, silver, gold or platinum level and has lower premiums than other plans with a similar provider network;
2. Protection against high out-of-pocket costs;
3. Coverage for three primary care visits per year before reaching the deductible;
4. Recommended preventative services without cost-sharing; and
5. No coverage of essential health benefits until the enrolled individual reaches the annual limitation in cost-sharing (45 CFR 156.155).

Issuers who elect to offer these plans must complete the Department's Catastrophic Checklist and submit it with the QHP recertification/certification application.

Section VII. Qualified Health Plan Specific Requirements

Plan ID Crosswalk: CMS developed and released a Plan ID Crosswalk Template for issuers to complete and submit to CMS. This template enables issuers to crosswalk their 2016 QHP plan ID and service area combinations (e.g., Plan ID and County combinations) to a 2017 QHP plan ID. CMS will conduct an overall data integrity review of submitted Plan ID Crosswalk data. This will include, but not be limited to, an evaluation for compliance with 45 C.F.R. 155.335(j) and with the final rule on Annual Eligibility Redeterminations for Marketplace Participation and Insurance Affordability Programs.

Attestations: Issuers need to download an Attestations Document found on the SERFF website, complete it, electronically sign it and upload it to SERFF. Additional supporting documents may need to be uploaded for the attestations. This Attestations document was created by CCIIO and includes attestations relating to QHP benefit standards, quality, enrollment, financial management, SHOP and reporting requirements.

State Licensure*:* Issuers must be licensed and in good standing with the state in order to offer QHPs on the Marketplace. (45 CFR 156.200(b) (4)). The Department will verify licensure in the Department's regulated entities database. Good standing means that the Issuer has no outstanding sanctions imposed by the Department. The Department will contact the Issuer regarding any further clarifications that are needed on licensure.

Good Standing (Solvency): Issuers must be in good standing with the state of Illinois in order to offer QHPs on the Marketplace. (45 CFR 156.200(b) (4)). Department regulators will monitor solvency by review of financial statements required by Part 925 of Title 50 to the Illinois Administrative Code. The annual or quarterly financial statement will be reviewed to determine if the Issuer meets the solvency requirements.

Benefit Design Standards and Essential Health Benefits: Issuers must offer coverage that is substantially equal to the coverage offered by the Essential Health Benefits (EHB) benchmark plan (45 CFR 156.115) and offer plans at metal levels specified by statute (45 CFR 156.140). Issuers must download the Plans & Benefits Template from SERFF, complete it and upload it to SERFF. The Department Recertification/Certification Checklist must be reviewed and completed for each Individual, SHOP, Catastrophic and dental plan submitted with the application.

The QHP Issuer must offer three silver plan variations for each silver QHP it submits for recertification/certification. The three variations must comply with the requirements of 45 CFR 156.420(a). Also, for each of its health plans at any metal level of coverage, the Issuer must offer one zero cost sharing plan variation and one limited cost sharing plan variation, and each must comply with the requirements of 45 CFR 156.420(b). Silver plan variations must have a reduced annual limitation on cost-sharing, cost-sharing requirements and Actuarial Values (AVs) that meet the required levels within a *de minimis* range. Covered

services, networks, non-EHB cost-sharing and premiums must be submitted for approval annually. Additionally, Issuers must make available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual through an Internet website and other means for individuals without access to the Internet. (45 CFR 156.220(d)).

The Plans & Benefits template includes a "Check AV" calculator that can be downloaded to automatically calculate Actuarial Values (AVs) for all plans on the cost share variance sheet. Issuers will be reimbursed directly by the federal government for applicable premium and cost-sharing reductions. The template must be validated and finalized before it is uploaded to SERFF.

Additionally, Issuers need to upload to SERFF an Actuarial Memorandum that includes an actuarial narrative and certification required of the rates for rate review, premium allocation for advance payments of the premium tax credits and CSR payment. The Actuarial Memorandum and any other documents should be submitted as searchable documents by converting them from Word to PDF rather than scanning.

The Department will confirm that the Issuer: 1) offers coverage substantially equal to the benchmark plan; 2) that substituted benefits demonstrate actuarial equivalence; and 3) that the AV for each QHP meets specified levels or falls within allowable variation (bronze plan: 60 percent (58-62 percent); silver plan: 70 percent (68-72 percent); gold plan: 80 percent (78-82 percent); and platinum plan: 90 percent (88-92 percent)). The Department will also review the AV and actuarial memorandums for unique benefit designs where applicable. Additionally, the Department will confirm the following:

1. That the benefit design complies with the federal Mental Health Parity and Addiction Equity Act, and applicable state mental health and substance use disorder statutes;
2. That there are meaningful differences between QHPs offered by Issuers;
3. That the plan complies with annual limitation on cost-sharing and cost-sharing does not exceed the limit described in section 233(c)(2)(A)(ii) of the Internal Revenue Code of 1986; the individual cost sharing limit is $7,150 and family coverage is $14,300 (with a maximum out-of-pocket for any family member of $7,150).
4. That cost-sharing is not discriminatory and that prior authorization of services or any limitation on coverage is not imposed on coverage of emergency department services out of network that is more restrictive than the in network requirements (45 CFR 156.130).

Standardized Plan Options: The 2017 CMS Payment Notice Proposed Rules provides a standardized plan option available at each of the bronze, silver (including the silver level cost-sharing reduction variations) and gold metal levels. This would allow a total of 6 standardized option plans. If an issuer offers a silver standardized option, they must offer the standardized option at the three cost-sharing reduction variations. Each standardized option will be standard in the following categories:

- In-network cost sharing
- Deductible
- Annual limitation on cost sharing
- Copayment/coinsurance for the key EHB benefits

The standardized plans will not be allowed to have more than one in-network provider tier in each plan. The standardized plans must have the term, "standardized" included in the name of the plan when completing the templates and binder submission.

2017 Standardized Plan Options						
	Bronze	**Silver**	**Silver 73% Actuarial Value Variation**	**Silver 87% Actuarial Value Variation**	**Silver 94% Actuarial Value Variation**	**Gold**
Actuarial Value (%)	61.88	70.63	73.55	87.47	94.30	79.98
Deductible	$6,650	$3,500	$3,000	$700	$250	$1,250
Annual Limitation on Cost Sharing	$7,150	$7,150	$5,700	$2,000	$1,250	$4,750
Emergency Room Services	50%	$400 (copay applies only after deductible)	$300 (copay applies only after deductible)	$150 (copay applies only after deductible)	$100 (copay applies only after deductible)	$250 (copay applies only after deductible)
Urgent Care	50%	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$65 (*)
Inpatient Hospital Services	50%	20%	20%	20%	5%	20%
Primary Care Visit	$45 (* first 3 visits, then subject to deductible and 50% co-insurance)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Specialist Visit	50%	$65 (*)	$65 (*)	$25 (*)	$15 (*)	$50 (*)
Mental Health/ Substance Use Disorder Outpatient Services	$45 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Imaging (CT/PET Scans, MRIs)	50%	20%	20%	20%	5%	20%
Rehabilitative Speech Therapy	50%	20%	20%	20%	5%	20%
Rehabilitative OT/PT	50%	20%	20%	20%	5%	20%
Laboratory Services	50%	20%	20%	20%	5%	20%
X-rays	50%	20%	20%	20%	5%	20%
Skilled Nursing Facility	50%	20%	20%	20%	5%	20%
Outpatient Facility Fee	50%	20%	20%	20%	5%	20%

2017 Standardized Plan Options						
	Bronze	**Silver**	**Silver 73% Actuarial Value Variation**	**Silver 87% Actuarial Value Variation**	**Silver 94% Actuarial Value Variation**	**Gold**
Outpatient Surgery Physician/ Surgical	50%	20%	20%	20%	5%	20%
Generic Drugs	$35 (*)	$15 (*)	$10 (*)	$5 (*)	$3 (*)	$10 (*)
Preferred Brand Drugs	35%	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$30 (*)
Non-Preferred Brand Drugs	40%	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*)
Specialty Drugs	45%	40% (*)	40% (*)	30% (*)	25% (*)	30% (*)

(*) = not subject to the deductible

Formulary: Plans must cover at least the greater of one drug in every United States Pharmacopeia (USP) category and class or the same number of drugs in each category and class as the benchmark plan. (45 CFR 156.120). The Department and CMS intend to ensure that all Marketplace consumers, regardless of medical condition, have appropriate access to prescription drugs. All formularies will be reviewed for clinical appropriateness to analyze the availability of covered drugs recommended by nationally-recognized clinical guidelines used in the treatment of the following specific medical conditions: bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia. The review will also consider whether issuers are offering a sufficient number and type of drugs needed to effectively treat these conditions, and on some first line drugs, are not restricting access through lack of coverage and inappropriate use of utilization management techniques. The review will also seek to identify outliers based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular USP category and class. The Department will also perform a supplementary review using actual utilization data. This will compare the formulary copays to the protected classes and the benchmark formulary as determined by the State of Illinois. This review will determine if protected classes are disadvantaged with higher copay than the benchmark formulary. The second comparison reviews the copay cost difference between the example of the formulary's maintenance drugs and the Protected Classes. Issuers also need to download the Formulary Template from SERFF, complete it and upload it to SERFF. Data points on the Formulary template include tier, drug types included, copayment, coinsurance, one to three month pharmacy and mail order benefits, a drug list, whether prior authorization or step therapy is required and other specified items. The template must be validated and finalized before it is uploaded to SERFF.

Non-Discrimination: An Issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions. (45 CFR 156.125). The Department will evaluate whether benefit substitutions are non-discriminatory through actuarial review. The Department's actuaries also determine whether cost-sharing limits and specified metal level designations of coverage are appropriate, and will review and approve actuarial explanations for plans that do not use the AV calculator due to unique benefit designs.

Rating: Issuers need to download the Rates Template from SERFF, complete it, validate, and upload it to SERFF. Data points on the Rates Template include rate effective date, age, tobacco, individual, family tier scenarios and other specified items. The template must be validated and finalized before it is uploaded to SERFF.

Rating factors are multiplicative for age, tobacco use and geography. Additionally, under the single risk pool requirements for non-grandfathered plans in the individual and small group markets respectively, future rate changes must be applied evenly, with only certain plan-specific modifications, such as actuarial value and cost-sharing design, provider network, delivery system characteristics, utilization management practices, and essential health benefits provided.
(45 CFR 156.80).

Age Rating: For age rating, Issuers must use the federal age curve in the Health Insurance Market Final Rule. The federal age curve in the rule requires one band for ages 0-20; one year bands between ages 21-63; and one band for ages 64 and older:

CMS STANDARD AGE CURVE					
AGE	**PREMIUM RATIO**	**AGE**	**PREMIUM RATIO**	**AGE**	**PREMIUM RATIO**
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and Older	3.000

The 3:1 age rating limitation applies only to adults age 21 and older. Age bands must be determined based on the enrollee's age on the first day of the plan year. For individuals who are added to the plan or coverage on a date other than the date of policy issuance or renewal, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage.

Tobacco Use: Tobacco use rating is not to exceed 1.5:1; Issuers may use a lower tobacco use factor for different ages, as long as the factor does not exceed 1.5 to 1 for any age group. Individuals in small group plans must be able to avoid the tobacco surcharge by participating in a wellness program.

Geography/Rating Areas: The thirteen geographic rating areas for Illinois are listed below:

- Area 1: Cook County
- Area 2: Lake, and McHenry Counties
- Area 3: DuPage, and Kane Counties
- Area 4: Grundy, Kankakee, Kendall, and Will Counties
- Area 5: Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, and Winnebago Counties
- Area 6: Bureau, Hancock, Henderson, Henry, Mercer, Rock Island, Warren, and Whiteside Counties
- Area 7: Fulton, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, and Woodford

Counties

- Area 8: Dewitt, Livingston, and Mclean Counties
- Area 9: Champaign, Clark, Coles, Cumberland, Douglas, Edgar, Ford, Iroquois, Piatt, and Vermilion Counties
- Area 10: Adams, Brown, Cass, Christian, Logan, Macon, Mason, Menard, Morgan, Moultrie, Pike, Sangamon, Schuyler, Scott, and Shelby Counties
- Area 11: Bond, Calhoun, Clinton, Greene, Jersey, Macoupin, Montgomery, Randolph, and Washington Counties
- Area 12: Madison, Monroe, and St. Clair Counties
- Area 13: Alexander, Clay, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, and Williamson Counties

The areas are arranged according to expected medical cost levels. Issuers shall develop and justify rating area factors.

Family Premiums: Family premiums will be determined by adding up the premiums of each family member to ensure that the age and tobacco use rating will only apply to that portion of the premium attributed to each family member. Issuers must not rate more than three children under the age of 21 when developing family premiums. Rating factors are multiplicative for age, tobacco use and geography. Therefore, for example, the oldest adult who used tobacco in rating area 1 could be charged 4.5 times more (3 x 1.5) than the youngest adult who did not use tobacco in rating area 1. Additionally, under the single risk pool requirements for non-grandfathered plans in the individual and small group markets respectively, future rate changes must be applied evenly, with only certain plan-specific modifications, such as actuarial value and cost- sharing design, provider network, delivery system characteristics, utilization management practices, and essential health benefits provided. (45 CFR 156.80).

Composite Rating: Please see Company Bulletin 2016-02 for the Illinois-specific alternate composite rating method for small group Off-Marketplace filings.

Business Rules: Issuers also need to download the Business Rules Template from SERFF, complete it, validate, and upload it to SERFF. Data points on the Business Rules Template include product ID, plan ID, how rates for contracts covering two or more enrollees are calculated, maximum age for a dependent, if domestic partners are treated the same as secondary subscribers and other specified data. This data will be used to populate the premium calculator for rate review and to perform calculations for risk adjustment.

QHPs offered through the Marketplace must have the same premium and cost-sharing rates as the same plans offered outside of the Marketplace; premiums may vary only in accordance with permitted rating variations, and Issuers must comply with the required rating curves, areas and ratio standards. The Department will review initial rate filings and rate increase filings for QHPs to see that sound assumptions and methodologies were used in developing QHP premium rates and will also review rates for compliance with relevant ACA requirements and Illinois Regulations. (50 Ill. Adm. Code 2026).

Rate Review: Issuers need to download the Rate Review Template from SERFF, complete it, validate, finalize, and upload it to SERFF. The template collects data on market experience, plan product information and financial information that is necessary for rate review and the evaluation of cost-sharing reduction payments, including base period claims experience, projected period medical trend factors and projected period administrative factors. Issuers must also complete and submit the Rate Review Checklist.

Marketing: Issuers must comply with state marketing laws and regulations. (45 CFR 156.225(a), 215 ILCS

5/149, 215 ILCS 5/364, 50 Ill. Adm. Code 2002. In Illinois, marketing standards are the same inside and outside the Marketplace. Additionally, products and rates must not be constructed or marketed in a way that discourages people from using the Marketplace.

Marketing activities should be fair and accurate. The standards include provisions for required and prohibited language, requirements for filing of marketing material, provision of educational material and an explanation of the policy features. Issuers may not employ marketing practices that discourage enrollment of individuals with significant health needs.

To assist consumers in identifying plans which have been certified on the Marketplace, the marketing material, including policy forms, distributed to enrollees and potential enrollees shall include a disclaimer which fully explains that the plans are Qualified Health Plans in the Health Insurance Marketplace.

Network Adequacy: Issuers are required to include a sufficient number and type of providers, including providers that specialize in substance use and mental health services, to ensure that all services are available without unreasonable delay (45 CFR 156.230). DOI determines sufficiency by reference to any reasonable criteria, which may include, but shall not be limited to the following:

a) Provider-covered person ratios by specialty;
b) Primary care professional-covered person ratios;
c) Geographic accessibility of providers;
d) Geographic variation and population dispersion;
e) Waiting times for an appointment with participating providers;
f) Hours of operation;
g) The ability to meet needs of covered persons, including low-income persons, children & adults with serious, chronic or complex health conditions or physical or mental disabilities, or persons with limited English proficiency;
h) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and
i) Volume of technological & specialty care services available to serve the needs of covered persons requiring technologically advance or specialty care services.

Issuers are required to download the Essential Community Provider/Network Adequacy Template in SERFF, complete it and upload it to SERFF. Data points on the Network Adequacy Template include, but are not limited to, the National Provider Identifier (NPI), provider name, provider type, provider address, facility name, facility type, facility address and network ID. Issuers need to validate and finalize the template before it is uploaded to SERFF.

The Department requires that networks associated with tier products meet the network adequacy requirements. Specifically, the network with the lowest cost sharing for beneficiaries (typically tier 1) must meet the Illinois and federal network adequacy requirements. For those issuers that offer a tiered network product, the Illinois Network Template must be completed in addition to the Essential Community Provider/ Network Adequacy Template found in SERFF. This template includes the items listed above as well as an identifier of the tier to which the provider or facility belong.

Additionally, QHP applicants are required to file a completed Network Adequacy Checklist and the Excel Spreadsheets with necessary documentation for review to verify compliance with the Network Adequacy and Access requirements included below:

- Service Areas
    - If an Issuer is not covering an entire rating area, the Issuer must provide which subsets of a rating area are included in the service area or the corresponding product and network.

- ✓ Rating areas the network coverage
- ✓ Definition of Service Area
- ✓ List of counties in the service area, by product and plan

- Provider Network
  - This list must be provided for each product and/or network that an Issuer is offering for ACA compliant products. In addition to the list of provider names the following information will be required:
    - ✓ Addresses (physical addresses as opposed to P.O. boxes)
    - ✓ Types and specialties
    - ✓ NPI number(s)
    - ✓ Indicator if accepting new patients
    - ✓ Network tier (if there are multiple tiers within a product)
    - ✓ Unique identification of providers who are available through telehealth or other innovative methods
  - Internet website with up to date provider directory which fully denotes which network applies to each plan sold on the Marketplace
  - Demonstration of 24/7 accessibility
    - ✓ Hours of operation for providers/after-hours access
    - ✓ Urgent care/emergency care hours and listing of providers
- Geographic map with providers marked
- Number of anticipated beneficiaries by county and/or number of actual beneficiaries by 5 digit zip

Each Issuer must supply the information outlined above in the QHP recertification/certification filing. The information must be supplied in the Supporting Documentation Tab in the plan filings submitted in SERFF. Both the checklist and spreadsheets may be found at the following link:

http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/IS3_Checklists.asp

The Illinois Department of Public Health (DPH) assists with review of the network adequacy components of HMO QHP recertification/certification applications and provides recommendations to the Department regarding whether HMO applicants meet these standards. Any changes to a HMOs service area requires advance approval by DPH.

Essential Community Providers (ECP): Issuers are required to include a sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of ECPs. (45 CFR 156.235). HHS has compiled a non-exhaustive database of ECP providers which Issuers should reference for accuracy to comply with the requirements. http://cciio.cms.gov/programs/exchanges/qhp.html. Issuers must:

1. Achieve at least 30 percent ECP participation in network in the service area, agree to offer contracts to at least one ECP of each type available by county, and agree to offer contracts to all available Indian providers;
2. If the 30 percent participation is not met, submit a satisfactory narrative justification as part of its QHP application.

In order to determine if the standards are met, the Issuer must supply the following material in the Supporting Documents Tab in the QHP application filing in SERFF:

- List of Provider names
  - Addresses (physical rather than PO boxes)
  - Categories

    - Identifier if provider is included or not on the list of providers supplied by CCIIO
    - NPI
- Geographic map with providers marked

Issuers also need to download an Essential Community Providers/Network Adequacy Template from SERFF, complete it and upload it to SERFF. Data points on the Essential Community Providers Template include national provider number, provider name, provider type, essential community provider category and other specified data. Stand-Alone Dental Plans will follow modified ECP standards, which will be determined by the federal government.

Service Area: Statewide coverage is not required, but a QHP must provide coverage to an entire rating area as defined herein or obtain an exception from the Department. The Issuer must provide service area maps to show compliance.

The service area of a QHP must be, at a minimum, an entire county or group of counties, unless the Department determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the Public Health Services Act, or other factors that exclude specific high utilizing, high cost or medically underserved populations. (45 CFR 155.1055). Partial-county requests will be reviewed on a case by case basis. An exception request form must be completed and submitted the Department for review. The review of the partial county request will not be based on a business plan by the QHP to simply offer a narrower network. The form is attached to these Guidelines. The Issuer must download a Service Area Template from SERFF, complete it and upload it to SERFF. Data points on the Service Area Template include service area ID, service area name, coverage area and zip codes. The Issuer needs to validate and finalize the template with buttons in the upper left corner of the Excel document before it is uploaded to SERFF.

Enrollee Termination: The Marketplace must determine the form and manner in which a QHP may be terminated in the circumstances below:

- An enrollee obtains other minimum essential coverage,
- An enrollee is no longer eligible for coverage,
- Non-payment of premiums by the enrollee
- The QHP terminates plans or decertified

The Issuer must provide reasonable notice of termination of coverage to the CCIIO and enrollee, including the effective date of the termination.
(45 CFR 155.430 and 156.270).

Accreditation: Issuers must be accredited in any line of business (commercial, Medicaid, or Marketplace) based on local performance by an accrediting entity recognized by HHS on the federal timeline (45 CFR 155.1045) and authorize the release of their accreditation survey data. Issuers need to download an Accreditation Template in SERFF, complete it and upload it to SERFF. Issuers must select the NCQA, URAC or the AAAHC Template. Data points on the Accreditation Template include Market Types, Accreditation Status, Expiration Date(s) and other specified data. The Department will be electronically advised of any changes in Issuer accreditation status through SERFF, which will track Issuer accreditation status. Accreditation standards do not apply to stand-alone dental plans.

Quality Reporting: A QHP issuer participating in a Marketplace for two or more consecutive years must implement and report on a Quality Improvement Strategy (QIS), in accordance with section 1311(g) of the Affordable Care Act, to cover all of its QHPs that meet the eligibility criteria described in Section 5.1 and/or

Multi-state Plans (MSPs). The QIS requirements apply to all issuers offering QHPs and MSPs, whether through the individual market or through the Small Business Health Options Program (SHOP). Issuers must comply with all four of the following requirements:

(1) Implement a QIS, defined as a payment structure that provides increased reimbursement or other incentives;
(2) Implement at least one of the following:
i. Activities for improving health outcomes;
ii. Activities to prevent hospital readmissions;
iii. Activities to improve patient safety and reduce medical errors;
iv. Wellness and health promotion activities; and/or
v. Activities to reduce health and health care disparities;
(3) Comply with guidelines established by the Secretary of Health and Human Services (HHS) in consultation with experts in health care quality and stakeholders;
(4) Report on progress implementing the QIS to the applicable Marketplace on a periodic basis.

Additional Supporting Documentation: Issuers need to upload additional supporting documentation to SERFF for review, including a compliance plan, organizational chart and data elements necessary to create the Summary of Benefits and Coverage scenarios for display on the Marketplace website.

Non-Discrimination: Discrimination is prohibited on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation as set forth in current Illinois insurance regulations (215 ILCS 5/424(3) and Section 364) and federal regulations. (45 CFR 156.200(e)). Additionally, Issuers must not employ benefit designs that discourage the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

Segregation of Abortion Funds: Federal funds may not be used for abortion. (45 CFR 156.280). Compliance will be monitored through market conduct reviews, including financial exam auditors verifying that federal premium tax credits and other federal funds are segregated. Additionally, 215 ILCS 5/356z.4 states, "Nothing in this section shall be construed to require an insurance company to cover services related to an abortion." The Illinois Abortion Law of 1975, as set forth in 720 ILCS 510/1 *et seq*, outlines the circumstances when an abortion can be performed and sets forth penalties for statutory violations All QHPs must abide by these statutes.

Guaranteed Availability Exceptions: In the Department's discretion, exceptions to guaranteed availability of coverage may allow Issuers to limit enrollment to certain open and special enrollment periods, an employer's eligible individuals who live, work or reside in the service area of a network plan, and in certain situations involving network capacity and financial capacity. (45 CFR 147.104). Issuers that seek to limit availability of a QHP due to network or financial capacity must make a specific request to the Department and must provide any necessary documentation to support the limited availability. If an exception is allowed, it must be applied uniformly to all employers and individuals, without regard to the enrollees' claims experience or health status-related factors. Generally, Issuers granted this type of exception would be barred from offering new coverage for at least 180 calendar days after coverage is denied, as directed by Public Health Service Act section 2702(c)(2) and (45 CFR 147.104).

Reporting:[2] Issuers must submit the following information in a quarterly report to the Department through SERFF and to CCIIO through HIOS:

1. Claims payment policies and practices;
2. Periodic financial disclosures;
3. Data on enrollment;

[2] This Reporting Requirement is contingent upon CCIIO's development of a reporting structure.

4. Data on disenrollment;
5. Data on the number of claims that are denied;
6. Data on rating practices;
7. Information on cost-sharing and payments with respect to any out-of-network coverage; and
8. Information on enrollee rights under Title I of the Affordable Care Act, including market reforms and Patient's Bill of Rights (45 CFR Part 156.220).

Section VIII. Corrective Action Plan

A QHP that is not in full compliance with recertification requirements may be subject to a corrective action plan, the purpose of which is to enable the QHP to reach full compliance within 60 days of receipt of the corrective action plan.

Section IX. Plan Decertification

Throughout the year, the Department will monitor ongoing Issuer compliance with certification criteria through complaint monitoring and random audits. Under the authority of the Illinois Insurance Code, 215 ILCS 5/143, if a QHP is not meeting one or more of the QHP requirements, the Director of Insurance may revoke, suspend or recommend decertification to CCIIO. Enrollees in a decertified plan will have the option to choose a new plan under a special enrollment period. If a plan leaves the market, the Issuer must help transfer members to an Issuer with approximately equal networks and coverage.

Section X. Issuer Oversight

Issuers are required to comply with all Department oversight activities. The Department will monitor complaints and financial standards, and conduct market conduct examinations. Complaints will be monitored by the Department and inquiries received may also be investigated. Additionally, financial monitoring, such as solvency strength tests, will be conducted monthly, quarterly, annually and triennially. Level I reviews will be conducted every six months, and more frequently if necessary with reviews being tailored to the precise problems at issue. More frequent and comprehensive market conduct examinations will be conducted when warranted based on complaints, claim payment history and other relevant factors. The cost of examination shall be paid by the Issuer being reviewed.

State of Illinois
ACA QHP Certification of Compliance

The undersigned represents and warrants that he/she is a duly authorized officer of the Company named below, and hereby certifies that he/she is knowledgeable concerning the requirements necessary to comply with federal ACA and associated health care reform legislation, and that the attached completed QHP Application Checklist, the policy forms contained herein and the associated documents and any other reporting requirements conform with all relevant checklist and relevant code citations (statutes/regulations) contained therein.

I understand that the Illinois Department of Insurance will rely on this Certification of Compliance for the QHP Application Checklist, policy forms contained herein, along with associated documents and should it subsequently be determined that these documents listed do not comply with the required statutes and regulations or that this certification is false or incorrect, corrective and disciplinary action, including retroactive disapproval, as authorized by law, may be taken by the Department against the Company.

The Company will complete any data reporting requirements set out within the QHP Guidelines and complete the Statement of Detailed Attestation required for State Partnership QHP issuers. I have attached the QHP attestation form within the company's binder submitted to the state of Illinois Department of Insurance. The attestation form can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/SPMProgramAttestations_Version1_022916.pdf

By:_____ Date:_____

Printed name: _____

Title: _____

Company:_____ Company FEIN: _____

Address: _____ Company NAIC #:_____

_____

Phone: _____

Email: _____

320 West Washington St.
Springfield, Illinois 62767-0001
(217) 782-4515
http://insurance.illinois.gov

Company Name (Name in Illinois Company is Licensed under):	
NAIC Company Number:	
Company Address:	
Contact Person for filing:	
Contact Person for filing address:	
Contact Person for filing telephone number:	
Contact Person for filing email:	
☑Individual ☐SHOP ☐CO-OP ☐Dental only	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
I		**Licensed and in good standing**	45 CFR §156.200(b)(4)		
	1.1	☐ Is licensed or authorized in Illinois as: ☐ Domestic ☐ Foreign ☐ Stock ☐ Mutual ☐ Fraternal Benefit Society ☐ HMO ☐ Non Profit Health Care Plan		Mark all applicable boxes.	
	1.2	☐ Authorized by Illinois DOI to offer **health** insurance ☐ Authorized by Illinois DOI to offer **dental** insurance		Mark all applicable boxes.	
	1.3	☐ Is in good standing		DOI will review financial documents and regulated entities database for compliance.	
II		**Benefit Standards and Product Offerings**		All provisions contained below should be reviewed for compliance with our checklist which may be found at the DOI Website - http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
				IS3_Checklists.asp Please choose the checklist of the plan type you are filing.	
	2.1	☐ Covers the Essential Health Benefit Package. • EHB substitutions will require an actuarial certification to support the substitution is compliant and is an actuarially equivalent substitution.	42 USC §18022	If the policy form contains an EHB substitution, please indicate in the location column of this checklist and provide the needed certification. An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, and degree of medical dependency, quality of life or other health conditions. (45 CFR 156.125). Please see above referenced check list for requirements	
	2.2	☐ Complies with Annual Limitation on Cost-Sharing. ☐ Cost-sharing shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for	42 USC §18022	Please QHP Guidelines for requirements	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
		self-only and family coverage. For the plan year beginning in 2017, cost-sharing for self-only and family coverage may not exceed the amount established under section 223(c)(2)(A)(ii) of the Internal Revenue Code, which is the cost-sharing limit for high-deductible health plans. For 2017, the estimated amount is $7,150 for an individual and $14,300 for a family.			
	2.3	☐ Offers through the Exchange: ☐ One silver level plan (AV 70%), • Three variations offered. **AND** ☐ One gold level plan (AV 80%).	45 CFR §156.200 (c)(1)	An issuer must offer three silver plan variations for each silver QHP, one zero cost-sharing plan variation, and one limited cost-sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost-sharing, cost-sharing requirements, and AVs that meet the required levels within a de minimis range.	
	2.4	☐ If offers a Catastrophic Plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan. Eligible individuals: ▣ Individuals that have not attained the age of 30 before the beginning of the plan year; or ▣ Individual has a certification in effect for any plan year exempt from the	42 USC §18022(e)	Please review Catastrophic Plan checklist for compliance. The checklist may be found at the DOI Website – http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
		Shared Responsibility Payment by reason of lack of affordable coverage or hardship. ☐ If offered, Catastrophic Plans are offered only in the individual exchange and **not** in the SHOP. ☐ If offered, Catastrophic Plan complies with specific requirements for benefits.		IS3_Checklists.asp	
	2.5	☐ Offers a child-only plan at the same level of coverage—bronze, silver, gold, or platinum—as any other plan offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained age 21.	45 CFR §156.200(c)	Please use the checklist of the plan type you are filing.	
	2.6	☐ Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	This will provision will be determined by DOI review of policy forms.	
III		**Rate Filings and other Rate Disclosure Requirements**			
	3.1	☐ Files rates for review		DOI will review all rates for the QHP recommendation in accordance with current rate review requirements. The checklist may be found at the DOI Website - http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/IS3_Checklists.asp	
	3.2	☐ Submits to the Exchange a justification for a rate increase prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR §156.210(c)	Insurance carrier should submit a statement to DOI that addresses these	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
				requirements	
	3.3	☐ Prominently posts the rate increase justification on issuer website prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR §156.210(c)	Insurance carrier should submit a statement to DOI that addresses these requirements	
IV		**Rating Standards—General**			
	4.1	☐ Sets rates for an entire benefit year, or for the SHOP, plan year.	45 CFR §156.210(a)	Any rate for an individual policy will be reviewed to verify the rate will not change for the entire benefit year.	
	4.2	☐ Rates must be the same for products inside and outside Exchange.	45 CFR §156.255(b)		
V		**Allowable Rating Variations**	42 U.S.C. 300gg §2701; 45 CFR §156.255		
	5.1	☐ Varies rates only based on: ☐ Geographic area ☐ Age (3 to 1) ☐ Tobacco use (1.5 to 1)	42 U.S.C. 300gg §2701; 45 CFR §156.255	Verify which applicable provisions have been met by marking the appropriate box.	
VI		**Marketing**			
	6.1	☐ Complies with all Illinois marketing laws & regulations.	45 CFR §156.225(a)	QHP Applicants must adhere to 215 ILCS 5/149 and 5/364 of the insurance code to ensure marketing activities are fair and accurate. Applicants must provide a statement for adherence.	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
	6.2	☐ Marketing practices do not discourage the enrollment of individuals with significant health needs.	45 CFR §156.225(b)		
VII		**Network Adequacy Requirements**	45 CFR §155.1050; 45 CFR §156.230		
	7.1	☐ Complies with Illinois network requirements listed below.		Review the network adequacy requirements in accordance the checklist found at the DOI Website- http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/IS3_Checklists.asp	
	7.2	☐ Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay. ☐ Network must include providers that specialize in mental health and substance abuse services.	45 CFR §156.230(a)(2)		
	7.3	☐ Has a network with sufficient geographic distribution of providers for each plan.	45 CFR §156.230(a)(2)	A geographic map of the area proposed to be served by the carrier by county and zip code, including marked locations of preferred providers if applicable.	
	7.4	☐ Has sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area.	45 CFR §156.230(a)(1) 45 CFR §156.235		
	7.5	☐ Makes its provider directory available: ☐ For publication online in accordance with guidance and	45 CFR §156.230(b)	QHP applicants must provide a ratio of providers to	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
		☐ To potential enrollees in hard copy upon request. ☐ Provider directory identifies providers that are not accepting new patients.		beneficiaries, greatest travel distance, inadequate networks, policies for closing providers and opening new providers and referral procedures.	
	7.6	☐The service area of a QHP must be at a minimum an entire county, or group of counties, unless DOI determines that serving a smaller geographic area in necessary, nondiscriminatory, in the best interest of the qualified individuals and employers.			
VIII		**Enrollment Periods**		QHP Applicant will need to provide a reference for review of these enrollment requirements.	
	8.1	☐ Provides an **annual open enrollment** period.	45 CFR §155.410(e)		
	8.2	☐ Provides notice prior to the annual open enrollment period.	45 CFR §155.410(d)		
IX		**Termination of Coverage of Qualified Individuals**	45 CFR §155.430(b) 45 CFR § 156.270	Termination provisions need to be referenced for review.	
	9.1	☐Terminates coverage only if: ☐ Enrollee is no longer eligible for coverage through the Exchange; ☐ Enrollee's coverage is rescinded; ☐ QHP terminates or is decertified; ☐ Enrollee switches coverage: ☐ During an annual open enrollment period; ☐ Special enrollment period; or ☐ Obtains other minimum essential coverage. ☐ For non-payment of premium only if:	45 CFR §155.430(b) 45 CFR § 156.270		

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
X		☐ Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances; ☐ Enrollee is delinquent on premium payment; ☐ Provides the enrollee with notice of such payment delinquency; and ☐ Provides a grace period of at least 3 consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium.			
		Accreditation Standards	45 CFR §1045; 45 CFR § 156.275		
	10.1	☐ Accredited on the basis of local performance by an accrediting entity recognized by HHS and within required timeline established by HHS.	45 CFR § 156.275(a)(1)	The accreditation template must be completed and sent in SERFF. There are templates for URAC, NCQA. See guidance if assistance is needed for templates.	
	10.2	☐ Authorizes the accrediting entity to release a copy of its most recent accreditation survey and survey-related information.	45 CFR §156.275 (a)(2)	QHP applicant will need to show compliance with this requirement.	
	XI	**Quality Assurance Program**	45 CFR §156.200(b)(5) 42 U.S.C §13031	Please refer to QHP instructions, templates and material web page: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-	

		Requirements	Federal Source	DESCRIPTION OF REVIEW REQIREMENTS	Location of Standard in Filing
				Insurance-Marketplaces/qhp.html	
	11.1	☐ Submit a Quality Plan that includes ongoing, written, internal quality assessment of the program, guidelines for monitoring and evaluating the quality and appropriateness of care and services provided to enrollees, including accessibility to health care providers, appropriateness of utilization, concerns identified by the plans' medical or administrative staff and enrollees. Improvement strategy • Corrective action plans to correct quality problems, and follow-up measures to evaluate the effectiveness of the action plan			
	XII	**Segregation of Funds**			
	12.1	☐ Does not use federal funds for abortion.	45 CFR §156.280	QHP applicant will submit statement of compliance. This will be monitored by market conduct and financial exams.	