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From: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

Title: 2015 Letter to Issuers in the Federally-facilitated Marketplaces

The Centers for Medicare & Medicaid Services (CMS) is releasing this Final 2015 Letter to Issuers in the Federally-facilitated Marketplaces (Letter). This Letter provides issuers seeking to offer Qualified Health Plans (QHPs), including stand-alone dental plans (SADPs), in a Federally-facilitated Marketplace (FFM) and/or Federally-facilitated Small Business Health Options Program (FF-SHOP), with operational and technical guidance to help them successfully participate in the Marketplaces. Except where noted, it finalizes the policies in the Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces (Draft 2015 Letter to Issuers)¹ published on February 4, 2014. Some policies with operational implications in the Draft 2015 Letter to Issuers are not being finalized in this Final 2015 Letter to Issuers, with the intent to continue work to accomplish them. Unless otherwise specified, references to the Marketplaces or FFMs include the FF-SHOP.

As indicated in previous guidance,² states that are performing plan management functions in an FFM have some flexibility in assessing compliance with certification standards and adjusting processes. Throughout this Letter, we identify the areas in which states performing plan management functions in an FFM have flexibility to follow an approach different from that articulated in this guidance. We note that the policies articulated in this Letter apply to QHP issuers starting with the certification process for the 2015 benefit year and beyond, until or unless they are superseded by subsequent guidance or regulations. In the future, CMS intends to issue similar letters and other guidance to provide operational updates to QHP issuers, but we do not intend to issue these letters on more than an annual basis.

¹ Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces, available at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf>.

² Guidance on the State Partnership Exchange, available at: <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf>.

CMS has previously published regulations and guidance on market-wide and QHP certification standards, eligibility and enrollment procedures, and other Marketplace-related topics in several phases. Additional proposed requirements are included in a regulation titled “Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond,” CMS-9949-P, that is being released simultaneously with this letter.

These regulations are set out in 45 C.F.R. Subtitle A, Subchapter B as well as in Federal Register issuances. Issuers are advised to consult these materials in conjunction with the Letter to ensure full compliance with the requirements of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (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>. Unless otherwise indicated, regulatory references herein are to Title 45 of the Code of Federal Regulations. QHP issuers in FFMs may also be subject to other requirements for the 2015 certification year, as made in future rulemaking.

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CHAPTER 1: CERTIFICATION PROCESS AND STANDARDS FOR QUALIFIED HEALTH PLANS

The Affordable Care Act and the applicable Marketplace regulations establish that health plans must meet a number of standards to be certified as qualified health plans (QHPs). Several of these standards apply generally to plans offered in the individual and small group markets regardless of whether the plan is offered through or outside of the Marketplace; the remaining standards are specific to QHPs seeking certification from the Marketplace. CMS expects that states will enforce 2014 market reforms³; accordingly, CMS expects to rely on states' reviews of policy forms and rate filings for market reforms as part of its QHP certification process, provided that such states review for compliance with standards that are consistent with federal regulatory standards and complete such reviews in a manner consistent with operational timelines. Issuers should follow state guidance regarding compliance with the processes and criteria for reviews conducted by states.

The following sections describe CMS's approach to reviewing plans against standards that generally apply only to issuers seeking certification of QHPs from a Marketplace. The reviews described in these sections will be conducted either by a state that is performing plan management functions and making QHP certification recommendations to CMS, or by CMS as a part of the process of certifying a QHP in the applicable FFM. Each section describes CMS's planned approach to evaluating QHPs against a certification standard when the state is not performing plan management functions. As noted in previously released guidance, states that are performing QHP certification reviews have some flexibility in their application of QHP certification standards, provided that the state's application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP certification in states that are performing plan management functions should refer to state direction in addition to this guidance. State-based Marketplaces will conduct their own reviews for QHP-specific standards.

This Chapter provides an overview of the QHP certification process in FFMs, both when a state is performing plan management functions as well as when the FFM is performing plan management functions. The QHP certification process for the FFM for the 2015 benefit year maintains many aspects of the process carried out for 2014, including close coordination and

³ 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 Marketplaces. Under §§ 2723 and 2761 of the PHS Act and existing regulations, codified at 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. As necessary, CMS will provide additional information on enforcement.

collaboration with states. The 2015 process also incorporates some adjusted review standards as well as operational changes.

Similar to the QHP certification process in 2014, in 2015, states may choose to conduct reviews of QHP Applications and provide recommendations to CMS on QHP certification determinations. These states will evaluate health plans against QHP certification standards as part of the state's traditional regulatory role for the insurance industry and/or enforcement of Title XXVII of the Public Health Service Act (PHS Act), or otherwise for state purposes. Based on the state's analysis and review, the state will recommend plans for QHP certification to CMS, and CMS will decide whether to certify the plans as QHPs. Similarly, in states not conducting all reviews or making QHP certification recommendations to CMS, CMS anticipates integrating state regulatory activities that the states conduct into its decision-making for QHP certification in the FFM, provided that states make these determinations and provide information to CMS consistent with federal standards and FFM timelines. These principles underlie the discussion in this Letter about the QHP certification process.

CMS will review the state's recommendations or findings to confirm that they are consistent with federal regulatory standards, and will communicate to the state any concerns that would preclude CMS's implementation of the state's recommendations or findings according to the process and timeline outlined below and in other guidance. CMS is responsible for the final QHP certification decisions in each FFM state.

Section 1. FFM QHP Application and Certification Process

This section describes how CMS, as administrator of the FFMs, will conduct QHP certification when CMS is performing the review and certification of QHPs, including stand-alone dental plans (SADPs).

In accordance with 45 C.F.R. part 155 subpart K, CMS will review and approve or deny QHP Applications from issuers that are applying to offer QHPs in an FFM. Table 1.1 presents a high-level overview of key dates in the FFM QHP certification process. Each major component of the process is described in greater detail in the subsections that follow.

For certification of a plan as a QHP for the 2015 benefit year, issuers will be required to submit a complete QHP Application, including for plans that were certified as QHPs for the 2014 benefit year. CMS will review QHP applications against all QHP certification standards for issuers that are currently offering QHPs in the FFM as well as issuers that are applying for QHP certification in the FFM for the first time. CMS also expects that states performing plan management functions in an FFM will review QHP Applications from all issuers applying for certification of a QHP for the 2015 benefit year.

For the 2014 certification cycle for the 2015 benefit year, CMS will allow issuers additional time to modify their plan data, in the following manner:

- *Ongoing data revision, with specified deadlines for review.* After the close of the initial application submission window, issuers will be able to upload revised data templates on an as-needed basis until the final data submission deadline. CMS reviews will occur at pre-defined times during this window and will be based on the QHP data in the system on certain dates.
- *Stand-alone dental plan QHP Application timeline synchronized with medical submissions.* Stand-alone and embedded dental plan data submission will follow the same timeline as that of medical plans.

We also intend to provide more specific guidance regarding the QHP certification timeline noted below before the beginning of the application submission window.

Table 1.1 Key Dates: QHP Certification in an FFM

Note: All dates are subject to change.

Activity		Dates (Approximate)
QHP Application Submission and Review Process	Initial FFM QHP Application Submission Window	5/27/2014 – 6/27/2014
	FFM Review of QHP Application Submissions as of Initial Submission Deadline	6/30/2014 – 7/25/2014
	1 st Correction Notice Sent	7/29/2014
	Deadline for Submission of Revised QHP Data for Re-review	8/7/2014
	FFM Reviews of Corrected QHP Application Submissions Received as of August 7	8/8/2014 – 8/25/2014
	2 nd Correction Notice Sent	8/26/2014
	Deadline for Final Submission of QHP Application data	9/4/2014
	FFM Completes Re-review of QHP Application Data; Data Locked Down	9/22/2014
	Limited Data Correction Window	9/24/2014 – 10/6/2014
QHP Agreement/ Final Certification	Certification Notices and QHP Agreements Sent to Issuers, Agreements Signed, QHP Data Finalized	10/14/2014 – 11/3/2014

Activity	Dates (Approximate)
Open Enrollment	11/15/2014

i. Registration and QHP Application

To offer QHPs in FFMs for the 2015 benefit year in states where CMS is performing both the primary review and certification of QHPs, health insurance issuers will complete QHP Applications electronically through the Health Insurance Oversight System (HIOS). Before submitting an application, issuers must gain access to HIOS and request user roles (such as QHP Issuer Submitter and QHP Issuer Validator), and obtain HIOS user IDs.

We expect that between May 27 and June 27, 2014, issuers will access the QHP Application in HIOS to submit all information necessary for certification of health plans and stand-alone dental plans as QHPs. The QHP Application will collect both issuer-level information and plan-level benefit and rate data, 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 provide requested supporting documentation. Based on the requirement set forth in 45 C.F.R. 156.340 that QHP issuers maintain responsibility for the compliance of their delegated and downstream entities, these attestations will also reflect that vendors and contractors of the issuer will adhere to applicable requirements.

Issuers seeking to offer QHPs must also submit the Unified Rate Review Template (URRT) to CMS via HIOS according to the same timeline. Issuers not seeking to offer any QHPs should consult with state regulators and CMS regarding their rate review obligations. Consistent with the approach in 2014, issuers do not need to submit URRTs for SADPs.

ii. Issuer Data Collection and Coordination with States

CMS expects that states will review potential QHPs for compliance with all requirements under state law, as well as with market-wide standards established by the Affordable Care Act. Specifically, CMS expects states to review potential QHPs for compliance with essential health benefits (EHB) and actuarial value (AV) standards, among others.⁴ CMS expects that state regulators may request access to QHP data templates to facilitate review of potential QHPs. Issuers that wish to prevent CMS from sharing QHP Application and oversight information with

⁴ We note that, because SADP issuers are only required under federal law to adhere to pediatric dental essential health benefits requirements for SADPs offered through a Marketplace, CMS does not have the same expectation of state review for SADPs offered through the Marketplace if such standards are otherwise not applied under state law. Accordingly, CMS plans to review SADPs for compliance with applicable Affordable Care Act standards.

the relevant state department of insurance must do so by notifying CMS via email at CMS_QHP_Applications@cms.hhs.gov prior to the QHP Application submission deadline. In this case, the issuer may need to share this information directly with the state in addition to sharing it with CMS.

We expect that states will establish the timeline, communication process, and resubmission window for any reviews conducted under state authority. Issuers should comply with any state-specific guidelines for review and resubmission related to state-reviewed standards. CMS notes that issuers may be required to submit data to state regulators in addition to that required for QHP certification through the FFM, 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. In addition, CMS will conduct outreach to all state departments of insurance at the end of the QHP certification cycle to confirm that all potential QHPs meet applicable state and federal standards, and are approved for sale in the Marketplace.

iii. FFM review of QHP Applications

Issuers applying for QHP certification in the FFM will submit complete and accurate QHP Applications into HIOS by June 27, 2014. Plans for which QHP applications are received after this date and plans for which significant changes to the initial submission are submitted after this date without CMS approval may not be considered for certification.

CMS expects to review FFM QHP Applications in two rounds; one between June 30 and July 25, and a second between August 8 and August 25. Following each review period, CMS will send applicants notices summarizing any need for correction identified during CMS's review. Issuers will be able to upload revised QHP data templates and make other necessary changes to QHP Applications in response to CMS's feedback until September 4. Issuers will also be able to make changes based on state feedback and make other minor corrections to their applications, with state approval, on the same timeline. CMS also intends to implement a petition process to receive requests from issuers and review additional requested changes that are particularly significant during this time, such as changes to service area. Requests to make these more substantial changes must be reviewed and approved by CMS and the state prior to submission of an update to the QHP Application. CMS intends to release further guidance on this process.

As stated previously, all final QHP data must be submitted by September 4, 2014. After this date, issuers will conduct a limited data correction window, where issuers will not be allowed to make further changes to QHP data unless necessary to correct data display errors or align QHPs with products and plans as approved by the state. All such changes must be pre-approved by CMS and the state. CMS expects to review final QHP data, verify and confirm state approval, and inform issuers of its final certification determinations by October 14, 2014. CMS intends to provide a

process through which issuers will be able to review submitted plan data prior (timeline to be provided).

Section 2. QHP Certification Process in a State Performing Plan Management Functions in an FFM

This section describes how states performing plan management functions in an FFM will conduct QHP certification. Issuers applying in states where CMS is performing all QHP Application review and QHP certification should refer to Section 1 above.

In an FFM state where the state is performing plan management functions, issuers will work directly with the state to submit all QHP issuer application data in accordance with state guidance.⁵ FFM states performing review of QHP Applications will likely utilize the System for Electronic Rate and Form Filing (SERFF) system to collect QHP Applications from issuers. The state will review QHP Applications for compliance with the standards described in this guidance and will provide a certification recommendation for each proposed plan to CMS. CMS will review and confirm the state’s QHP certification recommendations, make final QHP certification decisions, and load certified QHP plans on the Marketplace website. CMS will work closely with states that are performing plan management functions to coordinate this process.

As indicated in Table 1.2, the QHP certification process in FFM states where the state is performing plan management functions will align with the process for issuers for which CMS is performing the review. Each major component of the process is described in greater detail in the subsections that follow. We also intend to provide more specific guidance regarding the QHP certification timeline noted below as the application submission period approaches.

Table 1.2 Key Dates: QHP Certification in FFM States Where the State is Performing Plan Management Functions

Note: All dates are subject to change.

Activity		Dates (Approximate)
QHP Application Submission and	Issuers Submit Plan Data to States, States Review	Varied
	1 st SERFF Data Transfer Deadline	8/8/2014
	FFM Reviews Plan Data	8/11/2014-8/25/2014
	FFM Notifies States of any Needed Corrections to QHP Data	8/26/2014

⁵ CMS will work with states performing plan management functions in an FFM to ensure that such guidance is consistent with federal regulatory standards and operational timelines.

Activity		Dates (Approximate)
Review Process	Last date for Issuers to Resubmit Plan Data into SERFF	9/4/2014
	2 nd SERFF Data Transfer	9/5/2014-9/10/2014
	FFM Completes Re-review of Plan Data and State Recommendations	9/22/2014
	Limited Data Correction Window	9/24/2014 – 10/6/2014
QHP Agreement/Final Certification	Certification Notices and QHP Agreements Sent to Issuers, Agreements Signed, QHP Data Finalized	10/14/2014 – 11/3/2014
Open Enrollment		11/15/2014

i. QHP Application and State Review Process

An issuer’s HIOS issuer ID will be used to link the state and federal records for a given issuer or QHP. Therefore, like an issuer applying in HIOS, an issuer applying to a state via SERFF must access HIOS and obtain the necessary identification numbers and user roles.

Issuers in states performing plan management functions in an FFM are to submit QHP Applications, typically in SERFF, according to the timeline set by each state. Each state will define the relevant submission window as well as dates and processes for corrections and resubmissions. Issuers seeking to offer QHPs must submit the URRT to the state, and to CMS via HIOS, on the same timeline as the submission of the QHP Application. Issuers that are applying for QHP certification in states performing plan management functions in an FFM should not submit QHP Applications into HIOS.

CMS will provide two defined SERFF transfer windows in order to better coordinate the flow of QHP data from states performing plan management functions in an FFM. The first SERFF transfer will take place by August 8, 2014 and will constitute an initial transfer by each state. QHP data in this transfer do not need to be final, and the plans included in the transfer do not need to be in final, approved status. CMS will review the plan data in the initial transfer, and will notify states of any needed corrections. States will work with issuers to revise their submissions according to CMS and state feedback.

The second SERFF transfer is planned to take place between September 5 and September 10, 2014. CMS will use the data transferred by September 10 to make final QHP certification decisions based on state recommendations. After this transfer, issuers will not be allowed to make any further changes to QHP data unless necessary to correct data display errors or align QHPs with products and plans approved by the state. All such changes must be pre-approved by

CMS and the state. CMS intends to provide a process through which issuers will be able to review submitted plan data (timeline to be provided).

Section 3. Recertification for 2015

Based on comments received to the Draft 2015 Letter to Issuers, we are including this section on our intended approach to recertification of 2014 QHPs for the 2015 plan year. For the 2015 plan year, CMS's process for recertifying a QHP or SADP that was certified for the 2014 benefit year will largely mirror the 2015 process for certification of a plan that was not a QHP or SADP in 2014. While there may be the opportunity for some streamlining for 2014 QHP issuers that submit applications for 2015 certification, issuers seeking recertification will generally resubmit the majority of information required under the 2015 QHP Application for plans that were not QHPs or SADPs in 2014. We anticipate moving to a more streamlined recertification process for future plan years.

A QHP that was certified in 2014 and that is recertified in 2015 can maintain the same plan and HIOS identification numbers that it used in 2014. Additionally, current enrollees in recertified plans will remain enrolled into the new benefit year, as long as those enrollees do not terminate their coverage.

If a plan being offered in 2015 is guaranteed renewable under the market-wide guaranteed renewability requirement,⁶ meaning that, outside the FFM, 2014 enrollees in the plan would be guaranteed the right to renew the plan for another plan year (subject to the exceptions to guaranteed renewability), and that plan was certified as a QHP in 2014, then the plan being offered in 2015 as a renewal of the 2014 QHP may be recertified if it continues to meet the certification criteria. For purposes of SADPs, we will apply the same standard, treating the SADP as if it were a QHP subject to guaranteed renewability.

In the regulation that is being released simultaneously with this letter, we are proposing to specify circumstances in which a plan is undergoing a uniform modification and, therefore, is guaranteed renewable, as opposed to being withdrawn and a new plan filed, in which case, the plan would not be guaranteed renewable. If that regulation is finalized as proposed, the criteria in that regulation regarding guaranteed renewability would apply in the context of recertification as well.

⁶ In the regulation that is being released simultaneously with this letter, we are proposing to specify circumstances in which a plan is undergoing a uniform modification and, therefore, is guaranteed renewable, as opposed to being withdrawn and a new plan filed, in which case, the plan would not be guaranteed renewable. If that regulation is finalized as proposed, the criteria in that regulation regarding guaranteed renewability would apply in the context of recertification as well.

Section 4. Review of Rates

This section addresses how CMS will work with states to review rate increases for QHPs when certifying plans as QHPs for participation in the FFM. States performing plan management functions in an FFM may use a similar approach. The approach for stand-alone dental plans is discussed in Section 8.

i. Consideration of Rate Increases

Regulations at 45 C.F.R. 155.1020 require a Marketplace to consider all rate increases when certifying plans as QHPs. For the 2015 benefit year, CMS will consider issuers' data and actuarial justifications provided in the Unified Rate Review Template (URRT), other information submitted as part of a filing under an Effective Rate Review program and any recommendations provided to CMS by the applicable state regulator about patterns or practices of excessive or unjustified rate increases and whether or not particular issuers should be excluded from participation in the Marketplace. In future years, CMS will also take into account other factors such as rate growth inside and outside the Marketplace as required by the Affordable Care Act.

CMS does not plan to duplicate reviews that a state is already conducting to enforce state law, and will take into consideration reviews the agency has conducted on behalf of a state for those states that do not have Effective Rate Review programs. 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 a state under an Effective Rate Review program or CMS on behalf of a state (for those states that do not have Effective Rate Review programs):

- The QHP issuer's justification for all rate increases will be captured in the submission of Part I of the rate filing justification (URRT).
- To ensure consumer transparency, issuers must publish information from Part I of the rate filing justification by either: (1) posting a link on the issuer's website to the Marketplace's website (or HealthCare.gov), or (2) posting the information on the issuer's website.

ii. Review of QHP Rates

Rates that are too high or too low could have undesirable consequences for consumers. If rates are too high, consumers may be overpaying for coverage. If rates are too low, consumers may purchase a plan in which the pricing is not sustainable over time, potentially leading to significant rate increases in future years. Such increases could be disruptive to consumers who remain in the plan and to consumers who switch to more effectively priced plans but experience changes in prescription drug formularies or provider networks. In addition, QHP rates –

specifically, the rate for the second lowest cost silver plan – directly impact the value of premium tax credits as well as other federal outlays.

As detailed above, CMS does not plan to duplicate reviews that a state is already conducting as a matter of state law. CMS intends to implement a process that, in collaboration with existing state Effective Rate Review programs, will help ensure that QHP rates are reasonable and that, accordingly, offering the QHP through the FFM would be in the interest of consumers. Specifically, as it did in 2014, CMS will conduct an outlier analysis on QHP rates to identify rates that are relatively high or low compared to other QHP rates in the same rating area.

CMS recognizes that the identification of a QHP rate as an outlier does not necessarily indicate inappropriate rate development. CMS will notify the appropriate state entity of the results of its outlier identification process and will consider the state’s assessment of the plan’s rates when determining whether, based on its rates, certifying the QHP to be offered on the FFM would be in the interest of consumers.

Section 5. OPM Certification of Multi-State Plans

This section provides additional guidance for health insurance issuers seeking to offer multi-State plans in FFMs and State-based Marketplaces (SBMs).

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan (MSP) Program as required under section 1334 of the Affordable Care Act. In accordance with section 1334(d) of the Affordable Care Act, MSP options offered by MSP issuers under contract with OPM are deemed to be certified by a Marketplace.

OPM anticipates that the process for MSP issuers to participate in a Marketplace for the 2015 benefit year will largely mirror that used for 2014. Issuers seeking to offer MSP coverage must apply to participate via OPM’s online application portal. OPM will evaluate issuer applications and determine which issuers are qualified to become MSP issuers. OPM works closely with states in reviewing benefits and rates to achieve its goals of offering more choice for consumers and maintaining a level playing field for all issuers within a state.

OPM’s contract with each MSP issuer identifies each MSP option that the issuer will offer and in what state it will be offered. Each MSP option so identified is deemed to be certified by OPM to be offered through the Marketplace(s) operating in those states. In addition, the MSP Program contract sets forth performance requirements for MSP issuers.

For more information on requirements for MSP issuers, issuers should visit <http://www.opm.gov/healthcare-insurance/multi-state-plan-program/issuer/>. OPM will post specific instructions regarding the 2015 application timeline and process when available. The 2015 MSP Program Call Letter describes OPM program priorities and is available at http://www.opm.gov/media/4517978/2014-002_dms_.pdf.

Section 6. Certification of Consumer Operated and Oriented Plans (CO-OPs)

Consistent with the statute and the approach applied for 2014, CO-OPs are expected to apply for QHP certification using the same processes applied to other QHP issuers.

CHAPTER 2. QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS

Section 1. Licensure and Good Standing

This section describes how CMS will conduct QHP certification and recertification. States performing plan management functions in an FFM may use a similar approach.

Consistent with 45 C.F.R. 156.200(b)(4), each QHP issuer must be licensed and in good standing in each state in which it applies to offer QHPs for the applicable market, product type, and service area. CMS interprets the good standing requirement to mean that the issuer is in compliance with all applicable state solvency requirements and is in good standing in the state in relation to compliance with state laws and regulations. Applicable state licenses or certificates of authority will need to be provided with the QHP Application as supporting documentation. In addition, for the 2015 benefit year, CMS will require issuers to submit a State Certification Form. The issuer will need to indicate on this form that it is licensed and in good standing in each state in which it is applying to offer QHPs. The form must further include a certification from the applicable state insurance regulator that the issuer is licensed and in good standing in the state, including meeting state solvency requirements. Issuers applying for QHP certification must be able to demonstrate state licensure by no later than the first resubmission period during the QHP certification process, August 10, 2014.

In addition to requiring state certification of good standing, CMS will consider any complaints it receives and other QHP issuer oversight findings that occur during the 2014 benefit year, including state enforcement findings, in its determination of whether an issuer's offering of a plan is in the interest of consumers. CMS will consult with the applicable state on these findings.

Section 2. Service Area

This section describes how CMS will conduct QHP certification and recertification in an FFM. States performing plan management functions in an FFM may use a similar approach.

Consistent with regulations at 45 C.F.R. 155.1055(a), the Marketplace must ensure that each service area of a QHP covers a minimum geographic area that is at least the entire geographic area of a county, or a group of counties defined by the Marketplace, unless the Marketplace determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. The Marketplace must also ensure that

the service area of a QHP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

For the 2015 benefit year, CMS will review requests for service areas that serve a geographic area smaller than a county to ensure that each service area meets the above regulatory standards, particularly with respect to ensuring that the establishment of this partial county service area is not discriminatory.

In the QHP Application process, CMS considers the service area of a plan to be the county or set of counties (or partial counties) that is covered by that particular plan. Any change to the list of counties associated with a particular plan is considered a change in the service area, even if the issuer offers other plans or products in the counties (or partial counties) in question. For the 2015 benefit year, QHP issuers will not be allowed to change their service area after their initial data submission except via petition to CMS. Petitions for service area changes must follow a CMS-prescribed format that will be detailed in future guidance and will only be allowed with state approval. Changes to service areas will only be approved under very limited circumstances, such as:

- To address limitations in provider contracting: issuers will need to provide substantial documentation of their contracting efforts in the geographic areas dropped, including lists of providers with whom the issuer attempted to contract and the contracts offered.
- Expansions at the request of the state and/or CMS to address an unmet consumer need.
- To address a data error in the issuer's initial Service Area Template submission: issuers will need to provide significant evidence documenting the error, including evidence in other parts of the QHP Application indicating an intent to cover a different area and/or a mismatch with the service area in the issuer's form filing.

Any additional circumstances would be severely limited and determined on a case by case basis and only based on state approval and significant evidence of necessity and the best interest of the consumer. CMS will not allow changes to service area after the final data submission date.

Section 3. Network Adequacy

This section describes how CMS will conduct QHP certification and recertification. States performing plan management functions in an FFM may use a similar approach. This section includes changes from the approach for network adequacy that were in the Draft 2015 Letter to Issuers.

Pursuant to 45 C.F.R. 156.230(a)(2), an issuer of a QHP that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be

accessible to enrollees without unreasonable delay. All issuers applying for QHP certification will need to attest that they meet this standard as part of the certification/recertification process.

Unlike the certification process for benefit year 2014, CMS will no longer simply utilize issuer accreditation status, identify states with review processes at least as stringent as those identified in 45 C.F.R. 156.230(a), or collect network access plans as part of its evaluation of plans' network adequacy. Rather, CMS will assess provider networks using a "reasonable access" standard, and will identify networks that fail to provide access without unreasonable delay as required by 45 C.F.R. 156.230(a)(2). In order to determine whether an issuer meets the "reasonable access" standard, CMS will focus most closely on those areas which have historically raised network adequacy concerns. These areas may include the following:

- Hospital systems,
- Mental health providers,
- Oncology providers, and
- Primary care providers.

If CMS determines that an issuer's network is inadequate under the reasonable access review standard, CMS will notify the issuer of the identified problem area(s) and will consider the issuer's response in assessing whether the issuer has met the regulatory requirement and prior to making the certification or recertification determination. CMS will share information and analysis and coordinate with states which are conducting network adequacy reviews. Additional technical guidance regarding the collection method for a plan's provider list will be provided as part of the certification/recertification instructions.

CMS also intends to use information learned during the QHP Application process to assist in its articulation of time and distance or other standards for FFM QHP networks that CMS intends to reflect in future rulemaking. CMS will share its network adequacy findings with states and will incorporate state input into its network adequacy review process. CMS will also continue to monitor network adequacy, for example, via complaint tracking, to determine whether the QHP's network(s) continues to meet these certification standards. For future years, CMS is further considering appropriate formats for collection of provider network data, which would both enable CMS to review provider network adequacy and allow for the creation of a search engine function for consumers to find particular providers and provider types on HealthCare.gov.

Section 4. Essential Community Providers

This section describes how CMS plans to conduct QHP certification and recertification. States performing plan management functions in an FFM may use a similar approach. This section also discusses payment requirements for services provided by Federally Qualified Health Centers (FQHCs).

Essential community providers (ECPs) include providers that serve predominantly low-income and medically underserved individuals, and specifically include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA). At 45 C.F.R. 156.235, CMS establishes requirements for inclusion of ECPs in QHP provider networks and provides an alternate standard for issuers that provide a majority of covered services through physicians employed by the issuer or a single contracted medical group. Indian health providers are included among ECPs, as reflected in table 2.1.

i. Evaluation of Network Adequacy with respect to ECPs

Because the number and types of ECPs available vary significantly by location, CMS intends to evaluate QHP Applications for sufficient inclusion of ECPs for the 2015 benefit year against the ECP inclusion expectations described below. Specifically, CMS will consider a QHP issuer in compliance with the ECP guideline and will not pursue an enforcement action against an issuer with regards to meeting the ECP regulatory standard if it satisfies the ECP guidelines described below.

ECP Guideline: An application for QHP certification that adheres to the general ECP inclusion standard does not need to provide further documentation. For benefit year 2015, we will utilize a general ECP enforcement guideline whereby if an application demonstrates that at least 30 percent of available ECPs in each plan's service area participate in the provider network, we will consider the issuer to have satisfied the regulatory standard. In addition, and as required for the prior year, we expect that the issuer offer contracts in good faith to:

- All available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, using the recommended model QHP Addendum⁷ for Indian health providers developed by CMS; and
- 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.

As part of the issuer's QHP application, we expect that the issuer list the contract offers that it has extended to all available Indian health providers and at least one ECP in each ECP category in each county in the service area. To be offered in good faith, a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted. We would expect issuers to be able to provide verification of such offers if CMS chooses to verify the offers.

⁷ The model QHP Addendum for Indian health providers is available at <http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>.

If an issuer's application does not satisfy the 30 percent ECP guideline described above, the issuer would be required to include as part of its application a satisfactory narrative justification describing how the issuer's provider network(s), as currently designed, provides an adequate level of service for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network(s) in future years, as necessary.

An issuer that would have met only the 2014 minimum expectation standard option if the option had been extended for the 2015 benefit year will still be considered for QHP certification for the 2015 benefit year, contingent on the issuer's satisfactory narrative justification described above. As only one issuer submitted a justification for the 2014 benefit year as a means to satisfy the 20 percent ECP threshold, we anticipate that issuers will readily be able to contract with at least 30 percent of ECPs in a service area and that issuers will largely be able to satisfy this without having to submit written justification.

At a minimum, such narrative justification would include the following:

- Number of contracts offered to ECPs for the 2015 benefit year;
- Number of additional contracts issuer expects to offer for the 2015 benefit year and the timeframe of those planned negotiations;
- Names of the ECP hospitals and FQHCs to which the issuer has offered contracts, but an agreement with the providers has not yet been reached;
- Attestation that the issuer has satisfied the "good faith" contracting requirement with respect to offering contracts to all available Indian health providers, and one ECP in each major ECP category per county, where an ECP in that category is available; and
- Contingency plans for how, absent participation of the available ECP and Indian health providers, the plan will be able to provide adequate care to enrollees who might otherwise be cared for by relevant ECP providers. For example, if available Hemophilia Treatment Centers, Ryan White HIV/AIDS Program providers or Indian health providers are missing from the network(s), the Application must explain how its target populations will be served.

Examples:

- Issuer A proposes a service area in which 80 ECPs are available. Issuer A's network includes 35 ECPs, and Issuer A attests that it has offered "good faith" contracts to available Indian health providers and one ECP in each major ECP category per county, where an ECP in that category is available. Issuer A would meet the ECP standard; no additional documentation would be required.
- Issuer B also proposes a service area in which 80 ECPs (including 10 Indian health providers) are available. Issuer B's network includes 20 ECPs, which would not satisfy

the 30 percent ECP guideline. Issuer B provides a narrative justification that includes the following:

- Explanation for why its network includes only 20 ECPs and how it will ensure service for low-income and medically underserved enrollees;
- Attestation that the issuer has satisfied the “good faith” contracting requirement with respect to offering contracts to all available Indian health providers and one ECP in each major ECP category per county, where an ECP in that category is available;
- Number of contracts offered to ECPs for the 2015 benefit year;
- Number of additional contracts issuer expects to offer for the 2015 benefit year and the timeframe of those planned negotiations;
- Names of the hospitals and FQHCs to which the issuer has offered contracts, but the providers have not yet accepted; and
- A description of how care will be provided to specific populations (e.g., American Indians/Alaska Natives, persons with HIV, persons with hemophilia, etc.) that would otherwise be served by ECPs that are missing in the service area.

Under this general ECP standard, issuer B would be considered for QHP certification, despite not satisfying the 30 percent ECP guideline, based on the quantity of contracts being offered and the quality of the justification offered for not yet meeting this guideline. CMS would take into account factors and circumstances identified in the ECP Supplemental Response Form,⁸ along with an explanation of how the issuer will provide access to low-income and underserved populations. Additionally, justifications that include verification of contracts offered in good faith, that include terms that a willing, similarly-situated, non-ECP provider would accept or has accepted, would be considered toward satisfaction of the ECP guideline.

To assist issuers in identifying these providers, CMS published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies, which issuers may use to assess their satisfaction of the ECP guideline. This non-exhaustive list is available at: <http://cciio.cms.gov/programs/exchanges/qhp.html>. For providers on CMS’s non-exhaustive ECP list (including all Indian health providers), issuers would contract with the corporate entity named on the CMS list for that provider to be counted as an ECP. Individual practitioners having the same address as another ECP on the CMS list would not be counted as ECPs for purposes of meeting this standard.

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

⁸ More information on the supplemental response can be found on the CCIIO website at: <http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>.

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, conditioned on the issuer satisfying the ECP write-in criteria provided below. Allowable write-ins will count toward the satisfaction of the 30 percent ECP guideline and will count toward the denominator of available ECPs for the issuer writing in the additional ECPs. CMS intends to credit the issuer with only one ECP write-in per street address. Examples of allowable write-ins include any providers that are currently eligible to participate in 340B programs but that are not included on the CMS-developed list, or not-for-profit or state-owned providers that would be entities described in section 340B but do not receive federal funding under the relevant section of law referred to in section 340B. Such providers include not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act.

Table 2.1: ECP Categories and Types in FFM

Major ECP Category	ECP Provider Types
Federally Qualified Health Centers (FQHC)	FQHC and FQHC “Look-Alike” Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Family Planning Provider	Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics
Indian Health Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

To write in a provider not on the CMS-developed ECP list, an issuer would maintain the following for each write-in to be considered an ECP:

- Provide National Provider Identifier (NPI) number, if provider has an NPI number;
- Indicate whether the provider is a not-for-profit provider entity;
- List the provider’s zip code reflecting provider location within a Medically Underserved Area (MUA) and/or Health Professional Shortage Area (HPSA), or otherwise low-income, medically underserved area;
- Provide the provider’s address (PO Box not sufficient, and only one ECP will be counted per address); and
- Attest that the provider is a not-for-profit entity operating in an MUA/HPSA and serves predominantly low-income, medically-underserved individuals; or provide a written justification describing how the provider serves predominantly low-income, medically-underserved individuals or otherwise meets the regulatory definition of an ECP.

Examples:

- Issuer C proposes a service area in which 80 ECPs are included on the CMS-developed ECP list. Issuer C’s network includes 30 ECPs – 23 of which the issuer selects from the CMS-developed ECP list, and 7 of which the issuer writes in. Issuer C satisfactorily maintains all the required ECP write-in criteria for each ECP write-in. Issuer C’s satisfaction of the 30 percent ECP guideline would be calculated by dividing 30 by 87, as the 7 approved ECP write-ins are counted toward the denominator of available ECPs in the issuer’s service area (totaling 87). Issuer C would satisfy the 30 percent ECP guideline.
- Issuer D also proposes a service area in which 80 ECPs are included on the CMS-developed ECP list. Issuer D’s network includes 25 ECPs – 5 of which the issuer selects from the CMS-developed ECP list, and 20 of which the issuer writes in. Issuer D satisfactorily maintains all the required ECP write-in criteria for each ECP write-in. Issuer D’s satisfaction of the 30 percent ECP guideline is calculated by dividing 25 by 100 (as the 20 approved ECP write-ins are counted toward the denominator of available ECPs in the issuer’s service area, totaling 100). Since issuer D’s network demonstrates only 25 percent participation of available ECPs in the issuer’s service area, Issuer D would not satisfy the 30 percent ECP guideline.

Note that CMS may conduct targeted audits of issuers that satisfy the ECP guideline by virtue of writing in a significant number of their ECPs.

Issuers that qualify for the alternate ECP standard articulated in 45 C.F.R. 156.235(a)(2) and (b)⁹ must demonstrate a sufficient number and geographic distribution of employed providers and

⁹ 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.

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 Marketplace's network adequacy standards. CMS interprets this standard as being met if the issuer complies with the ECP guideline described above, based on employed or contracted providers located in or contiguous to Health Professional Shortage Areas (HPSA)¹⁰ and 5-digit zip codes in which 30 percent or more of the population falls below 200 percent of the federal poverty level (FPL). For example, if an issuer's service area includes 50 available ECPs, the issuer would need 15 providers (30 percent of 50) in the service area that are also in or contiguous to a HPSA or low-income zip code to meet the 30 percent ECP guideline. CMS would not pursue an enforcement action against an issuer for failing to meet the regulatory ECP requirement if it meets this standard.

As with the general ECP guideline, an application that does not demonstrate compliance with the 30 percent ECP standard must include a narrative justification describing how the issuer's provider network(s) complies with the regulatory standard. In this context, an issuer's explanation in the ECP Supplemental Response Form would address how the issuer intends to ensure coverage in HPSAs or low-income zip codes in the service area(s). 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 and Alaska Natives (AI/AN); and
- Low-income and underserved individuals seeking women's health and reproductive health services.
- Other specific populations served by ECPs in the service area.

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 FPL. The database is available at <http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>. Issuers that qualify for the alternate standard would use the same data template as other issuers to complete this section of the application.

CMS will continue to assess QHP provider networks, including ECPs, and may revise its approach to reviewing for compliance with network adequacy and ECPs in later years.

¹⁰ More information on Health Professional Shortage Areas is available at: <http://bhpr.hrsa.gov/shortage/>.

ii. *Requirements for Payment of Federally Qualified Health Centers*

We reiterate the importance of issuers complying with 45 C.F.R. 156.235(e) regarding payment of FQHCs. For covered services provided by an FQHC, QHP issuers must pay an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the SSA for such item or service, as specified in section 1302(g) of the Affordable Care Act. Section 156.235(e) does allow the QHP issuer and FQHC to mutually agree upon payment rates other than those that would have been paid to the center under section 1902(bb) of the SSA, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer. We note that state law may define covered services for closed-panel HMO plans to be limited to those services provided by in-network providers. In such cases, this requirement would not apply to non-covered services, which would include non-emergent out-of-network services if provided by FQHCs if such services are not treated under state law as covered services. Otherwise, we would expect issuers to pay FQHCs for covered services in accordance with section 1902(bb) of the SSA. We encourage issuers and FQHCs, as well as other ECPs, to develop mutually beneficial business relationships that promote effective care for medically underserved and vulnerable populations. We intend to assess available data to understand the degree to which such patients are cared for effectively and to inform our future regulatory approach.

Section 5. Accreditation

This section describes how CMS will conduct QHP certification and recertification. States performing plan management functions in an FFM may use a similar approach.

Requirements at 45 C.F.R. 155.1045(b) establish the timeline by which QHP issuers offering coverage in an FFM must be accredited. CMS is continuing its phased approach to accreditation for QHP issuers in FFMs. Prior to a QHP issuer's second year of QHP certification, the QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to its Marketplace products, or a QHP issuer must have commercial or Medicaid health plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is offering Marketplace coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP. SADP issuers will not be reviewed for accreditation status.

To meet the 2015 benefit year requirement for QHP issuers entering their second year of Marketplace participation, QHP issuers will be required to attest that the administrative policies and procedures applicable to their Marketplace products have been reviewed and approved by a recognized accrediting entity in compliance with §155.1045(b)(2). The timeline in §155.1045(b) will be applied by looking at the issuer's accreditation status 90 days prior to open enrollment.

Issuers entering their initial year of QHP certification for the 2015 benefit year (i.e., issuers that did not offer a QHP the previous year) that do not have an existing commercial, Medicaid, or Marketplace health plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is applying to offer coverage must schedule or plan to schedule with a recognized accrediting entity a review of its QHP policies and procedures. New QHP issuers may submit accreditation information for display if they have existing accreditation. The requirements for first-year accreditation are described in more detail in the 2014 Letter to Issuers.¹¹

In addition to the attestation noted above, issuers will be asked to provide some information about their accreditation status to determine if the standard in §155.1045(b) is met. This information will be verified with the indicated accrediting entity. For certification in 2014 for the 2015 benefit year, the National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC) have been recognized by CMS as accrediting entities for the purpose of QHP certification. The issuer will be asked for information related to accreditation of their commercial, Medicaid, or Marketplace products.

Issuers will be considered accredited if the QHP issuer is accredited with the following status: by AAAHC with “Accredited,” status; by NCQA with “Excellent,” “Commendable,” “Accredited,” and /or “Interim” status; or by URAC with “Full,” “Provisional,” and/ or “Conditional,” status. An issuer will not be considered accredited if the accreditation review is scheduled or in process.

Section 6. Patient Safety Standards for QHP Issuers

This section describes how CMS will review issuer compliance with the patient safety standards for purposes of QHP certification and recertification. States performing plan management functions in an FFM may use a similar approach. SADP issuers will not be reviewed for patient safety standards compliance in 2015.

Section 1311(h) of the Affordable Care Act states that beginning on January 1, 2015, QHP issuers are required to comply with patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria. Section 156.1110 in the 2015 Payment Notice¹² outlines how QHP issuers can demonstrate compliance with these standards, on a transitional basis, for 2 years beginning January 1, 2015 or until further regulations are issued, whichever is later. Specifically, the regulation requires QHP issuers that

¹¹ Letter to Issuers on Federally-facilitated and State Partnership Exchanges, April 5, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

¹² Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2015, 79 FR 13744 (March 11, 2014) (to be codified at 45 CFR parts 144, 147, 153, 155, and 156).

contract with a hospital with greater than 50 beds to verify that the hospital, as defined in section 1861(e) of the SSA, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:

- (1) A quality assessment and performance improvement program as specified in 42 C.F.R. 482.21; and
- (2) Discharge planning as specified in 42 C.F.R. 482.43.

In addition, QHP issuers are required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the certification for the 2015 benefit year, QHP issuers will be required to demonstrate compliance with these patient safety standards as part of the QHP application with an attestation that they have collected and are maintaining the required documentation from their network hospitals.

Section 7. QHP and SADP Agreements

Issuers offering QHPs or SADPs in an FFM, including FFMs in states performing plan management functions, will be required to sign an agreement with CMS at the end of the certification or recertification process, as applicable. We anticipate that the QHP Issuer Agreement for the 2015 benefit year will be similar to the agreement signed by issuers for the 2014 benefit year. The agreement will cover all of the QHPs offered by a single issuer at the HIOS Issuer ID level, and must be signed by an officer of the legal entity who has legal authority to contractually bind the QHP or SADP legal entity. Of note, issuers should ensure that the legal entity information listed in HIOS (Issuer General Information section) is identical to the legal entity information that will be used when executing the agreement.

CHAPTER 3. QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN DESIGN

Section 1. Discriminatory Benefit Design: 2015 Approach

This section addresses how CMS will review health plans applying to be QHPs in an FFM for compliance with nondiscrimination standards. States performing plan management functions in an FFM are encouraged to use a similar approach to ensure issuer and plan compliance with nondiscrimination standards. In the future, CMS may require that states performing plan management functions provide details regarding their respective nondiscrimination review process.

i. EHB Discriminatory Benefit Design

Non-discrimination in benefit design with respect to EHB is a market-wide consumer protection that applies inside and outside of Marketplaces. Accordingly, the enforcement of this standard is largely conducted by states. CMS encourages states that are enforcing the Affordable Care Act to consider a number of strategies for assessing compliance with this standard including, but not limited to: analysis of information entered in the “explanations” and “exclusions” sections of the QHP Plans and Benefits Template.

For purposes of QHP certification, CMS will collect an attestation 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 continue to assess compliance through issuer monitoring and compliance reviews, including analysis of appeals and complaints, as set forth in Chapter 4 and Chapter 6.

ii. QHP Discriminatory Benefit Design

In addition to complying with EHB non-discrimination standards, 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 QHP benefit design, CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) as part of the QHP certification application process. QHPs identified as outliers may be given the opportunity to modify cost sharing for certain benefits if CMS determines that the cost sharing structure of the plan that was submitted for certification could 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 to identify cost-sharing outliers with respect to specific benefits, including but not limited to those benefits listed below.

- Inpatient hospital stays,
- Inpatient mental/behavioral health stays,
- Specialist visits,
- Emergency room visits, and
- Prescription drugs.

With respect to prescription drugs, CMS intends to review plans that are outliers based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular category and class. We encourage states performing plan management functions in an FFM to implement this type of review.

Section 156.122(c) requires issuers that provide EHB to have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the plan. We are concerned that some enrollees, particularly those with certain complex medical conditions, are having trouble accessing in a timely fashion clinically appropriate prescription drugs, such as prescription drugs that are combination drugs not covered by their plans' formularies.

Accordingly, we are considering amending the formulary exceptions standards under 45 C.F.R. §156.122(c) to require that these processes can be expedited when necessary based on exigent circumstances, such as when an enrollee is suffering from a serious health condition or an enrollee is in a current course of treatment using a non-formulary drug. For example, we could specify that an issuer render decisions regarding formulary exceptions requests within 24 hours following the issuer's receipt of the exceptions request. This is currently suggested in the 2014 Letter to Issuers. As clarification, the prescription drug standard in §156.122(a)(1) was not intended to discourage issuers from offering clinically appropriate drugs to enrollees, including combination drugs.

Also in reviewing a plan's cost-sharing structure, CMS will analyze information contained in the Plans and Benefits Template, including, but not limited to, the "explanations" and "exclusions" sections, with the objective of identifying potentially discriminatory anomalies or wording. In the Draft 2015 Letter to Issuers, we stated that we would identify "clearly" discriminatory anomalies or wording but now change this to "potentially" as this is a nuanced analysis, and as noted below, CMS may offer issuers the opportunity to provide an explanation or revise the application based on any CMS follow-up. Discriminatory cost-sharing language would typically involve reduction in the generosity of a benefit in some manner for subsets of individuals other than based on clinically indicated common medical management practices. As in the case of cost-sharing outliers, where CMS identifies a potentially discriminatory practice, CMS may offer issuers the opportunity to revise the language in the "explanations" and "exclusions" portions of the Plans and Benefits Template (or other section(s) as applicable) to address the potentially discriminatory practices.

If CMS flags a potential QHP for follow-up based on this review, CMS may offer the issuer the opportunity to resolve the question identified and proceed in the certification process. Specifically, we anticipate that CMS may offer the issuer will be given the opportunity to submit a justification with supporting documentation to CMS explaining how the plan is not discriminatory or to make a change to its application to address the concern.

Section 2. Prescription Drugs

Regulations at 45 C.F.R. 156.122 establish that a health plan that provides EHB must cover at least the greater of (1) one drug in every United States Pharmacopeial Convention (USP) category and class or (2) the same number of prescription drugs in each USP category and class as the state's EHB -benchmark plan. All plans seeking QHP certification must cover EHB and comply with §156.122. With respect to prescription drugs, CMS uses data collected in the

Prescription Drug Template to review compliance with this standard. As part of the QHP Application, issuers must provide a URL to their formularies and must also provide information regarding formularies to consumers, pursuant to 45 C.F.R. 147.200(a)(2)(i)(K). CMS expects the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, that are specific to a given QHP. The URL provided to the Marketplace as part of the QHP Application should link directly to the formulary, such that consumers do not have to log on, enter a policy number or otherwise navigate the issuer's website before locating it. If an issuer has multiple formularies, it should be clear to consumers which formulary applies to which QHP(s). CMS will make formulary links provided by issuers available to consumers on HealthCare.gov.

As stated in the interim final rule published on December 17, 2013 at 78 FR 76212, we encourage issuers to accommodate the needs of new enrollees by covering a transitional fill of non-formulary drugs to new enrollees. We encourage issuers to help with transitions for other types of care (e.g., continuity of access to specialists for individuals in the midst of a course of cancer treatment).

Section 3. Supporting Informed Consumer Choice

The content of this section applies to QHP issuers in the FFMs, including issuers participating in states that are performing plan management functions in FFMs. States with SBMs may consider following these same guidelines. We have updated this section to reflect the policy in the final 2015 Payment Notice.

Consistent with §156.298 as finalized in the 2015 Payment Notice, for 2015, CMS will use the following approach to assess whether all benefit packages proposed to be offered by potential QHP issuers are meaningfully different from other plans with the same plan characteristics that are proposed by the same issuer. CMS will use this review to target potential QHPs for additional review. The process for review described below is based on the CMS's interpretation as to what would be required for a reasonable consumer to identify differences in the characteristics of a plan. For example, CMS believes that a reasonable consumer is likely to identify a difference in deductibles of \$50 or more. The approach described below is consistent with the policies in the 2015 Payment Notice.

- First, an issuer's plans from a given state would be organized into subgroups based on plan type, metal level and overlapping counties/service areas.
- Second, CMS would review each subgroup to determine whether the potential QHPs in that subgroup differ from each other in at least one of the following criteria:
 - Different network;
 - Different formulary;
 - \$50 or more difference in both individual and family in-network deductibles;

- \$100 or more difference in both individual and family in-network annual limit on cost sharing;
- Difference in covered benefits;
- Difference in Health Savings Account (HSA) eligibility; and
- Difference in child-only, adult-only, or adult and child coverage offerings.
- If CMS finds that two or more plans within a subgroup do not differ based on at least one of the above criteria (that is, the two or more QHPs are of the same plan type and metal level; have overlapping service areas; have the same provider network, formulary, covered benefits; HSA eligibility, and child-only coverage; and have less than a \$50 difference in deductibles and less than a \$100 difference in annual limit on cost sharing), then those QHPs will be flagged for additional review and follow-up.
- Per §156.298(c) of the 2015 Payment Notice, if CMS determines that the plan offerings at a particular metal level (including catastrophic plans) within a county are limited, CMS could elect not to review plans for meaningful difference at the impacted metal level.

If CMS flags a potential QHP for follow-up based on this review, the plan(s) will not be removed from the certification process; rather, CMS may offer the issuer the opportunity to resolve the question identified and proceed in the certification process. Specifically, we anticipate that the issuer will be given the opportunity to amend or withdraw its submission for one or more of the identified health plans. Alternatively, the issuer will also be able to submit supporting documentation to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP. For example, an issuer could highlight a feature of the plan(s) that they believe a reasonable consumer would consider a material difference that is not accounted for in the methods outlined above and at §156.298. This additional information will factor into the determination of whether it is in the interest of the qualified individuals and qualified employers to certify the plan as a QHP (*see* 45 C.F.R. 155.1000).

As stated in the 2015 Payment Notice, given the uniqueness of the stand-alone dental plan market, CMS will not review stand-alone dental plans for meaningful difference as part of the certification of those plans.

Section 4. Stand-alone Dental Plans: 2015 Approach

Issuers submitting applications for certification of SADPs will have several unique standards due to their excepted benefit status, as described in the 2014 Letter to Issuers, and their limited scope of benefits. The chart below (Table 3.1), which was not included in the Draft 2015 Letter to Issuers, is intended to assist issuers in understanding those standards that are applicable to SADPs seeking certification in the FFEs for the 2015 coverage year. We note that in addition to the certification standards outlined below, SADP issuers will need to comply with operational processes and standards. The application of QHP standards is addressed throughout the sections

of this Letter to Issuers. Therefore, this section only addresses those standards or evaluations that are unique to SADPs.

Table 3.1: Certification Standards Applicable to Stand-alone Dental Plans

Certification Standard Applies (* denotes modified standard)		Certification Standard Does Not Apply
Essential Health Benefits*	Actuarial Value*	Accreditation
Annual Limits on Cost Sharing*	Licensure	Cost-sharing Reduction Plan Variations
Network Adequacy	Inclusion of ECPs	Unified Rate Review Template
Marketing	Service Area	Meaningful Difference
Non-discrimination		

i. Stand-alone Dental Plan Rates

In the 2014 Letter to Issuers, CMS outlined a process for SADPs to complete the rating template portion of the QHP Application. SADP issuers were instructed to complete the rating templates in accordance with the associated rating and business rules and to indicate in the 2014 Plan and Benefits Template whether they were committing to charging that rate (“guaranteed” rates) or retaining flexibility to change the rate (“estimated” rates). As noted in the proposed 2015 QHP information collection request, CMS proposes to collect the average premium actually charged for those SADP issuers that indicated estimated rates in their template to determine the average difference using the 2015 Plan and Benefits Template.

ii. Intent to Apply

As described in the 2014 Letter to Issuers, QHP issuers are permitted to offer QHPs through a Marketplace that omit coverage of the pediatric dental EHB if a SADP exists in the same service area in which they intend to offer coverage. In 2014, CMS conducted a voluntary reporting process for SADP issuers to communicate their intent to apply and is following a similar approach for 2015.

Section 5. Cost Sharing Reduction Plan Variation Reviews

We have updated this section to reflect the policy in the 2015 Payment Notice. Regulations at 45 C.F.R. 156.420 generally require QHP issuers to submit three plan variations for each silver level QHP an issuer offers through the Marketplace, as well as zero and limited cost-sharing plan variations for all QHPs an issuer offers through the Marketplace.¹³ As part of the 2015 certification cycle, CMS will review QHP Applications for compliance with part 156, subpart E, including new standards for 2015 established in the 2015 Payment Notice under §156.420. The

¹³ This section does not apply to SADPs, which are not eligible for cost-sharing reductions.

certification review will include a review of each submitted Plans and Benefits Template to ensure that Silver plan variations:

- Meet AV requirements.
- Do not have an annual limitation on cost sharing that exceeds the permissible threshold for the specified plan variation, as finalized in the 2015 Payment Notice.

The cost sharing for enrollees under any silver plan variation for an EHB (or non-EHB, under the non-EHB out-of-pocket policy as modified in the 2015 Payment Notice) does not exceed the corresponding cost sharing in the standard silver plan or any other silver plan variation of the standard silver plan with a lower AV. For example, the cost sharing associated with a particular benefit must remain constant or decrease for a 94 percent AV plan variation compared to its associated 87 percent AV plan variation. Example:

Table 3.2

	Inpatient Hospital Services		Specialist Visit	
Enrollee Cost Sharing, 87% Plan Variation	25%	25%	\$40	\$40
Enrollee Cost Sharing, 94% Plan Variation	20%	30%	\$40	\$45
Review Outcome	Compliant	Not Compliant	Compliant	Not Compliant

- In accordance with 45 C.F.R. 156.420(b)(1), zero cost sharing plan variations do not have positive cost sharing for any EHB, whether in or out-of-network. (Under 45 C.F.R. 155.20, cost sharing means any expenditure required by or on behalf of an enrollee with respect to EHB, including deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.)¹⁴
- The out-of-pocket spending for a zero cost sharing plan variation of a QHP for a non-EHB may not exceed the corresponding out-of-pocket spending in the limited cost sharing plan variation of the QHP, and the corresponding out-of-pocket spending required in the 94 percent silver plan variation of the QHP, in the case of a silver metal level QHP.

¹⁴ If the QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network (i.e., cost sharing for services provided by an out-of-network provider is at 100 percent), the cost sharing, for these non-covered services would not need to be eliminated for the zero cost sharing plan variation, and should be entered as it would be for non-covered out-of-network services under the corresponding standard plan.

- The out-of-pocket spending for a limited cost sharing plan variation of the QHP for a non-EHB may not exceed the corresponding out-of-pocket spending required in the QHP with no cost-sharing reductions.

Section 6. Calculation of Cost-Sharing Reduction Advance Payments

As described in the 2014 Payment Notice, for the 2014 benefit year, cost-sharing reduction advance payment rates were calculated using actuarial data value data submitted by issuers under 45 C.F.R. 156.420 and data on claims costs allocable to EHB submitted by issuers under §156.470. In the FFM, including FFM in states performing plan management functions, these data were collected via the Plans and Benefits Template and the Unified Rate Review Template. QHP issuers were also given the option under 45 CFR 156.430(a)(2) to submit an estimate of the value of the cost-sharing reductions that they will provide under any limited cost sharing plan variations, via the Plans and Benefits Template, in order to receive advance payments for these cost-sharing reductions.

For the 2015 benefit year, we modified the methodology for calculating cost-sharing reduction advance payment rates. As described in the 2015 Payment Notice at §156.430(b)(1), Marketplaces will use a methodology for calculating the advance payment amounts that will not require QHP issuers to submit an estimate of the value of cost-sharing reductions to be provided or the EHB portion of expected allowed claims costs. Instead, Marketplaces will calculate the monthly advance payment amount for a specific policy as the product of (x) the total monthly premium for the specific policy, and (y) a cost-sharing reduction plan variation multiplier. HHS will make appropriate modifications to the templates and QHP certification instructions.

CHAPTER 4. QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

Section 1. Account Management: 2015 Issues

All issuers participating in FFM, including issuers participating in states that are performing plan management functions, will continue to have an assigned federal Account Manager. Newly certified issuers will be assigned a federal Account Manager in September prior to the start of the benefit year. The Account Managers will serve as the QHP and SADP issuer's primary point of contact with the FFM for non-technical QHP and SADP related issues and will provide QHP issuers with clarification and other assistance related to issuers' responsibilities and requirements for participating in the FFM. Additionally, the Account Manager will communicate updates to issuers, direct issuers to other resources as appropriate, and coordinate resolution of cross-cutting issues. CMS expects that states, regardless of Marketplace type, will continue to take the lead in addressing market-wide issues, such as complaints related to market conduct.

CMS has also assigned a CO-OP Program Account Manager to each CO-OP in addition to the federal Account Manager. The CO-OP Program Account Manager serves as the CO-OP's primary point of contact with the CO-OP Program Division for questions and issues regarding CO-OP responsibilities and requirements pursuant to section 1322 of the Affordable Care Act, 45 C.F.R. part 156 subpart F, and the CO-OP Program Funding Opportunity Announcement.

Section 2. QHP Issuer Compliance Monitoring Program

This section describes how CMS, as administrator of the FFMs, will monitor ongoing QHP compliance in 2015 in all FFMs, including in states that are performing plan management functions. The Final 2015 Letter to Issuers adds that we do not intend to extend the 2014 good faith enforcement safe harbor, though we intend to continue our existing approach to work with issuers to resolve compliance issues, as noted below.

In the Program Integrity: Exchange, SHOP, and Eligibility Appeals Final Rule,¹⁵ CMS acknowledged the transitional nature of the 2014 benefit year, and agreed not to impose civil money penalties or decertify QHPs for non-compliance with certain Marketplace requirements if the QHP issuer has made good faith efforts to comply with applicable requirements. CMS expects that by 2015, issuers will have gained more experience operating in the FFM environment and/or will be more familiar with the Marketplace requirements. We believe that our compliance approach provides issuers an adequate opportunity to resolve all but the most serious compliance issues. We encourage issuers to be proactive in monitoring their own compliance with applicable FFM standards and guidance, and to contact their CMS Account Managers if they have questions. CMS will also continue coordinating with states on federal monitoring, including compliance reviews (described in more detail below) and enforcement actions so as to minimize any unnecessary duplication of oversight activities.

Section 3. QHP Issuer Compliance Reviews

This section describes how CMS, as administrator of the FFMs, will monitor QHP issuers' compliance and evaluate QHP issuers' performance in the FFMs. States performing plan management functions in an FFM may take a similar approach to monitoring issuers' compliance with applicable FFM standards. CMS will also conduct routine monitoring of QHPs in FFMs, including, but not limited to, review of aggregate complaints data.

As required by 45 C.F.R. 155.1010, CMS will be monitoring QHP issuers for demonstration of ongoing compliance with the certification requirements outlined in 45 C.F.R. 155.1000(c). CMS will also evaluate issuers' compliance with general issuer standards and requirements in part 156,

¹⁵ Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule, 78 Federal Register 54070 (Aug. 30, 2013) (codified at 45 CFR Parts 147, 153, 155, and 156).

as well as issuers' performance with respect to its QHPs offered in the FFM as part of its determination that making the QHP available is in the interest of qualified individuals and qualified employers in accordance with 45 C.F.R. 155.1000(c)(2). CMS will monitor compliance and evaluate performance using information received from various sources, including states, which may include: aggregate complaint data, issuer self-reporting of problems, information related to customer service and satisfaction, health care quality and outcomes, QHP issuer operations, and network adequacy. We will examine trends in complaint data to assist us with evaluating the compliance of issuers and the performance of their QHPs.

Consistent with CMS's authority under 45 C.F.R. 156.715, CMS will perform a limited number of compliance reviews to address performance issues or non-compliance. These compliance reviews will focus on applicable FFM requirements, and CMS will review data at both the issuer and the QHP level. CMS will generally use a risk-based process, based in part on the compliance monitoring (e.g., aggregate complaint data) and performance data available, to select QHPs/issuers for compliance reviews. CMS intends to coordinate with the state regulatory entities, where appropriate, in conducting the compliance reviews.

Section 4. FFM Oversight of Agents/Brokers

Pursuant to 45 C.F.R. 156.340, a QHP issuer maintains responsibility for the compliance of its delegated and downstream entities, including affiliated agents, brokers, and web-brokers. Accordingly, CMS expects QHP issuers to check all affiliated agents' and brokers' licensure statuses and verify that they fulfilled the applicable FFM registration and training requirements, executed the FFM Privacy/Security Agreement, and (if applicable), signed the General FFM Marketplace Agreement before allowing them to access the issuer's tools and/or assist consumers with enrollment through the FFM. Agents, brokers and web-brokers should provide a copy of their FFM User ID and training completion certificate (if applicable) to each affiliated QHP issuer.

CMS strongly suggests that agents and brokers not use "Marketplace" or "Exchange" in the name of their businesses or websites. As required by 45 C.F.R. 155.220(c)(3)(vii), if an agent or broker assists a qualified individual with QHP selection through the agent, broker, or web-broker's non-FFM website, a standardized disclaimer must be prominently displayed to indicate that the site is not the Health Insurance Marketplace website, and a link to the FFM website must also be provided. Pursuant to 45 C.F.R. §155.220(i), as finalized in the 2015 Payment Notice, SHOPS may permit agents and brokers, in states that permit such activity under state law, to use an Internet website to provide assistance to qualified employers and facilitate enrollment of qualified employees in SHOP QHPs, subject to the requirements of §155.220(c)(3).

Section 5. Monitoring of Marketing Activities

This section describes how CMS will monitor QHP marketing during the 2015 benefit year in all FFMs and provides information that supplements what was discussed in the 2014 Letter to Issuers.

Regulations at 45 C.F.R. 156.200(e) provide that QHP issuers must not, with respect to their QHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Section 156.225(a) requires that in order to have a plan certified as a QHP, a QHP issuer must comply with all applicable state laws on health plan marketing by health insurance issuers. In addition, §156.225(b) states that a QHP issuer must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

As we noted in the 2014 Letter to Issuers, states generally regulate health plan marketing materials and other related documents under state law, and CMS does not intend to review QHP marketing materials for compliance with state standards as described at §156.225(a). In FFM states where there is no or minimal review of QHP marketing materials for compliance with §156.200(e) and §156.225(b), CMS may review QHP marketing materials for compliance with these standards. CMS will work with states to determine where additional monitoring and review of marketing activities may be needed. For all QHP issuers in the FFMs, we recommend that agreements with agents and brokers, as well as marketing materials distributed to enrollees and to prospective enrollees, contain a clause such as the following: “[Insert plan’s legal or marketing name] does not discriminate on the basis of basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.” If CMS receives a consumer complaint about an issuer’s marketing activities or about an agent’s, broker’s, or Web-broker’s conduct which is generally overseen by the state, CMS will send the complaint to the state department of insurance, as appropriate, for investigation. Following the state’s investigation, CMS may take the necessary enforcement action against the issuer or agent, broker, or Web-broker.

CHAPTER 5. EMPLOYEE CHOICE AND PREMIUM AGGREGATION SERVICES IN FF-SHOPS

Section 1. Overview

This chapter applies to the FFM, including FFMs in states performing plan management functions. It provides policy, operational, and technical information to assist issuers as they prepare for employee choice and premium aggregation services in FF-SHOPS for plan years beginning in 2015.

Facilitation of employee choice at a single level of coverage selected by the employer – bronze, silver, gold, or platinum – is a required SHOP function for plan years beginning on or after January 1, 2015 under 45 C.F.R. 155.705(b)(2). In a Notice of Proposed Rulemaking being released today, we are proposing a one-year transition policy under which a SHOP would be permitted to limit employee choice in 2015 in a particular state, based on a recommendation from the state regulatory agency, under the following circumstances: (1) if employee choice would result in significant adverse selection in the state’s small group market that could not be fully remediated by the single risk pool or premium stabilization programs; or (2) if there is an insufficient number of issuers offering qualified health plans or qualified stand-alone dental plans at the selected level of coverage chosen by the employer to allow for meaningful choice in the state’s SHOP. Through this rulemaking, we have solicited comments on all aspects of this proposal. If this proposal is finalized, we would provide additional detail about the timing of such decisions in the final rule. This proposed policy would be an option for all SHOPS meeting the requisite criteria, including the FF-SHOP. If this proposal is finalized, CMS will also provide further guidance in the final rule regarding other policies that might also be affected.

Pending the finalization of this proposal, unless a state meets the criteria specified in the proposal, for plan years beginning on or after January 1, 2015, the FF-SHOP in that state will provide qualified employers with a choice of two methods to make QHPs available to qualified employees: they can offer employees a choice of all QHPs at a single level of coverage (as detailed in section 1302(d)(1) of the Affordable Care Act) or they can offer a single QHP. As outlined in 45 C.F.R. 155.705(b)(4), FF-SHOPS will also provide premium aggregation in plan years beginning on or after January 1, 2015. Premium aggregation services allow an employer to receive one bill and make one payment to the FF-SHOP instead of having to interact with multiple issuers for account set up and premium payment purposes.

Additionally, as finalized in the 2015 Payment Notice, for plan years beginning on or after January 1, 2015, qualified employers in FF-SHOPS may offer employees a choice of (1) all stand-alone dental plans offered through the FF-SHOP at a level of coverage as described in 45 CFR 156.150(b)(2); or (2) a single stand-alone dental plan.

Section 2. Single Bill, Single Payment under Premium Aggregation

Pursuant to §155.705(b)(4), for plan years beginning on or after January 1, 2015, the FF-SHOP will send each participating employer a single monthly bill covering all employees covered through the FF-SHOP and the employer will remit a single monthly payment to the FF-SHOP. For plan years beginning on or after January 1, 2015, CMS will provide these premium aggregation services for all issuers participating in the FF-SHOP, regardless of whether an employer chooses to offer a single plan or all plans at a single actuarial value level of coverage through employee choice. (Issuers will continue billing and receiving payments through the end of plan years that began in 2014.) Issuers need to be ready to accept initial enrollments and

payments as early as November 15, 2014 for groups enrolling in FF-SHOP coverage beginning as soon as January 1, 2015.

The FF-SHOP expects to generate invoices on or around the 10th of each month prior to the coverage month. CMS expects that the aggregated monthly bill will provide information about each employee's coverage and the employer and employee contributions toward that coverage. CMS anticipates that employers would be required to make an initial premium payment at least two days prior to the employer's desired coverage effectuation date.

Employers would be required to make their full monthly payment to the FF-SHOP before the end of the FF-SHOP's employer grace period as outlined at 45 C.F.R. 155.735(c)(2)(ii). CMS interprets §§155.705(b)(4)(i)(B) and 155.735(c) as requiring premium payment to be made to the FF-SHOP, not the issuer, by the end of the FF-SHOP grace period. Thus, an issuer should not terminate a group for non-payment of premiums unless it has been informed by the FF-SHOP that an employer has not paid its monthly premium amount by the end of the FF-SHOP's employer grace period, even if the FF-SHOP has not yet transmitted the employer's full monthly premium amount to the issuer by the end of the FF-SHOP's employer grace period. CMS will make every effort to remit payments promptly to issuers so any delay in transmitting payments to issuers at the end of the FF-SHOP's grace period should not inconvenience issuers.

The amount due each month would be the lesser of 1) the invoiced amount, or 2) the current account balance as outlined in the FF-SHOP payment portal (the current balance owed may be less than the invoiced amount because an enrollee may have dropped coverage after the invoice was generated). If a new person was added to a group's policy after an invoice was generated, CMS expects that an employer would be back-billed on the next monthly invoice or make an immediate payment to cover the new enrollment. CMS would use an EFT payment transaction to transmit payments and would not send partial payments to issuers. A partial payment not sent to issuers would be sent back to an employer if the employer is terminated for non-payment of premiums.

Section 3. FF-SHOP Enrollment and Payment Portals

CMS expects that the FF-SHOP website will maintain a payment system portal that can be accessed through an employer's MyAccount. Regardless of whether an employer selects a single QHP to offer to its employees or a single metal level, the employer would always be redirected to the FF-SHOP site and not any specific issuer's website for invoicing and payment purposes. CMS expects that employers may perform a variety of functions on this site, including: making a payment, verifying the status of payment, and downloading invoices. There is expected to be a seamless connection between the FF-SHOP's payment portal and the employer's MyAccount, where the employer may access enrollment matters impacting monthly invoices.

Section 4. Beginning Balances for Plan Years Beginning on and after January 1, 2015

For reconciliation purposes with the FF-SHOP, CMS expects issuers to have a zero balance on their accounts as they begin interacting with the FF-SHOP's premium aggregation services for plan years beginning on and after January 1, 2015. Issuers that have balances due from employers from FF-SHOP plan years that began in 2014 would be expected to collect that amount directly with the employer through their delinquency process, subject to 45 C.F.R. 156.270. If there is a credit on the employer's account at the end of a group's 2014 benefit year, the issuer would be expected to refund the balance on the account directly to the employer.

Section 5. Bank Accounts

The FF-SHOP expects that it will have the capability to make payments to one bank account for each issuer participating in the FF-SHOPs. CMS expects to request that issuers provide basic banking information, including the account and routing numbers and the type of account (savings/checking). If the FF-SHOP receives a payment rejection from a bank for payment to an issuer, CMS would notify the issuer to update its account information.

Section 6. Initial Payments for New Group Coverage and Frequency of Issuer Payments

For plan years beginning on or after January 1, 2015, employers will use the FF-SHOP's payment portal instead of an issuer's payment portal for purposes of finalizing an initial FF-SHOP enrollment. Employers may also make initial payments by calling the FF-SHOP's Employer Contact Center or by mailing in a check to the FF-SHOP. Issuers must effectuate coverage upon receipt of new group enrollment transactions unless CMS sends a termination transaction for non-payment of the initial payment.

CMS expects that the FF-SHOP will generally make payments to issuers on a weekly basis.

Section 7. Enrollment and HIX 820 Transactions

Employers will be expected to use the FF-SHOP enrollment portal to apply, enroll, and make changes to enrollments for plan years beginning on and after January 1, 2015. This online activity will generate group XML and 834 enrollment transactions that will be sent by the FF-SHOP to applicable issuers. An 820 transaction is expected to be generated each time CMS makes a payment to an issuer. The 820 transaction would inform issuers how to allocate funds received to active SHOP accounts.

Section 8. Terminations for and Reinstatements after Non-payment of Premiums

For plan years beginning in 2015, the FF-SHOP, will initiate termination of coverage for groups enrolled in the FF-SHOPs for non-payment of premiums. Pursuant to 45 C.F.R. 155.735(c)(2), employers wishing to be reinstated following non-payment of premium must contact the FF-

SHOP Employer Contact Center and arrange to bring their account up to date within 30 days of being terminated for non-payment of premium. After a group has paid its outstanding balance and pre-paid the next month's premium payment, the FF-SHOP will send a reinstatement transaction to the affected issuer (or issuers).

Section 9. Premium Payment Reconciliations

As part of its administration of premium aggregation, in plan years beginning on or after 2015, the FF-SHOP will reconcile issuer employee enrollment information submitted pursuant to 45 C.F.R. 156.285(c)(4) with FF-SHOP data about enrollment and paid premiums. The premium aggregation contractor will take corrective action to resolve any payment discrepancies discovered through the reconciliation process and will report payment reconciliation resolutions to issuers upon request. Issuers may contact the SHOP Employer Contact Center with any questions or concerns about premium payment reconciliations.

Section 10. Agent and Broker Commissions and User Fees

Issuers could continue to pay agent and broker commissions for FF-SHOP coverage in plan years beginning in 2015, just as they do today. In addition, the FF-SHOP would not take user fees out of FF-SHOP premiums owed issuers. CMS, as operator of the FFMs, would continue to calculate user fees each month based on current confirmed enrollments and would make adjustments for retroactive enrollments, terminations, changes, and cancellations. For issuers that also offer QHPs in the individual market FFM, the FF-SHOP would net user fee amounts against advance payments of the premium tax credit (APTC)/cost sharing reduction (CSR) payments during the monthly payment cycle, and invoice to the issuer any user fee totals that exceed APTC/CSR payments. CMS, as operator of the FFMs, would bill issuers not participating in the individual market FFM separately for user-fees.

Section 11. Customer Service for FF-SHOPs

Back-office functions for all FF-SHOPs, including premium aggregation, employer billing, receipt of payments, and disbursement of premium payments to issuers, will be facilitated by a single CMS contractor, which will also operate a call center that issuers and employers may contact for ongoing support and questions related to billing and payment. This call center will have dedicated customer service representatives for enrollment and premium payment reconciliations.

For billing inquiries, employers and agents/brokers and other authorized assisters calling on behalf of employers will be able to call the SHOP Employer Contact Center.

Section 12. Premium Aggregation Technical Assistance

CMS will continue to provide technical assistance to issuers through webinars and ongoing issuer calls. CMS expects that information specific to employee choice and premium aggregation will be available shortly.

Section 13. Minimum Participation Rates and Renewals during November 15-December 15

Due to consumer considerations, employers will not have to meet the FF-SHOP's minimum participation rate for renewals occurring between November 15 and December 15. The guaranteed availability regulation, at 45 C.F.R. 147.104(b)(1), requires that an employer be allowed to purchase coverage from November 15 through December 15, even if the employer cannot meet minimum participation requirements. We believe it would impose undue burden on employers, their employees, issuers, and the FF-SHOP to non-renew coverage under the exception to guaranteed renewability for failure to meet minimum participation rates and then re-enroll employers under guaranteed availability during this period. Therefore, the FF-SHOP will not impose (and QHP issuers offering coverage through the FF-SHOP may not enforce) minimum participation requirements for renewals occurring between November 15 and December 15.

CHAPTER 6. CONSUMER SUPPORT AND RELATED ISSUES

Section 1. Provider Directory

The content of this section applies to all QHP Issuers in the FFMs, including FFMs in states performing plan management functions in an FFM. States with SBMs may consider following these same guidelines.

Pursuant to 45 C.F.R. 156.230(b), CMS, as administrator of the FFMs, will require QHPs to make their provider directories available to the Marketplace for publication online by providing the URL link to their network directory. CMS expects the URL link to direct consumers to an up-to-date provider directory where the consumer can view the provider network that is specific to a given QHP. The URL provided to the Marketplace as part of the QHP Application should link directly to the directory, such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer's website before locating the directory. If an issuer has multiple provider directories, it should be clear to consumers which directory applies to which QHP(s). Further, CMS expects the directory to include location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. CMS encourages issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider. Directory information for Indian health providers should describe the service population served by each provider, as some

Indian health providers may limit services to Indian beneficiaries, while others may choose to serve the general public.

Section 2. Complaints Tracking and Resolution

The content of this section applies to QHP Issuers in the FFM, including FFM in states performing plan management functions. States with SBMs may consider following these same guidelines.

CMS encourages consumers to report complaints and concerns to the Marketplace Call Center as well as to the issuers of the QHPs in which they are enrolled. CMS expects QHP issuers to thoroughly investigate and resolve consumer complaints received directly from members or forwarded to the issuer by the state through the issuer's internal customer service process and as required by state law. Additionally, QHP issuers operating in an FFM must investigate and resolve consumer complaints forwarded by CMS in accordance with the requirements at §156.1010. Complaints may be forwarded through the Health Insurance Casework System (HICS) developed by CMS or by other means as determined by CMS. 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 at 45 C.F.R. 156.200. Timeframes for resolving cases forwarded by CMS are specified in 45 C.F.R. 156.1010(d).

QHP issuers operating in an FFM, including FFM in states performing plan management functions, are expected to comply with all applicable state and federal laws related to consumer complaints, including any applicable requirement to advise consumers of their appeal rights. CMS intends to track complaints and use aggregated complaints information as a tool for directing oversight activities in FFM. To the greatest degree possible, CMS will collaborate with states in tracking complaints and sharing information suggestive of issuer performance problems.

Section 3. Coverage Appeals

The content of this section applies to all QHP Issuers in the FFM, including FFM in states performing plan management functions. States with SBMs may consider following these same guidelines.

QHPs are required to meet the standards for internal claims and appeals and external review established at 45 C.F.R. 147.136, which implements section 2719 of the PHS Act, as added by the Affordable Care Act. Section 2719 of the PHS Act requires that all non-grandfathered group health plans and non-grandfathered health insurance issuers offering group or individual health insurance coverage implement an effective process for internal claims and appeals and external review. QHPs must fully comply with the requirements of §147.136 as interpreted by any applicable guidance documents.

Section 4. Meaningful Access

This section describes how the measures that QHP issuers are encouraged to take to comply with the requirements that they ensure meaningful access by limited-English proficient (LEP) speakers and by individuals with disabilities. CMS is considering whether to develop model notices to assist issuers in meeting these standards.

QHP issuers are reminded that meaningful access requirements at 45 C.F.R. 155.205(c), 155.230(b), and 156.250, as well as discrimination prohibitions at 45 C.F.R. 156.200(e), are independent of other obligations QHPs may have. For example, QHP issuers that receive federal financial assistance are subject to Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and section 1557 of the Affordable Care Act, and as a result, have separate responsibilities under the law not to discriminate on the basis of race, color, national origin, sex, age and disability, in providing access to their services. More information about language access can be found at www.lep.gov/interp_translation/trans_interpret.html. We also encourage QHP issuers to follow the Office of Minority Health's (OMH) National Standards on Culturally and Linguistically Appropriate Services (CLAS), available for review at www.ThinkCulturalHealth.HHS.gov.

In addition to ensuring meaningful access for individuals with LEP, QHP issuers must also ensure access for individuals with disabilities, including through the provision of auxiliary aids and services. CMS notes that all web content or communications materials produced by the FFM and its contractors – including text, audio or video, will conform to applicable standards related to section 508 of the Rehabilitation Act and, where applicable, the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

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 the Summary of Benefits and Coverage (SBC) would not be included in this list because they are subject to separate regulatory standards with which issuers must comply.

Section 5. Summary of Benefits and Coverage

The content of this section applies to all QHP issuers in the FFM, including states performing plan management functions in an FFM. States with SBMs may consider following these same guidelines.

QHPs are required to provide the Summary of Benefits and Coverage (SBC) in manner compliant with the standards set forth in 45 C.F.R. 147.200, which implements section 2715 of the PHS Act, as added by the Affordable Care Act. Section 2715 of the PHS Act requires that all group health plans and health insurance issuers offering group or individual health insurance coverage compile and provide an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. QHPs must fully comply with the requirements of §147.200 and any applicable guidance.

While QHP issuers are not required to create separate SBCs to reflect different levels of cost-sharing reductions for each plan variation, QHP issuers should create an SBC that represents the base plan, consistent with the requirements set forth in §147.200. QHPs may not combine information about multiple plan variations in one SBC. However, QHP issuers are permitted, and encouraged, to create separate SBCs for each plan variation.

Section 6. Transparency

The content of this section applies to all QHP issuers in the FFMs, including FFMs in states that are performing plan management functions. States with SBMs may consider following these same guidelines.

QHPs in the FFMs are required to submit specified information to the Marketplace and other entities in a timely and accurate manner as required by 45 C.F.R. 156.220, implementing section 1311(e)(3) of the Affordable Care Act. Under these provisions, QHP issuers must provide the specified information to the Marketplace, CMS and the State insurance commissioner. As clarified in Affordable Care Act Implementation FAQs Set 15 Q4,¹⁶ QHP issuers will begin submitting information after they have been certified as QHPs for one benefit year. We intend to provide details on the implementation of the transparency in coverage reporting requirements, including what information must be provided and timing of submissions, through future guidance.

¹⁶ Affordable Care Act Implementation FAQs – Set 15, available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.

CHAPTER 7: TRIBAL RELATIONS AND SUPPORT

Section 1. Model Contract Addendum for Issuers Working with Indian Health 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 expects issuers to offer contracts to Indian health care providers and use the recommended Model QHP Addendum (Addendum) as described in the 2014 Letter to Issuers. Issuers should refer to that document and the addendum itself, both of which are available on the CCIIO website, for further details.

We also note that Section 206 of the Indian Health Care Improvement Act (25 USC Section 1621e) provides that all Indian providers have the right to recover from third party payers, including QHPs, up to the reasonable charges billed for providing health services, or, if higher, the highest amount an insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. Under Section 206 of IHCIA, an Indian health provider can seek recovery from a QHP if it has a contract with the QHP or not. We encourage issuers and Indian health providers to set up payment terms and contracted relationships to which both parties agree.

Section 2. Tribal Sponsorship of Premiums

Regulations at 45 C.F.R. 155.240(b) provide Marketplaces 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 Marketplace. During consultations with tribal governments, tribal leaders indicated the importance of tribes having the ability to pay premiums on behalf of their members.

For the 2014 benefit year, CMS assessed its various systems to determine how the FFMs could establish a process to facilitate Tribal Premium Sponsorship or the ability of Indian tribes, tribal organizations, and urban Indian organizations to pay premiums on behalf of AI/ANs. Because the FFMs will not collect premiums directly from individuals, CMS concluded that the FFMs will not be able to establish a process that would facilitate premium sponsorship, including Tribal Premium Sponsorship, for October 1, 2013. This determination remains unchanged for the 2015 benefit year.

CMS recognizes that aggregating premium payments can be an effective mechanism for increasing the enrollment of AI/ANs in QHPs and will continue to work on this option for future years. It should be noted that tribes are able to work with issuers or tribal members directly to

pay premiums. Additionally, this determination does not preclude State-based Marketplaces from developing and implementing a process for Tribal Premium Sponsorship. CMS encourages tribes to continue to work closely with State-based Marketplaces, including the option to explore tribal premium sponsorship.