

February 28, 2013  
(corrected on March 7, 2013)

## **Recommendations of the Qualified Health Plan (QHP) Issuer Certification Process Working Group**

This report is submitted by the QHP Issuer Certification Working Group Chair (Kevin Lucia) and Vice Chair (Katherine Stocks). The purpose of this report is to outline the recommendations of the QHP Issuer Certification Working Group regarding what issuers will be required to submit the DC Health Benefit Exchange Authority (HBX) with respect to becoming certified to sell health insurance through the HBX.

### **Background**

For health insurance coverage beginning in 2014, individuals and small groups will be able to purchase coverage through exchanges, the purpose of which is to provide a competitive marketplace and facilitate comparison of health plans based on quality, price, coverage and other factors. Health insurance issuers must be certified as meeting minimum standards in order to participate in the exchange and issue qualified health plans. In March of 2012, the U.S. Department of Health and Human Services issued a final (some parts interim final) rule on “Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers.” (45 CFR Parts 155, 156 and 157). The preamble to the rule and the rule itself provide detailed guidance to exchange operators on the federal standards with which the exchange and the issuers must comply, such as state licensure; benefit and product standards; rating, rate filing and rating disclosures; marketing; quality, network adequacy and accreditation; and other required processes, procedures and disclosures.

To assist the working group in its discussions and deliberations, the working group used a document developed by the Georgetown University Health Policy Institute outlining the certification requirements, as adapted by the working group’s facilitator after she thoroughly reviewed the federal rule. That document is attached. (Attachment A)

One of the ways departments of insurance (DOIs) across the nation operate is to use attestations (also known as certifications) of issuers that they are in compliance with the law. For example, company actuaries routinely certify that their rates are reasonable in relation to the premium charged and that they are not unfairly discriminatory. State DOIs, including DC’s Department of Insurance Securities and Banking (DISB), accept these actuarial certifications. Similarly, issuers file annual financial statements and certify that they are correct. Again, state DOIs, including DISB, routinely accept these certifications.

DISB retains regulatory authority by acceptance of attestations, since it has full authority to enforce correction of an issuer error and impose any sanction, such as a fine, commensurate with the gravity of the error.

A significant portion of the working group's discussion recognized the fact that the DC HBX is in start-up mode, and time is of the essence in getting processes underway in order for plans to have qualified products and the HBX to be ready for the initial open enrollment period, which starts on October 1, 2013. Due to this very real time crunch, the bulk of the working group's recommendations are to accept issuer certifications of compliance with the various standards for first plan year. However, the working group also recognizes that operation of the HBX will be an evolving experience and in fact the HBX will have more data as the HBX grows and adds more enrollees. The working group recommends that the HBX Board revisit these standards prior to QHP recertification in the second plan year, since the HBX will have additional data and experience to evaluate whether regulator verifications based on prospective evidence or means of accreditation other than issuer certifications should be required for certain standards.

It is also important to note that under the federal regulation, exchanges have an obligation to monitor compliance with federal standards for QHP and issuer certification. As HBX gains experience, becomes fully staffed and gains enrollees, actions such as spot checks of issuer websites and other monitoring activities should increase.

### **Working Group Members**

The QHP Certification Process Working Group is comprised of representatives from health plans, benefit advisors and consumer advocates. Two meetings were held, on February 20 and 21, 2013, the first in-person and conference call participation, and the second by conference call.

Kevin Lucia	Georgetown University Health Policy Institute
Katherine Stocks	The Goldblatt Group
Dave Chandra	Center on Budget Policy and Priorities
Laurie Kuiper	Kaiser Permanente
Stacy Mills	Adventurous Consulting
Louisa Tavakoli	Care First
Colleen Cohan	UnitedHealthcare
James McSpadden	AARP DC
Kim Ruggiero	Aetna
Keith MacCannon	Chartered Health

## **Recommendations**

The discussion and recommendations below follow the categories of Attachment A in order.

### **I – Licensed and in good standing**

#### ***Consensus Recommendation:***

- The regulator will verify that the issuer has a certificate of authority to conduct insurance business in DC for health (or dental) insurance
  
- Attestations for the following will be accepted:
  - Service area
  - General attestation that issuer has appropriate structure, staffing, management, etc. to administer QHP effectively and in conformance with federal requirements now and in the future
  - General attestation that issuer is in good standing – faces no outstanding licensing sanctions imposed by the Division of Insurance, Securities and Banking (DISB) and is not under a corrective action plan related to solvency

### **II – Benefit Standards and Product Offerings**

The working group noted that DISB presently reviews and approves all forms before the products are allowed on the market. DISB will, in the future, review the forms to ensure compliance with the Affordable Care Act standards for benefits, including the determination of the actuarial value of the products, and whether they meet the requirements to be a QHP, or to be designated a Bronze, Gold, Silver or Platinum plan as proffered by the issuer. In fact, the federal government has developed, and made publicly available, an actuarial value calculator that is available to DISB staff to verify the metal level standard.

#### ***Consensus Recommendation:***

- Attestations for the following will be accepted:
  - Product compliance for QHP and child-only policies
  - Compliance with nondiscrimination standards

### **III, IV and V – Rating Issues**

The working group noted that DC has an “approved rate review program” (Center for Consumer Information and Insurance Oversight (CCIIO) determination) across all aspects of the individual and small group markets. The working group noted that DISB presently reviews and approves all rates before the products are allowed on the market.

#### ***Consensus Recommendation:***

Attestations for all the standards will be accepted.

### **VI – Marketing**

Due to the approaching enrollment start date, there will not be time for a front-end review of marketing materials. The working group noted that in most jurisdictions, with respect to major medical health insurance, Departments of Insurances tend to regulate marketing on the back end – through market conduct reviews or in response to consumer complaints. The working group also noted that generally speaking, on a national basis, major medical insurance has not seen problems with marketing issues. DC should be cautious, though, because there are no local standards for marketing and other lines of health insurance have been problematic in the past, such as Medicare Advantage when it was first introduced.

#### ***Consensus Recommendation:***

Attestations for the standard will be accepted.

### **VII – Network Adequacy**

The working group noted that both network adequacy and quality assurance are scrutinized thoroughly in the accreditation process. Presently, all issuers licensed to do business in DC are accredited.\*

#### ***Consensus Recommendation:***

- If an issuer is accredited, attestation for all the standards will be accepted.
- If an issuer is not accredited, it will be required to submit an access plan.

\*Policy currently being reviewed by DC HBX network adequacy working group.

## **VIII – Applications and Notices**

## **IX – Transparency Requirements**

The working group noted the transparency standards will be self-regulating as the HBX will know if the issuer has reported to it as required.

### ***Consensus Recommendation:***

Attestations for all the standards will be accepted.

## **X – Enrollment Periods**

## **XI – Enrollment Process for Qualified Individuals**

## **XII- Termination of Qualified Individuals**

The working group noted that if there were issues with any of these three groups of standards, the HBX would discover it very quickly as aggrieved individuals would likely file complaints about the alleged misconduct. State DOIs, including DISB, have a variety of data collection systems in place and track complaints very closely.

### ***Consensus Recommendation:***

Attestations for all the standards will be accepted.

## **XIII – Accreditation Standards**

The working group noted that it would be imprudent for an issuer to attest to being accredited if that were not the case, since accreditation status can be easily verified through the accreditation bodies. The accreditation bodies perform a thorough review of issuer operations and processes before awarding accreditation.

### ***Consensus Recommendation:***

- If an issuer is accredited, attestation for all the standards will be accepted.
- If an issuer is not accredited, it will be required to attest that it is in the process of becoming accredited prior to whatever standard (e.g. one year) is set by the HBX Board.

## **XIV – Quality Assurance Program**

The working group noted that both network adequacy and quality assurance are scrutinized thoroughly in the accreditation process. Presently, all issuers licensed to do business in DC are accredited.

***Consensus Recommendation:***

- If an issuer is accredited, attestation for all the standards will be accepted.
- If an issuer is not accredited, it will be required to submit a written quality improvement strategy.

**XV – Segregation of Funds**

The working group noted that DISB performs periodic financial examinations of all issuers, and this standard can be checked within that process.

***Consensus Recommendation:***

Attestations for the standard will be accepted.

**XVI – Other Substantive Requirements**

***Consensus Recommendation:***

Attestations for the remaining standards will be accepted.

**XVII – Other Reporting Requirements**

The working group noted that HHS would notify the HBX if an issuer was not complying with this standard on Rx drug reporting data.

***Consensus Recommendation:***

Attestation for the standard will be accepted.

Company Name (Name in DC Company is Licensed under):	
NAIC Company Number:	
Company Address:	
Contact Person for Filing:	
Contact Person for filing address:	
Contact Person for filing telephone number:	
Contact Person for filing email:	
<input type="checkbox"/> Individual <input type="checkbox"/> SHOP <input type="checkbox"/> CO-OP <input type="checkbox"/> Multistate plan (under contract with OPM) <input type="checkbox"/> Dental only	

		Requirements	Federal Source	SERFF-supported function*	SERFF could be used for data collection**	Notes
<input type="checkbox"/>	I	Licensed and in good standing	45 CFR § 156.200(b)(4)		X	1.Regulator verifies directly through evidence that requirement is met. 2.Regulator will accept verification by company officer that requirement has been met. 3.Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	1.1	<input type="checkbox"/> Is licensed or authorized in {State} as: <input type="checkbox"/> Domestic <input type="checkbox"/> Foreign <input type="checkbox"/> Stock <input type="checkbox"/> Reciprocal <input type="checkbox"/> Mutual <input type="checkbox"/> Fraternal Benefit Society <input type="checkbox"/> HMO <input type="checkbox"/> Non Profit Health Care Plan <input type="checkbox"/> {additional licenses available in DC}			X	
	1.2	<input type="checkbox"/> Authorized by DISB to offer <b>health</b> insurance <input type="checkbox"/> Authorized by DISB to offer <b>dental</b> insurance			X	

	1.3	<input type="checkbox"/> Is in good standing			X	
	1.4	<input type="checkbox"/> Service area				
	1.5	<input type="checkbox"/> General attestation regarding ability to participate in and abide by requirements of HBX, comply with the risk adjustment program, and that the products are in the interest of qualified individuals	45 CFR § 156.200(b); 45 CFR § 155.1000(c)(2)			
<input type="checkbox"/>	II	Benefit Standards and Product Offerings				1.Regulator verifies directly through evidence that requirement is met. 2.Regulator will accept verification by company officer that requirement has been met. 3.Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	2.1	<input type="checkbox"/> Covers the Essential Health Benefit Package	42 USC §18022	X		
	2.2	<input type="checkbox"/> Complies with Annual Limitation on Cost Sharing.  <input type="checkbox"/> <u>Cost-sharing</u> shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage.  FOR SHOP ONLY: <input type="checkbox"/> Complies with Annual Limitations on Deductibles for Employer-Sponsored Plans.	42 USC §18022	X		
	2.3	<input type="checkbox"/> Offers through the Exchange: <input type="checkbox"/> one silver level plan (AV 70%), <b>AND</b> <input type="checkbox"/> one gold level plan (AV 80%).	45 CFR §156.200 (c)(1)	X		
	2.4	<input type="checkbox"/> Offers a child-only plan at the same level of coverage—bronze, silver, gold, or platinum—as	45 CFR §156.200(c)	X		



		any other plan offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained age 21.				
	2.5	<input type="checkbox"/> Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.	45 CFR §156.200(e)		X	
	2.6	<input type="checkbox"/> Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	X		
	2.7	<input type="checkbox"/> Submits a description of covered benefits and cost-sharing provisions to the Exchange at least annually.	45 CFR §156.210(b)		X	
<input type="checkbox"/>	III	Rate Filings and other Rate Disclosure Requirements				1.Regulator verifies directly through evidence that requirement is met. 2.Regulator will accept verification by company officer that requirement has been met. 3.Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	3.1	<input type="checkbox"/> Files rates for prior approval.	{ State law cite }	X		
	3.2	<input type="checkbox"/> Submits rate information to the Exchange at least annually.	45 CFR §155.1020 45 CFR §156.210(b)	X		
	3.3	<input type="checkbox"/> Submits to the Exchange a justification for a rate increase prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR §156.210(c)	X		
	3.4	<input type="checkbox"/> Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR		X	

			§156.210(c)			
<input type="checkbox"/>	IV	Rating Standards—General				
	4.1	<input type="checkbox"/> Sets rates for an entire benefit year, or for the SHOP, plan year.	45 CFR §156.210(a)	X		
	4.2	<input type="checkbox"/> Rates must be the same for products inside and outside Exchange.	45 CFR §156.255(b)	X		
<input type="checkbox"/>	V	Allowable Rating Variations	42 U.S.C. 300gg §2701; 45 CFR §156.255			1.Regulator verifies directly through evidence that requirement is met. 2.Regulator will accept verification by company officer that requirement has been met. 3.Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	5.1	<input type="checkbox"/> Varies rates only based on: <input type="checkbox"/> geographic area <input type="checkbox"/> age (3 to 1) <input type="checkbox"/> tobacco use (1.5 to 1) <input type="checkbox"/> family composition: <input type="checkbox"/> Individual; <input type="checkbox"/> Two-adult families; <input type="checkbox"/> One-adult family with child(ren) <input type="checkbox"/> All other families.	42 U.S.C. 300gg §2701; 45 CFR §156.255	X		
<input type="checkbox"/>	VI	Marketing				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is

						taking steps to meet the requirements prior to [DATE]
	6.1	<input type="checkbox"/> Marketing practices do not discourage the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	X		
<input type="checkbox"/>	VII	Network Adequacy Requirements	45 CFR §155.1050; 45 CFR §156.230			<ol style="list-style-type: none"> <li>1. Regulator verifies directly through evidence that requirement is met.</li> <li>2. Regulator will accept verification by company officer that requirement has been met.</li> <li>3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]</li> </ol>
	7.1	<input type="checkbox"/> Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.  <input type="checkbox"/> Network must include providers that specialize in mental health and substance abuse services.	45 CFR §156.230(a)(2)		X	
	7.2	<input type="checkbox"/> Has a network with sufficient geographic distribution of providers for each plan.	45 CFR §156.230(a)(2)		X	
	7.3	<input type="checkbox"/> Has sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area.	45 CFR §156.230(a)(1) ; 45 CFR §156.235		X	
	7.4	Alternate standard for QHP issuers that provide major services through employed physicians or a single medical group	45 CFR §156.235(b)			
<input type="checkbox"/>	7.5	<input type="checkbox"/> Makes its provider directory available: <input type="checkbox"/> to the Exchange for publication online in accordance with guidance from the Exchange;	45 CFR §156.230(b)		X	

		and <input type="checkbox"/> to potential enrollees in hard copy upon request.  <input type="checkbox"/> Provider directory identifies providers that are not accepting new patients.				
<input type="checkbox"/>	VIII	Applications and Notices				1.Regulator verifies directly through evidence that requirement is met. 2.Regulator will accept verification by company officer that requirement has been met. 3.Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	8.1	<input type="checkbox"/> Provides to applicants and enrollees all applications and other material: <input type="checkbox"/> in plain language; and <input type="checkbox"/> in a manner that is accessible and timely to: <input type="checkbox"/> individuals living with disabilities, and <input type="checkbox"/> to individuals with limited English proficiency through the provision of language services at no cost to the individual.	45 CFR §155.230(b)		X	
	8.2	<input type="checkbox"/> Complies with DC minimum language simplification standards.	{State law cite}		X	
<input type="checkbox"/>	IX	Transparency Requirements	45 CFR §155.1040; 45 CFR §156.220			1.Regulator verifies directly through evidence that requirement is met. 2.Regulator will accept verification by company officer that requirement has been met. 3.Regulator will accept verification by company officer that company is taking steps to meet the requirements

					prior to [DATE]
9.1	<input type="checkbox"/> Makes available to the public in an accurate and timely manner, and in plain language: <input type="checkbox"/> Claims payment policies and practices; <input type="checkbox"/> Periodic financial disclosures; <input type="checkbox"/> Data on enrollment; <input type="checkbox"/> Data on disenrollment; <input type="checkbox"/> Data on the number of claims that are denied; <input type="checkbox"/> Data on rating practices; <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage; <input type="checkbox"/> Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	
9.2	<input type="checkbox"/> Makes available to the Exchange in an accurate and timely manner, and in plain language: <input type="checkbox"/> Claims payment policies and practices; <input type="checkbox"/> Periodic financial disclosures; <input type="checkbox"/> Data on enrollment; <input type="checkbox"/> Data on disenrollment; <input type="checkbox"/> Data on the number of claims that are denied; <input type="checkbox"/> Data on rating practices; <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage; <input type="checkbox"/> Information on enrollee rights under Title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	
9.3	<input type="checkbox"/> Makes available to Commissioner of Insurance in an accurate and timely manner, and in plain language: <input type="checkbox"/> Claims payment policies and practices; <input type="checkbox"/> Periodic financial disclosures;	45 CFR §156.220		X	

	<input type="checkbox"/> Data on enrollment; <input type="checkbox"/> Data on disenrollment; <input type="checkbox"/> Data on the number of claims that are denied; <input type="checkbox"/> Data on rating practices; <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage; <input type="checkbox"/> Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient’s Bill of Rights).				
9.4	<input type="checkbox"/> Makes available to the U.S. DHHS in an accurate and timely manner, and in plain language: <input type="checkbox"/> Claims payment policies and practices; <input type="checkbox"/> Periodic financial disclosures; <input type="checkbox"/> Data on enrollment; <input type="checkbox"/> Data on disenrollment; <input type="checkbox"/> Data on the number of claims that are denied; <input type="checkbox"/> Data on rating practices; <input type="checkbox"/> Information on cost-sharing and payments for out-of network coverage; <input type="checkbox"/> Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient’s Bill of Rights).	45 CFR §156.220		X	
9.5	<input type="checkbox"/> Makes available the amount of enrollee cost sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual.  <input type="checkbox"/> Makes available such information through: <input type="checkbox"/> Internet Web site; and <input type="checkbox"/> Other means for individuals without access to the Internet.	45 CFR § 156.220(d)		X	
9.6	<input type="checkbox"/> Provides required notices on internal and	45 CFR		X	

		external appeals in a culturally and linguistically appropriate manner.	§147.136(e)			
<input type="checkbox"/>	X	Enrollment Periods				<ol style="list-style-type: none"> <li>1. Regulator verifies directly through evidence that requirement is met.</li> <li>2. Regulator will accept verification by company officer that requirement has been met.</li> <li>3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]</li> </ol>
	10.1	<input type="checkbox"/> Provides an <b>initial open enrollment</b> period October 1, 2013 to March 31, 2014.	45 CFR §155.410(b)		X	
	10.2	<input type="checkbox"/> Provides an <b>annual open enrollment</b> period October 15 to December 7.	45 CFR §155.410(e)		X	
	10.3	<input type="checkbox"/> Enrolls qualified individuals under 10.1 and 10.2 with the proper effective coverage date	45 CFR §155.410(c)		X	
	10.4	<input type="checkbox"/> Provides <b>special enrollment</b> periods for qualified enrollees with proper effective coverage date	45 CFR §155.420		X	
<input type="checkbox"/>	XI	Enrollment Process for Qualified Individuals				<ol style="list-style-type: none"> <li>1. Regulator verifies directly through evidence that requirement is met.</li> <li>2. Regulator will accept verification by company officer that requirement has been met.</li> <li>3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]</li> </ol>
	11.1	<input type="checkbox"/> Enrolls a qualified individual when Exchange	45 CFR §156.265		X	

		notifies the issuer that the individual is a qualified individual and transmits information to the issuer.	(b)(1)			
11.2	<input type="checkbox"/>	If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: <input type="checkbox"/> Directs the individual to file an application with the Exchange; or <input type="checkbox"/> Ensures that the individual received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.	45 CFR §156.265 (b)(2)		X	
11.3	<input type="checkbox"/>	Accepts enrollment information consistent with the privacy and security requirements established by the Exchange.	45 CFR §156.265 (c)		X	
11.4	<input type="checkbox"/>	Uses the premium payment process established by the Exchange.	45 CFR §156.265 (d)		X	
11.5	<input type="checkbox"/>	Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards.	45 CFR §156.265 (e)		X	
11.6	<input type="checkbox"/>	Reconciles enrollment files with HHS and the Exchange no less than once a month.	45 CFR §156.265 (f); 45 CFR §156.400 (d)		X	
11.7	<input type="checkbox"/>	Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.	45 CFR §156.265 (g)		X	
<input type="checkbox"/>	XII	Termination of Coverage of Qualified Individuals	45 CFR §155.430; 45 CFR §156.270			<ol style="list-style-type: none"> <li>1. Regulator verifies directly through evidence that requirement is met.</li> <li>2. Regulator will accept verification by company officer that requirement has been met.</li> <li>3. Regulator will accept verification by company officer that company is taking steps to meet the requirements</li> </ol>



					prior to [DATE]
12.1	<input type="checkbox"/> Terminates coverage only if: <input type="checkbox"/> Enrollee is no longer eligible for coverage through the Exchange; <input type="checkbox"/> Enrollee's coverage is rescinded; <input type="checkbox"/> QHP terminates or is decertified; <input type="checkbox"/> Enrollee switch coverage: <input type="checkbox"/> during an annual open enrollment period; <input type="checkbox"/> special enrollment period; or <input type="checkbox"/> obtains other minimum essential coverage. <input type="checkbox"/> For non-payment of premium only if: <input type="checkbox"/> Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances; <input type="checkbox"/> Enrollee is delinquent on premium payment; <input type="checkbox"/> Provides the enrollee with notice of such payment delinquency; and <input type="checkbox"/> Provides a grace period of at least 3 consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium.	45 CFR §155.430(b); 45 CFR §156.270		X	
12.2	<input type="checkbox"/> Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination).	45 CFR §155.430 (d); 45 CFR §156.270 (b)		X	
12.3	<input type="checkbox"/> Maintains records of terminations of coverage for auditing.	45 CFR §155.430(c); 45 CFR		X	

			§156.270(h)			
<input type="checkbox"/>	XIII	Accreditation Standards	45 CFR §1045; 45 CFR §156.275			1.Regulator verifies directly through evidence that requirement is met. 2.Regulator will accept verification by company officer that requirement has been met. 3.Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	13.1	<input type="checkbox"/> Accredited on the basis of local performance in the following categories by an accrediting entity recognized by HHS: <input type="checkbox"/> Clinical quality measures, such as the HEDIS; <input type="checkbox"/> Patient experience ratings on a standardized CAHPS survey; <input type="checkbox"/> Consumer access; <input type="checkbox"/> Utilization management; <input type="checkbox"/> Quality assurance; <input type="checkbox"/> Provider credentialing; <input type="checkbox"/> Complaints and appeals; <input type="checkbox"/> Network adequacy and access; <b>and</b> <input type="checkbox"/> Patient information programs.	45 CFR §156.275(a)(1)	X (Standardized CAHPS data will not be captured in SERFF for plan year 1)	X (States could require CAHPS data be submitted via SERFF for plan year 1)	
	13.2	<input type="checkbox"/> Authorizes the accrediting entity to release to the Exchange and HHS a copy of its most recent accreditation survey and survey-related information.	45 CFR §156.275(a)(2)	X		
	13.3	<input type="checkbox"/> Accredited within the timeframe established by the Exchange.  <input type="checkbox"/> Maintains accreditation.	45 CFR §156.275(b)	X		

	XIV	Quality Assurance Program				
<input type="checkbox"/>	14.1	<input type="checkbox"/> Implements and reports on a <u>quality improvement strategy</u> or strategies used to reward quality through the use of market based incentives.  <u>Improvement strategy</u> is any strategy that includes increased reimbursement or other financial incentive for: <ul style="list-style-type: none"> <li>• Improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including use of the medical home model, for treatment or services under the plan or coverage;</li> <li>• Implementation of activities to prevent hospital readmissions through a comprehensive program that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;</li> <li>• Implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology;</li> <li>• Implementation of wellness and health promotion activities; and</li> <li>• Implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.</li> </ul>	45 CFR §156.200 (b)(5)  42 U.S.C. §13031			X

<input type="checkbox"/>	XV	Segregation of Funds				
	15.1	<input type="checkbox"/> Does not use federal funds for abortion.	45 CFR §156.280		X	
<input type="checkbox"/>	XVI	Other Substantive Requirements				
	16.1	<input type="checkbox"/> Complies with internal claims and appeals and external review processes.	45 CFR §147.136		X	
	16.2	<input type="checkbox"/> If provides coverage through a direct primary care medical home: <input type="checkbox"/> medical home meets criteria established by HHS; <input type="checkbox"/> issuer meets all requirements otherwise required; <b>and</b> <input type="checkbox"/> issuer coordinates the services covered by the direct primary care medical home.	45 CFR §156.245		X	
<input type="checkbox"/>	XVII	Other Reporting Requirements				<ol style="list-style-type: none"> <li>1. Regulator verifies directly through evidence that requirement is met.</li> <li>2. Regulator will accept verification by company officer that requirement has been met.</li> <li>3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]</li> </ol>
<input type="checkbox"/>	17.2	<input type="checkbox"/> Reports to U.S. DHHS on prescription drug distribution and cost the following information (paid by PBM or issuer): <input type="checkbox"/> Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and	45 CFR §156.295			

		<ul style="list-style-type: none"> <li><input type="checkbox"/> Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> independent pharmacy,</li> <li><input type="checkbox"/> supermarket pharmacy, <b>and</b></li> <li><input type="checkbox"/> mass merchandiser pharmacy.</li> </ul> </li> <li><input type="checkbox"/> Aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> attributable to patient utilization, and</li> <li><input type="checkbox"/> passed through to the issuer.</li> </ul> </li> <li><input type="checkbox"/> Total number of prescriptions that were dispensed.</li> <li><input type="checkbox"/> Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.</li> </ul>				
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\*SERFF is expected to collect data for analysis of the requirements in this column.

\*\*SERFF may be used to collect state-specific, document-based information to support review of requirements in this column..