



Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

TO: ALL INSURERS

FROM: ANDREW BORON, DIRECTOR OF INSURANCE 

DATE: MARCH 20, 2013

RE: BULLETIN # 2013-03
DRAFT ILLINOIS QUALIFIED HEALTH PLAN APPLICATION GUIDELINES

Background

Section 1311 of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, (together known as the Affordable Care Act) established a Health Benefit Exchange (Exchange) in each state beginning January 1, 2014. On October 16, 2012, Governor Pat Quinn sent a letter to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services declaring Illinois a Partnership Exchange for plan year 2014 and on November 16, 2012, the Illinois Department of Insurance (DOI) submitted its "Blueprint Application" to the federal Center for Consumer Information and Insurance Oversight (CCIIO) detailing its plans to partner with the federal government to conduct Plan Management and Consumer Assistance activities.

The Affordable Care Act (ACA) requires all health plans offered in an Exchange to be certified as a Qualified Health Plan (QHP). As a Plan Management partner in plan year 2014, DOI with the assistance of the Illinois Department of Public Health (DPH) will review QHP applications and recommend applicants that meet the application standards to CCIIO for QHP certification. CCIIO will then certify QHPs, issue contractual agreements with QHPs, post plan information on the federally-run "Health Insurance Marketplace" (Marketplace) website, charge QHPs a user fee, transmit premium and cost-sharing subsidies to issuers, and administer the risk adjustment, reinsurance and risk corridors programs.

The Illinois Health Insurance Marketplace is intended to provide affordable health insurance for Illinois consumers. It is DOI's intention to ensure that the choices between plans from providers are easily understood and offer significant choices for consumers. DOI encourages new insurers seeking to participate in the exchange to submit their plans so that there is robust competition.

Illinois Qualified Health Plan Application Guidelines

As part of the certification process under the ACA, DOI has drafted the Qualified Health Plan Application Guidelines and the Illinois QHP Application Checklist, which are included with this Bulletin. The draft QHP guideline specifies the criteria issuers, including Consumer Operated and Oriented Plans (CO-OPs) and Stand-Alone Dental Plans, must meet to become a certified QHP in the individual Exchange and/or Small Business Health Options Program (SHOP)

Exchange. The guideline notes alternative standards for stand-alone dental plans when appropriate.

To apply to become a QHP, issuers must submit all required documentation listed in the application checklist including rate and form filings through the System for Electronic Rate and Form Filing (SERFF) beginning on Monday, April 1, 2013, and all such required documentation must be submitted no later than Tuesday, April 30, 2013.

Questions regarding this Bulletin, including the Qualified Health Plan Application Guidelines and the Illinois QHP Application Checklist, may be submitted to DOI by email at DOI.HealthReform@illinois.gov, no later than close of business on Tuesday, March 26, 2013.

Related Documentation

- Illinois Qualified Health Plan Guidelines (attached)
- Illinois QHP Application Checklist (attached)
- Bulletin # 2013-04, Qualified Health Plan Fees



Illinois Qualified Health Plan Application Guidelines

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General Guidance

This QHP guideline specifies the criteria issuers, including Consumer Operated and Oriented Plans (CO-OPs) and Stand-Alone Dental Plans must meet to become a certified QHP in the individual Exchange and/or Small Business Health Options Program (SHOP) Exchange. The guideline notes alternative standards for stand-alone dental plans when appropriate.

To apply, issuers must submit all required documentation listed in the application checklist including rate and form filings through the System for Electronic Rate and Form Filing (SERFF) no later than 12:00 PM CST, Tuesday, April 30, 2013. Rate and form filings must be downloaded from the federal Health Insurance Oversight System (HIOS) and submitted to DOI through SERFF. Issuers will need to submit HIOS approved templates which may be downloaded from SERFF:

http://www.serff.com/plan_management_data_templates.htm

In order for the QHP application to be reviewed, all checklists, templates and supporting documentation must be submitted with the initial application in a SERFF QHP binder. All appropriate rate and form filings will need to be properly associated to QHP application in SERFF or the QHP binder will be returned. All form filings must be submitted in the format of a complete insurance policy. No matrix insert page filings will be accepted. Each plan being submitted to be sold on the Exchange Marketplace will need to be submitted as a complete plan with no variable language or brackets. The rate and form filings must be submitted separately and the rate filings must properly identify which policy forms will be associated with the specific rate filing. All fees related to the submission and review of each QHP application, the amount of which is to be determined by DOI, must be submitted with the initial application.

Each form filing submitted should provide a red-line version of the variations in plan benefit design. This will include variations of plan benefit designs between all metal levels, as well as, variations included in plan benefit designs in the same metal level. The red-lined version will allow DOI a more precise and quicker review of the variations in plan levels. Both the red-lined version and final form policy shall be submitted in the Form Schedule tab in SERFF.

To make sure your QHP application is complete, please review the Submission Checklist attached. The Submission Checklist will provide a list of documents which will need to be attached to the QHP application to make it complete.

Any outstanding fines, fees or other amounts owed by the issuer to DOI must be paid or otherwise resolved before a QHP application will be recommended for acceptance.

Statewide coverage is not a prerequisite to be recommended for certification, but a QHP must provide coverage to an entire rating area as defined in this guidance. The issuer must provide service area maps to show compliance.

Terms of Engagement

To be recommended as a QHP, issuers will be required to offer plans in at least the silver and gold coverage level, as well as at least one child-only plan, as defined by 2707(c) of PPACA. Meaningful difference between plan offerings will be reviewed by DOI. The criteria below will be used to determine a meaningful difference exists between plan offerings within the same metal level.

Examples of meaningful plan design differences include:

1. Plan design has a different payment structure (co-payment versus co-insurance versus deductible versus high-deductible health plan (HDHP))
2. Deductible and maximum out-of-pocket (OOP) differences:
 - Medical deductible difference of \$250 or more
 - Pharmacy deductible difference of \$100 or more
 - Maximum OOP difference greater than \$1000
3. Changes in Cost Sharing for key service categories:
 - Inpatient/Outpatient Visit: at least 10% difference or if applicability of deductible is changed
 - PCP/Specialist Visit: at least \$10 or 10% difference or if applicability of deductible is changed
 - Generic Drugs: at least a \$5 average difference or if applicability of deductible is changed
 - Brand Drugs: at least a \$10 average difference or if applicability of deductible is changed

DOI recommended QHPs that are certified by CCIIO will be offered on the Marketplace website. Open enrollment for individual and SHOP QHPs will begin on October 1, 2013 with the effective date of coverage beginning on January 1, 2014. QHPs will be offered for one plan year, ending December 31, 2014; QHPs will need to be recertified to be offered in future plan years.

Catastrophic plans will only be available on the individual Marketplace website, not in the SHOP. Catastrophic plans are available for adults under age 30 and consumers without other affordable insurance options. Catastrophic plans must offer:

1. coverage that is not in the bronze, silver, gold, or platinum level; lower premiums;
2. protection against high out-of-pocket costs;
3. coverage of three primary care visits per year before reaching the deductible;
4. recommended preventative services without cost-sharing; and
5. no coverage of essential health benefits until the enrolled individual reaches the annual limitation in cost-sharing

(45 CFR 156.155). Issuers who elect to offer these plans will need to complete the DOI Catastrophic checklist and submit it with the QHP application. The Catastrophic checklist is attached to the guidelines and may be found at the DOI website.

Qualified Health Plan Certification

Only certified QHPs will be offered on the Illinois Partnership Exchange, also known as the “Health Insurance Marketplace.” To be certified as a QHP, a plan must:

1. Be submitted to DOI through SERFF for review by 12:00 PM CST, April 30, 2013;
2. Meet all minimum federal and state requirements;
3. Be recommended by DOI to CCIIO; and
4. Be certified by CCIIO, which includes having a signed issuer agreement with CCIIO.

Qualified Health Plan Requirements

The ACA and relevant HHS regulations and guidance provide the regulatory framework for QHP application requirements. Issuers will be required to submit issuer-completed application templates, including benefit and service area data and rating tables, for review by DOI and certification by CCIIO. Additionally, issuers will have to agree to provide additional detail to CCIIO, such as reinsurance, enrollment and quality data. As a Plan Management partner, the use of federal Plan Management templates are required. Before uploading the completed application to SERFF, issuers will need to download the federal excel templates from the SERFF website, complete, validate and attach them in the application. These templates will adjust standards for stand-alone dental plans accordingly. DOI has created a submission and application checklist to assist in the completion of the QHP application. Both of these checklists are attached to these guidelines and may be found at the DOI website. In addition, there are checklists for the completion of the individual and SHOP requirements contained within the application. All of the checklists will need to be downloaded from the DOI website, completed and attached to the QHP application before submitted in SERFF.

Administrative Data: Issuers will need to download an administrative data template from SERFF, complete it and upload it to SERFF. This template includes general information about the company and its points of contact, such as issuer ID, issuer market coverage, NAIC company code, issuer marketing name, CFO contact information, customer service phone number and other specified information. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF.

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

State Licensure: Issuers must be licensed with the state. (45 CFR 156.200(b) (4)). DOI will verify licensure in the DOI regulated entities database. DOI will contact the Issuer regarding any further clarifications that are needed on licensure.

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

Benefit Design Standards and Essential Health Benefits: Issuers must offer coverage that is substantially equal to the coverage offered by the Essential Health Benefits benchmark plan (45 CFR 156.115) and offer plans at metal levels specified by statute. (45 CFR 156.135). Issuers will need to download the Plans & Benefits template from SERFF, complete it and upload it to SERFF. The DOI checklist will need to be reviewed and completed for each Individual, SHOP, Catastrophic and dental plan submitted with the application. These checklists can be downloaded from the DOI website.

An issuer must offer three silver plan variations for each silver QHP, one zero cost-sharing plan variation, and one limited cost-sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost-sharing, cost-sharing requirements and AVs that meet the required levels within a *de minimis* range; benefits, networks, non-EHB cost-sharing and premiums cannot change. Additionally, QHPs must make available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual through an Internet website and other means for individuals without access to the Internet. (45 CFR 156.220(d)).

Additionally, issuers will need to upload to SERFF an Actuarial Memorandum that includes an actuarial narrative and certification required of the review of rates for rate review, premium allocation for advance payments of the premium tax credits and CSR payment. This template includes a "Check AV" calculator that can be downloaded to automatically calculate Actuarial Values (AV) for all plans on the cost share variance sheet. Issuers will be reimbursed directly by the federal government for applicable premium and cost-sharing reductions. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF.

DOI will confirm that the issuer offers coverage that is substantially equal to the benchmark plan, that substituted benefits demonstrate actuarial equivalence, that the AV for each QHP meets specified levels or falls within allowable variation, those being bronze plan: 60 percent (58-62 percent); silver plan: 70 percent (68-72 percent); gold plan: 80 percent (78-82 percent); and platinum plan: 90 percent (88-92 percent), and review the AV and actuarial memorandums for unique benefit designs if applicable.

Additionally, DOI will confirm the following:

1. that the benefit design complies with the federal Mental Health Parity and Addiction Equity Act;
2. that there are meaningful differences between QHPs offered by issuers;
3. that the plan complies with annual limitation on cost-sharing and cost-sharing does not exceed the limit described in section 233(c)(2)(A)(ii) of the Internal Revenue Code of 1986;
4. that the annual limitation on deductibles for plans in the small group market does not exceed \$2,000 for self-only coverage or \$4,000 for family coverage in 2014; and
5. that cost-sharing is not discriminatory, that prior authorization of services or any limitation on coverage is not imposed on coverage of emergency department services out of network that is more restrictive than the in network requirements.

(45 CFR 156.130).

Plans must also cover at least the greater of one drug in every USP category and class or the same number of drugs in each category and class as the benchmark plan. (45 CFR 156.120). Issuers will also need to download the Formulary template from HIOS, complete it and upload it to SERFF. Data points on the Formulary template include tier, drug types included, copayment, coinsurance, one to three month pharmacy and mail order benefits, a drug list, whether prior authorization or step therapy is required and other specified items. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF.

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

Rating: Issuers will need to download the Rates template from HIOS, complete it and upload it to SERFF. Data points on the Rates template include rate effective date, age, tobacco, individual, family tier scenarios and other specified items. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF.

For age rating, all QHPs must use the federal age curve in the Health Insurance Market Final Rule. The federal age curve in the proposed rule requires one band for ages 1-20; one year bands between ages 21-63; and one band for ages 64 and older:

CMS PROPOSED STANDARD AGE CURVE

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

The 3:1 age rating limitation applies only to adults age 21 and older. Rating for ages 0-20 must be actuarially justified based on a standard population, and will be reviewed and approved by DOI actuaries. Age bands must be determined based on the enrollee’s age on the first day of the plan year.

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

Geographic rating areas will be the six rating areas listed below:

Area I: Cook County (all)

Area II: DuPage, Kane, Lake, McHenry, Kendall, Will Counties

Area III: Madison, St. Clair, Monroe Counties

Area IV: Boone, Bureau, Carroll, DeKalb, Ford, Fulton, Grundy, Henderson, Henry, Iroquois, Jo Daviess, Kankakee, Knox, La Salle, Lee, Livingston, Marshall, McDonough, McLean, Mercer, Ogle, Putnam, Peoria, Rock Island, Stark, Stephenson, Tazewell, Warren, Whiteside, Winnebago, Woodford Counties

Area V: Adams, Brown, Calhoun, Cass, Champaign, Christian, Coles, DeWitt, Douglas, Edgar, Greene, Hancock, Jersey, Logan, Macon, Macoupin, Mason, Menard, Montgomery, Morgan, Moultrie, Pike, Piatt, Sangamon, Schuyler, Scott, Shelby, Vermillion Counties

Area VI: Alexander, Bond, Clark, Clay, Clinton, Crawford, Cumberland, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Pope, Pulaski, Perry, Randolph, Richland, Saline, Union, Wabash, Washington, Wayne, White, Williamson Counties

The areas are arranged according to expected medical cost levels. Area rating factors will be developed and justified by the issuer.

Rating factors are multiplicative for age, tobacco use and geography. Therefore, the oldest adult who used tobacco in rating area D could be charged 4.5 times more (3×1.5) than the youngest adult who did not use tobacco in rating area D. Additionally, under the single risk pool requirements for non-grandfathered plans in the individual and small group markets respectively, future rate changes must be applied evenly, with only certain plan-specific modifications, such as actuarial value and cost-sharing design, provider network, delivery system characteristics, utilization management practices, and essential health benefits provided (45 CFR 156.80).

Additionally, family premiums will be determined by adding up the premiums of each family member to ensure that age and tobacco use rating will only apply to that portion of the premium attributed to each family member. Issuers must not rate more than three children under the age of 21 when developing family premiums.

Issuers also will need to download the Business Rules template from HIOS, complete it and upload it to SERFF. Data points on the Business Rules template include product ID, plan ID, how rates for contracts covering two or more enrollees are calculated, maximum age for a dependent, if domestic partners are treated the same as secondary subscribers and other specified data. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF. This data will be used to populate the premium calculator, for rate review and to perform calculations for risk adjustment.

Through review by DOI actuaries and insurance regulators, DOI will ensure that QHPs offered through the Marketplace website have the same premium and cost-sharing rates as the same plans offered outside of the Marketplace; that issuers vary premiums only in accordance with permitted rating variations; that issuers cover all groups using some combination of individuals, two-adult families, one-adult families with a child or children and all other families; and that issuers comply with the required rating curves, areas and ratio standards. DOI will review initial rate filings and rate increase filings for QHPs to see that sound assumptions and methodologies were used in developing QHP premium rates and will also review rates for compliance with relevant ACA requirements.

Rate Review: Issuers will also need to download the Rate Review template from SERFF, complete it and upload it to SERFF. The template collects data on market experience, plan product information and financial information that is necessary for rate review and the evaluation of cost-sharing reduction payments, including base period claims experience, projected period medical trend factors and projected period administrative factors. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF. Issuers will need to complete the rate review checklist which is attached or they may be download it from the DOI website

Marketing: Issuers must comply with state marketing laws and regulations. (45 CFR 156.225(a)). In Illinois, marketing standards will be the same inside and outside the Marketplace. Additionally, products and rates must not be constructed or marketed in a way that discourages people from using the Marketplace.

QHPs also will be required to comply with state marketing laws in Sections 5/149 and 5/364 of the Illinois Insurance Code and Part 2002 of the Department's administrative regulations. (50 Ill. Adm. Code 2002). These standards are set to ensure that marketing activities are fair and accurate. The standards include provisions for required and prohibited language, requirements for filing of marketing material, provision of educational material and an explanation of the policy features. QHPs may not employ marketing practices that discourage enrollment of individuals with significant health needs. Issuers will show compliance by completing the section listed as Marketing in the application checklist. The required signing of the application checklist will certify compliance.

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

Network Adequacy: Issuers are required to include a sufficient number and type of providers, including providers that treat substance use and mental health conditions, to ensure that all services are available without unreasonable delay. (45 CFR 156.230). Issuers will need to download a network template in SERFF, complete it and upload it to SERFF. Data points on the Network template include network name, network ID and network URL. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF.

To the extent the issuer is accredited by URAC or NCQA, the network adequacy requirements are deemed to meet network adequacy standards. Please verify the accreditation status in the SERFF binder.

Under the review process for QHPs, the plan must ensure that any plan which encompasses a provider network is sufficient in number and types of providers, including mental health and substance use providers and essential community providers, to assure all services are accessible without unreasonable delay. Additionally, QHP applicants will be required to file a completed network adequacy checklist with necessary documentation for review to verify compliance with the Network Adequacy and Access requirements, including 24/7 accessibility, a geographic map with providers marked, a list of provider names, addresses, and specialties, number of anticipated beneficiaries and an internet website and toll-free telephone number for beneficiaries to access up to date providers lists. Additionally, QHP applicants must provide a ratio of providers to beneficiaries, greatest travel distance, inadequate networks and policies for closing providers and opening new providers, as well as referral procedures if applicable. Additionally, each QHP must make its provider directory available for publication online and to potential enrollees in hard copy upon request, and the provider directory must identify providers that are not accepting new patients. (45 CFR 156.230(b)).

The Illinois Department of Public Health (DPH) will review the network adequacy components of HMO QHP applications and provide recommendations to DOI if HMO applicants meet these standards.

Issuers are required to include a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of ECPs (45 CFR 156.235); HHS is to compile a list of ECP providers which issuers should reference for accuracy to comply with the requirements. As a transitional policy, issuers must:

1. achieve at least 20 percent ECP participation in network in the service area, agree to offer contracts to at least one ECP of each type available by county, and agree to offer contracts to all available Indian providers;
2. achieve at least 10 percent ECP participation in network in the service area, and submit a satisfactory narrative justification as part of its QHP application; or
3. submit a satisfactory narrative justification as part of its QHP application.

Additionally, issuers that provide a majority of covered services through employed physicians or a single contracted medical group must comply with the alternate standard established by CCIO. (45 CFR 156.235(b)). As a transitional policy, under the alternate standard, issuers must:

1. achieve at least the same number of providers located in designated low-income areas as the equivalent of at least 20 percent of available ECPs in the service area;
2. achieve at least the same number of providers located in designated low-income areas as the equivalent of at least 10 percent of available ECPs in the service area and submit a satisfactory narrative justification as part of its QHP application; or
3. submit a satisfactory narrative justification as part of its QHP application.

Additionally, a geoaccess map outlining the ECPs, or providers located in designated low-income areas under the alternate standard must be submitted for review. A certification must be submitted verifying the inclusion of these ECPs in the provider directory. DOI and DPH will use the geoaccess map and any required justifications to ensure that QHPs have a sufficient number and type of ECPs, or providers located in designated low-income areas under the alternate standard, within the plan service area by comparing the QHP's plan against the number and type of ECPs in the plan's service area. DOI will evaluate appropriateness on a case by case basis, which may include discussions with the QHP applicant.

Issuers will also need to download an Essential Community Providers template from HIOS, complete it and upload it to SERFF. Data points on the Essential Community Providers template include national provider number, provider name, provider type, essential community provider category and other

specified data. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF. Stand-alone dental plans will follow modified ECP standards, which will be determined by the federal government.

Service Area: The service area of a QHP must be, at a minimum, an entire county or group of counties, unless DOI determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and was established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the Public Health Services Act, or other factors that exclude specific high utilizing, high cost or medically underserved populations. (45 CFR 155.1055). Partial-county requests will be reviewed on a case by case basis. Issuers will need to download a Service Area template from SERFF, complete it and upload it to SERFF. Data points on the Service Area template include service area ID, service area name, coverage area and zip codes. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF.

Enrollee Termination: A QHP may terminate coverage only if the enrollee is no longer eligible for coverage through the Marketplace website, the enrollee switches coverage, for non-payment of premium only if the enrollee is delinquent on premium payment, the issuer provides the enrollee with notice of such delinquency, and at least a three consecutive month grace period is provided if the enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium. The issuer must provide reasonable notice of termination of coverage to the CCIIO and enrollee, including the effective date of the termination. (45 CFR 155.430 and 156.270).

Issuer Withdrawal from Exchange

Non-renewal of recertification. If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must—

- (1) Notify the Exchange of its decision prior to the beginning of the recertification process and procedures adopted by the Exchange in accordance with §155.1075 of this subchapter;
- (2) Fulfill its obligation to cover benefits for each enrollee through the end of the plan or benefit year;
- (3) Fulfill data reporting obligations from the last plan or benefit year of the certification; (4) Provide notice to enrollees as described in paragraph (b) of this section; and
- (5) Terminate coverage for enrollees in the QHP in accordance with §156.270, as applicable.

The QHP Issuer must comply with the Illinois Health Insurance Portability and Accountability Act (HIPAA) 215 ILCS 97/30 & 50 in the event that it withdraws either itself or a plan(s) from the Exchange. All notification requirements must comply with the provisions referenced in the HIPAA Act.

Accreditation: Issuers must be accredited based on local performance by an accrediting entity recognized by HHS on the federal timeline (45 CFR 155.1045) and authorize the release of their accreditation survey data. Issuers will need to download an Accreditation template in SERFF, complete it and upload it to SERFF. Issuers must select either the NCQA or the URAC template. Data points on the Accreditation template includes Market Types, Accreditation Status (es), Expiration Date(s) and other specified data. The template will need to be validated and finalized with buttons in the upper left corner of the excel document before it is uploaded to SERFF. An issuer without existing commercial, Medicaid or Exchange health plan accreditation granted by NCQA or URAC must provide proof of a scheduled review, or a plan to schedule a review, by one of the these entities. For the year 2015, the issuer must have accreditation in any line of business, these being commercial, Medicaid or Exchange

lines of business. DOI will be electronically advised of any changes in QHP accreditation status through SERFF, which will track QHP accreditation status. Accreditation standards do not apply to stand-alone dental plans.

Quality Reporting: All QHP issuers must submit a quality plan that includes ongoing, written, internal quality assessment of the program, guidelines for monitoring and evaluating the quality and appropriateness of care and services provided to enrollees, including accessibility to health care providers and appropriateness of utilization. Plans will be “deemed” in compliance with this requirement if they are accredited by NCQA, URAC or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If accredited by one of the above organizations, the issuer must provide proof of the accreditation.

Additionally, issuers that are accredited in the commercial, Medicaid or Exchange lines of business will be required to agree to the release of Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, which will be submitted to CCIIO by the accrediting agency and will be displayed with the QHP on the Marketplace website. Medicaid CAHPS data will be displayed if commercial market CAHPS data are unavailable. The Marketplace website will not display an accredited status for a QHP issuer that does not have any products that have achieved at least “provisional” or “interim” status.

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

Non-Discrimination: DOI and DPH also will check to ensure that issuers do not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation during the service area, network adequacy, essential health benefits and marketing review in line with non-discrimination standards in current Illinois insurance regulations (215 ILCS 5/424(3) and Section 364) and federal regulations. (45 CFR 156.200(e)). Additionally, a QHP issuer must not employ benefit designs that will discourage the enrollment of individuals with significant health needs. (45 CFR 156.225(b)).

Segregation of Abortion Funds: Federal funds may not be used for abortion. (45 CFR 156.280). Compliance will be monitored through market conduct reviews, including financial exam auditors verifying that federal premium tax credits and other federal funds are segregated. Additionally, abortion services are governed by two existing Illinois statutes, 215 ILCS 5.356z.4 and the Illinois Abortion Law of 1975. Section 5.356z.4 includes a provision that states, “nothing in this section shall be construed to require an insurance company to cover services related to an abortion.” The Illinois Abortion Law of 1975 as set forth in 720 ILCS 510 outlines the circumstances within which an abortion can be performed and lays out any penalties for violating those provisions. All health plans must abide by these statutes.

Guaranteed Availability Exceptions: Exceptions to guaranteed availability of coverage allow issuers to limit enrollment to certain open and special enrollment periods, an employer’s eligible individuals who live, work or reside in the service area of a network plan, and in certain situations involving network capacity and financial capacity. (45 CFR 147.104). Issuers that seek to limit availability of a QHP due to network or financial capacity must contact DOI and provide any necessary documentation to support the limited availability. The issuer will need to request this limit by noting the issue in the cover letter of QHP application. Issuers would need to apply the denial of guaranteed availability uniformly to all employers and individuals, without regard to the enrollees’ claims experience or health status-related

factors, and issuers invoking this exception generally would be barred from offering new coverage for at least 180 calendar days after coverage is denied, as directed by PHS Act section 2702(c)(2). (45 CFR 147.104).

Reporting: A QHP issuer must submit the following information in a quarterly report to DOI through SERFF and to CCIIO through HIOS:

1. Claims payment policies and practices;
2. Periodic financial disclosures;
3. Data on enrollment;
4. Data on disenrollment;
5. Data on the number of claims that are denied;
6. Data on rating practices;
7. Information on cost-sharing and payments with respect to any out-of-network coverage; and
8. Information on enrollee rights under Title I of the Affordable Care Act, including market reforms and Patient’s Bill of Rights.

(45 CFR Part 156.220).

Plan Decertification

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

The required procedures for decertification will be posted on the DOI website.

QHP Oversight

QHPs will be required to comply with all DOI oversight activities. DOI will monitor complaints and financial standards, and conduct market conduct examinations. Complaints will be monitored by DOI staff and inquiries received may also be investigated. Additionally, financial monitoring, such as solvency strength tests, will take place monthly, quarterly, annually and triennially. Level 1 reviews will be conducted every six months, and more frequently if necessary with reviews being tailored to the precise problems at issue. More frequent and comprehensive market conduct examinations will be conducted when warranted based on complaints, claim payment history and other relevant factors. The examinations will be paid for by the QHPs being reviewed.

Timeline

Event	Date
SERFF opens to accept QHP applications	April 1, 2013
QHP applications due (submissions must be completed through SERFF)	April 30, 2013

DOI reviews QHP applications	May 1, 2013 – July 31, 2013
DOI recommends QHPs to CCIIO	July 31, 2013
Open enrollment begins in individual and SHOP Exchanges	October 1, 2013
QHP coverage begins	January 1, 2014
DOI conducts QHP oversight	January 1, 2014-December 1, 2014

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1 | Illinois QHP Application Checklist

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

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
<input type="checkbox"/> I	Licensed and in good standing	45 CFR §156.200(b)(4)	DOI will review financial documents and regulated entities database for compliance.	
1.1	<input type="checkbox"/> Is licensed or authorized in Illinois as: <input type="checkbox"/> Domestic <input type="checkbox"/> Foreign <input type="checkbox"/> Stock <input type="checkbox"/> Mutual <input type="checkbox"/> Fraternal Benefit Society <input type="checkbox"/> HMO <input type="checkbox"/> Non Profit Health Care Plan		Mark all applicable boxes.	
1.2	<input type="checkbox"/> Authorized by Illinois DOI to offer health insurance <input type="checkbox"/> Authorized by Illinois DOI to offer dental insurance		Mark all applicable boxes.	
1.3	<input type="checkbox"/> Is in good standing		DOI will review financial documents and regulated entities database for compliance.	



2 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
<input type="checkbox"/> II	Benefit Standards and Product Offerings		All provisions contained below should be reviewed for compliance with our checklist which may be found at the DOI Website - http://insurance.illinois.gov/Main/industry.asp	
2.1	<input type="checkbox"/> Covers the Essential Health Benefit Package. <ul style="list-style-type: none"> • EHB substitutions will require an actuarial certification to support the substitution is compliant and is an actuarially equivalent substitution. 	42 USC §18022	Please choose the checklist of the plan type you are filing. If the policy form contains an EHB substitution, please indicate in the location column of this checklist and provide the needed certification. An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, and degree of medical dependency, quality of life or other health conditions. (45 CFR 156.125).	
2.2	<input type="checkbox"/> Complies with Annual Limitation on Cost-Sharing. <input type="checkbox"/> Cost-sharing shall not exceed the dollar amounts in effect under section	42 USC §18022	Please see above referenced check list for requirements Please see above referenced check list for requirements	



3 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
	<p>223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage.</p> <p>For the plan year beginning in 2014, cost-sharing for self-only and family coverage may not exceed the amount established under section 223(c)(2)(A)(ii) of the Internal Revenue Code, which is the cost-sharing limit for high-deductible health plans. For 2014, the estimated amount is \$6,400 for an individual and \$12,800 for a family.</p> <p>FOR SHOP ONLY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complies with Annual Limitations on Deductibles for Employer Sponsored Plans. <p>In the case of deductibles, the law provides that plans sold after January 1, 2014 in the small group market and subject to essential benefit requirements may not impose deductibles that exceed \$2,000 for a single individuals or \$4,000 for families.</p>			
2.3	<ul style="list-style-type: none"> <input type="checkbox"/> Offers through the Exchange: <ul style="list-style-type: none"> <input type="checkbox"/> One silver level plan (AV 70%), <ul style="list-style-type: none"> • Three variations offered. <p>AND</p> <ul style="list-style-type: none"> <input type="checkbox"/> One gold level plan (AV 80%). 	45 CFR §156.200 (c)(1)	An issuer must offer three silver plan variations for each silver QHP, one zero cost-sharing plan variation, and one limited cost-sharing plan variation for each metal level QHP. Silver plan variations	



4 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
2.4	<p><input type="checkbox"/> If offers a Catastrophic Plan, it is only offered to eligible individuals eligible to enroll in a catastrophic plan.</p> <p>Eligible individuals:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Individuals that have not attained the age of 30 before the beginning of the plan year; or <input type="checkbox"/> Individual has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. <p><input type="checkbox"/> If offered, Catastrophic Plans are offered only in the individual exchange and not in the SHOP.</p> <p><input type="checkbox"/> If offered, Catastrophic Plan complies with specific requirements for benefits.</p>	42 USC §18022(e)	<p>must have a reduced annual limitation on cost-sharing, cost-sharing requirements, and AVs that meet the required levels within a de minimis range; benefits, networks, non-EHB cost-sharing, and premiums cannot change.</p> <p>Please review Catastrophic Plan checklist for compliance. The checklist may be found at the DOJ Website - http://insurance.illinois.gov/Main/industry.asp</p>	
2.5	<p><input type="checkbox"/> Offers a child-only plan at the same level of coverage—bronze, silver, gold, or platinum—as any other plan offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained age 21.</p>	45 CFR §156.200(c)	Please use the checklist of the plan type you are filing.	



5 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
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)	This will provision will be determined by DOI review of policy forms.	
<input type="checkbox"/> III	Rate Filings and other Rate Disclosure Requirements			
3.1	<input type="checkbox"/> Files rates for review		DOI will review all rates for the QHP recommendation in accordance with current rate review requirements. The checklist may be found at the DOI Website - http://insurance.illinois.gov/Main/industry.asp	
3.2	<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)	Insurance carrier should submit a statement to DOI that addresses these requirements	
3.3	<input type="checkbox"/> Prominently posts the rate increase justification on issuer website prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR §156.210(c)	Insurance carrier should submit a statement to DOI that addresses these requirements	
<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)	Any rate for an individual policy will be reviewed to verify the rate will not change for the entire benefit year.	
4.2	<input type="checkbox"/> Rates must be the same for products inside and outside Exchange.	45 CFR §156.255(b)		
<input type="checkbox"/> V	Allowable Rating Variations	42 U.S.C. 300gg §2701;		



6 | Illinois QIP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
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.	45 CFR §156.255 42 U.S.C. 300gg §2701; 45 CFR §156.255	Verify which applicable provisions have been met by marking the appropriate box.	
VI	Marketing			
6.1	<input type="checkbox"/> Complies with all Illinois marketing laws & regulations.	45 CFR §156.225(a)	QHP Applicants must adhere to 215 ILCS 5/149 and 5/364 of the insurance code to ensure marketing activities are fair and accurate. Applicants must provide a statement for adherence.	
6.2	<input type="checkbox"/> Marketing practices do not discourage the enrollment of individuals with significant health needs.	45 CFR §156.225(b)		
VII	Network Adequacy Requirements			
7.1	<input type="checkbox"/> Complies with Illinois network requirements listed below.	45 CFR §155.1050; 45 CFR §156.230	Review the network adequacy requirements in accordance the checklist found at the DOI	



7 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
7.2	<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)	Website- http://insurance.illinois.gov/Main/industry.asp	
7.3	<input type="checkbox"/> Has a network with sufficient geographic distribution of providers for each plan.	45 CFR §156.230(a)(2)	A geographic map of the area proposed to be served by the carrier by county and zip code, including marked locations of preferred providers if applicable.	
7.4	<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		
7.5	<input type="checkbox"/> Makes its provider directory available: <input type="checkbox"/> For publication online in accordance with guidance 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.	45 CFR §156.230(b)	QHP applicants must provide a ratio of providers to beneficiaries, greatest travel distance, inadequate networks, policies for closing providers and opening new providers and referral procedures.	
7.6	<input type="checkbox"/> The service area of a QHP must be at a minimum an entire county, or group of counties, unless DOI			



8 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
VIII	<p>determines that serving a smaller geographic area in necessary, nondiscriminatory, in the best interest of the qualified individuals and employers.</p> <p>Enrollment Periods</p>		<p>QHP Applicant will need to provide a reference for review of these enrollment requirements.</p>	
8.1	<p><input type="checkbox"/> Provides an initial open enrollment period October 1, 2013 to March 31, 2014.</p>	<p>45 CFR §155.410(b)</p>		
8.2	<p><input type="checkbox"/> Provides an annual open enrollment period October 15 to December 7.</p>	<p>45 CFR §155.410(e)</p>		
8.3	<p><input type="checkbox"/> Provides notice prior to the annual open enrollment period.</p>	<p>45 CFR §155.410(d)</p>		
IX	<p>Termination of Coverage of Qualified Individuals</p>	<p>45 CFR §155.430(b) 45 CFR § 156.270</p>	<p>Termination provisions need to be referenced for review.</p>	
9.1	<p><input type="checkbox"/> Terminates coverage only if:</p> <ul style="list-style-type: none"> <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 switches coverage: <ul style="list-style-type: none"> <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: <ul style="list-style-type: none"> <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 	<p>45 CFR §155.430(b) 45 CFR § 156.270</p>		



9 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
	<p>payment;</p> <p><input type="checkbox"/> Provides the enrollee with notice of such payment delinquency; and</p> <p><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.</p>			
X	Accreditation Standards	45 CFR §1045; 45 CFR § 156.275		
<input type="checkbox"/>	10.1	45 CFR § 156.275(a)(1)	The accreditation template must be completed and sent in SERFF. There are templates for URAC and NCQA. See guidance if assistance is needed for templates.	
	10.2	45 CFR §156.275 (a)(2)	QHP applicant will need to show compliance with this requirement.	
XI	Quality Assurance Program	45 CFR §156.200(b)(5) 42 U.S.C §13031		
11.1	<input type="checkbox"/> Verify accreditation for deemed status.		QHP applicants will submit plan for review and	



10 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
	<p><input type="checkbox"/> Submit a Quality Plan that includes ongoing, written, internal quality assessment of the program, guidelines for monitoring and evaluating the quality and appropriateness of care and services provided to enrollees, including accessibility to health care providers, appropriateness of utilization, concerns identified by the plans' medical or administrative staff and enrollees.</p> <p><u>Improvement strategy</u></p> <ul style="list-style-type: none"> • Corrective action plans to correct quality problems, and follow-up measures to evaluate the effectiveness of the action plan 		<p>compliance. If Plan is accredited by URAC, NCQA or JCAHO, the quality plan will be deemed acceptable. The plan must provide proof of accreditation.</p>	
XII	Segregation of Funds			
12.1	<p><input type="checkbox"/> Does not use federal funds for abortion.</p>	45 CFR §156.280	<p>QHP applicant will submit statement of compliance. This will be monitored by market conduct and financial exams.</p>	



11 | Illinois QHP Application Checklist

State of Illinois

ACA QHP Certification of Compliance

Company: _____ Company FEIN: _____

Company Filing Number: _____

I, _____, am a duly authorized officer of _____ (Company Name), and hereby certify that I am knowledgeable concerning requirements necessary to comply with federal PPACA and associated health care reform legislation, and that the above completed Application Checklist, policy forms contained herein, along with associated documents and any reporting requirements, conform with the requirements of the Application Checklist and relevant code citations (statutes/regulations) contained therein.

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

The following reporting requirements will be completed and reported as is required under 45 CFR §156.220. This certification signifies that _____ (Company Name) _____, will adhere to these reporting measures as outlined below:

- Makes available to DOI in a quarterly report through SERFF in an accurate and timely manner, and in plain language:
- Claims payment policies and practices;
- Periodic financial disclosures;
- Data on enrollment;
- Data on disenrollment;
- Data on the number of claims that are denied;
- Data on rating practices;
- Information on cost-sharing and payments for out-of-network coverage;
- Information on enrollee rights under Title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).



12 | Illinois QHP Application Checklist

- 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.
- Makes available such information through:
- Internet website; and
 - An 800 phone number for individuals without access to the Internet.

Signature of Corporate Officer: _____

Name of Corporate Officer (typed or printed): _____

Title: _____ **Direct Telephone Number:** _____

Date: _____

Original