

Illinois Department of Insurance



PAT QUINN
Governor

ANDREW BORON
Director

TO: ALL INSURERS

FROM: ANDREW BORON, DIRECTOR OF INSURANCE *AEB*

DATE: May 6, 2014

RE: COMPANY BULLETIN CB 2014 – 05
ILLINOIS QUALIFIED HEALTH PLANS 2015

Section I: Purpose and Scope

The purpose of this Bulletin is to provide instructions to Issuers seeking to have Illinois Qualified Health Plans recertified or certified for the 2015 Plan Year.

The following references are used in this Bulletin:

Affordable Care Act (ACA) means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

CCIIO means the Federal Center for Consumer Information and Insurance Oversight.

Department means the Illinois Department of Insurance.

Exchange means Get Covered Illinois or the Illinois Health Insurance Marketplace, an entity that meets the applicable standards of the Affordable Care Act and makes QHPs available to qualified individuals and qualified employers. See Marketplace.

HHS means the Federal Department of Health and Human Services

Issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in Illinois and which is subject to Illinois law which regulates

insurance.

Marketplace means Get Covered Illinois <http://getcoveredillinois.gov/> or the Illinois Health Insurance Marketplace, an entity that meets the applicable standards of the Affordable Care Act and makes QHPs available to qualified individuals and qualified employers. See Exchange.

Qualified Health Plan or QHP means a health plan that has in effect a certification that meets the standards established by CMS pursuant to section 1311(c) of the Affordable Care Act issued or recognized by the Illinois Health Benefits Exchange pursuant to the process established by CMS pursuant to sections 1311(d) and 1311(e) of the Affordable Care Act.

SHOP means a Small Business Health Options Program operated by the Illinois Health Benefits Exchange through which a qualified employer can provide its employees and their dependents with access to one or more qualified health plans.

Section II: Plan Year 2015 Timeline

Date	Requirement
March 3, 2014	The Department distributes QHP recertification notices.
March 21, 2014	Notice of Withdrawal by QHPs from the Illinois Health Insurance Marketplace due (if applicable).
April 17, 2014	CCIO released approved templates to Issuers.
May 27, 2014	SERFF opens to accept QHP applications.
June 10, 2014	QHP applications due to the Department (submissions must be completed through SERFF). <u>Off Marketplace plans subject to the same risk pool should be filed at the same time as the QHP Plan.</u>
June 11 to August 7, 2014	The Department reviews applications.
August 8, 2014	The Department forwards recommendations to HHS.

Section III: Background

In accordance with the options available under the Affordable Care Act (ACA), in November of 2012, the State of Illinois notified the U.S. Department of Health and Human Services that it intended to participate with the federal government in the creation of a Partnership Exchange. The ACA requires all plans offered in an exchange to be certified as a Qualified Health Plan (QHP). The Illinois Department of Insurance reviewed applications submitted by Issuers for QHPs for plan year 2014, and submitted

recommendations regarding certification to CCIO. Thereafter, CCIO reviewed and certified the QHPs, and the certified QHPs were included on Illinois' federally-run "Health Insurance Marketplace" website for the 2014 plan year.

All health plans offered in the Illinois Health Insurance Marketplace in any subsequent year must be recertified annually as a QHP. The recertification requirement also applies to Stand-Alone Dental Plans that are offered on the Illinois Health Insurance Marketplace. At a minimum, the review for recertification must include a review of the general certification criteria as outlined in 45 CFR §155.1000(c). The recertification review will also include a review of the QHP's performance over the last plan year. Issues that emerge through issuer audits, monitoring, consumer complaints, and/or concerns raised by states or consumers during the 2014 coverage year will factor into recertification decisions. In addition, all new health plans and Stand-Alone Dental Plans that Issuers intend to offer in the Marketplace must similarly be certified as a QHP.

The same review criteria apply to applications for QHP recertification and QHP certification except as noted, including that factors related to 2014 performance apply only to applications for recertification of previously certified QHPs.

Section IV: Illinois Qualified Health Plan Application Guidelines

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

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

To apply to be recertified/certified as a QHP, Issuers must submit all required documentation listed in the Application Checklist, including rate and form filings, through the System for Electronic Rate and Form Filing (SERFF) beginning on Tuesday, May 27, 2014, and all such required documentation must be submitted no later than Tuesday, June 10, 2014, at 11:59 p.m. Issuers that opt not to renew participation of any QHPs offered in the Marketplace should have already notified the Department as required by Company Bulletin CB 2014-02. The Issuer must follow all applicable laws and regulations and contractual requirements in terminating the respective QHP from the Marketplace, including notification to enrollees.

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

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 state.

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 2015, the Department, with the assistance of the Illinois Department of Public Health (DPH), will review QHP applications and recommend applicants that meet the application standards to CCIIO for QHP recertification/certification.

All health plans offered in the Illinois Health Insurance Marketplace need to be recertified/certified as a Qualified Health Plan. This requirement also applies to Stand-Alone Dental Plans that are offered through Illinois Health Insurance Marketplace. At a minimum, the review for recertification/certification must include a review of the general certification criteria as outlined in the Code of Federal Regulations, §155.1000(c), including but not limited to the following:

- Compliance with issuer licensure;
- Solvency requirements;
- Accreditation data;
- Network adequacy;
- Plan-level rate and benefit data;
- Consideration of changes to service areas;
- Changes in ownership, mergers, or acquisitions.

In addition, the review of any existing QHP for which an Issuer seeks recertification will also include a review of the Issuer's performance over the last plan year. Issues that emerge through issuer audits, monitoring, consumer complaints, and/or concerns raised by states or consumers during the 2014 coverage year will be factored into recertification decisions.

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

1. Be submitted to the Department through SERFF for review by 11:59 p.m CDT on June 10, 2014;
2. Meet all minimum federal and state requirements;
3. Be recommended by the Department to CCIIO; and

4. Be certified by CCIO, which includes having a signed Issuer agreement.

General Guidance

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

In order for the QHP application to be reviewed, all checklists, templates and supporting documentation must be submitted in a SERFF QHP binder. All appropriate rate and form filings will need to be properly associated to the QHP application in SERFF or the QHP binder will be returned. Issuers will need to submit HIOS approved templates which may be downloaded from SERFF <http://www.serff.com/hix.htm>. The approved templates are currently scheduled to be released by CMS on April 15, 2014. **Issuers may review, complete and validate the templates in advance of the May 27, 2014 SERFF upload date. Off Marketplace plans subject to the same risk pool should be filed at the same time as the QHP Plan.**

All form filings must be submitted in the format of a complete insurance policy. No matrix insert page filings or riders will be accepted. Each plan being submitted to be sold on the Illinois Health Insurance Marketplace must 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 must be submitted with the application. As set out in Company Bulletin CB 2013-04, each QHP plan submission in SERFF must be accompanied by a fee of \$3,000 and any QHP plan submission which is considered a renewal of an existing certified plan on the Marketplace must be accompanied by a fee of \$1,500.

Each form filing submitted for recertification should provide a red-lined version setting out the variations in plan benefit design from the plans submitted for 2014. The red-lined version will allow the Department a more precise and quicker review of the variations in plan levels. Both the red-lined version and final form policy must be submitted in the Form Schedule tab in SERFF.

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

Terms of Engagement

In order for its plans to be recommended for recertification/certification as QHPs,

Issuers are required to offer plans in, at least, the silver and gold coverage level as defined by 2707(c) of ACA. The Department will review the plans to determine if there are meaningful differences between plan offerings. The criteria below will be used to determine whether a meaningful difference exists between plan offerings within the same metal level.

Examples of meaningful plan design differences include, but are not limited to, the following:

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

Catastrophic plans may be sold only 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 and has lower premiums than other plans with a similar provider network;
2. Protection against high out-of-pocket costs;
3. Coverage for three primary care visits per year before reaching the deductible;
4. Recommended preventative services without cost-sharing; and
5. No coverage of essential health benefits until the enrolled individual reaches the annual limitation in cost-sharing (45 CFR 156.155).

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

Qualified Health Plan Requirements

The ACA and relevant HHS regulations and guidance provide the regulatory framework for QHP recertification/certification application requirements. Issuers are required to submit issuer-completed application templates, including benefit and service area data and rating tables, for review by the Department. Issuers must also

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

Administrative Data: Issuers 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 must be validated and finalized with buttons in the upper left corner of the Excel document before it is uploaded to SERFF.

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

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

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

Benefit Design Standards and Essential Health Benefits: Issuers must offer coverage that is substantially equal to the coverage offered by the Essential Health Benefits (EHB) benchmark plan (45 CFR 156.115) and offer plans at metal levels specified by statute. (45 CFR 156.135). Issuers must download the Plans & Benefits Template from SERFF, complete it and upload it to SERFF. The Department

Recertification/Certification Checklist must be reviewed and completed for each Individual, SHOP, Catastrophic and dental plan submitted with the application.

The QHP Issuer must offer three silver plan variations for each silver QHP it submits for recertification/certification. The three variations must comply with the requirements of 45 CFR 156.420(a). Also, for each of its health plans at any metal level of coverage, the Issuer must offer one zero cost sharing plan variation and one limited cost sharing plan variation, and each must comply with the requirements of 45 CFR 156.420(b). Silver plan variations must have a reduced annual limitation on cost-sharing, cost-sharing requirements and Actuarial Values (AVs) that meet the required levels within a *de minimis* range. Covered services, networks, non-EHB cost-sharing and premiums cannot change. Additionally, Issuers must make available the amount of enrollee cost-sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual through an Internet website and other means for individuals without access to the Internet. (45 CFR 156.220(d)).

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

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

The Department 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 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, the Department 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; the individual cost sharing limit is \$6,600 and family coverage is \$13,200 or as may be adjusted for 2015.
4. That cost-sharing is not discriminatory and that prior authorization of services or any limitation on coverage is not imposed on coverage of emergency

department services out of network that is more restrictive than the in network requirements. (45 CFR 156.130).

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

Non-Discrimination: An Issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions. (45 CFR 156.125). The Department will evaluate whether benefit substitutions are non-discriminatory through actuarial review. The Department's actuaries also 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 need to download the Rates Template from SERFF, 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 must be validated and finalized with buttons in the upper left corner of the Excel document before it is uploaded to SERFF.

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

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

CMS STANDARD AGE CURVE					
AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865

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

The 3:1 age rating limitation applies only to adults age 21 and older. Rating for ages 0-20 must be actuarially justified based on a standard population, and will be reviewed and approved by the Department's actuaries. Age bands must be determined based on the enrollee's age on the first day of the plan year. For individuals who are added to the plan or coverage on a date other than the date of policy issuance or renewal, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage.

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

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

Area 1: Cook County

Area 2: Lake, and McHenry Counties

Area 3: DuPage, and Kane Counties

Area 4: Grundy, Kankakee, Kendall, and Will Counties

Area 5: Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, and Winnebago Counties

Area 6: Bureau, Hancock, Henderson, Henry, Mercer, Rock Island, Warren, and Whiteside Counties

Area 7: Fulton, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, and Woodford Counties

Area 8: Dewitt, Livingston, and Mclean Counties

Area 9: Champaign, Clark, Coles, Cumberland, Douglas, Edgar, Ford, Iroquois, Piatt, and Vermilion Counties

Area 10: Adams, Brown, Cass, Christian, Logan, Macon, Mason, Menard, Morgan, Moultrie, Pike, Sangamon, Schuyler, Scott, and Shelby Counties

Area 11: Bond, Calhoun, Clinton, Greene, Jersey, Macoupin, Montgomery, Randolph, and Washington Counties

Area 12: Madison, Monroe, and St. Clair Counties

Area 13: Alexander, Clay, Crawford, Edwards, Effingham,, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, and Williamson Counties

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

Family Premiums: Family premiums will be determined by adding up the premiums of each family member to ensure that the age and tobacco use rating will only apply to that portion of the premium attributed to each family member. Issuers must not rate more than three children under the age of 21 when developing family premiums. Rating factors are multiplicative for age, tobacco use and geography. Therefore, for example, the oldest adult who used tobacco in rating area I could be charged 4.5 times more (3×1.5) than the youngest adult who did not use tobacco in rating area I. 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).

Business Rules: Issuers also need to download the Business Rules Template from SERFF, 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 the Department's actuaries and insurance regulators, the Department 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. The Department will review initial rate filings and rate increase filings for QHPs to see that sound assumptions and methodologies were used in developing QHP premium rates and will also review rates for compliance with relevant ACA requirements.

Rate Review: Issuers 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. Issuers will need to validate and finalize the template with buttons in the upper left corner of the Excel document before it is uploaded to SERFF. Issuers will also need to complete the Rate Review Checklist.

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

Issuers must also 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. Issuers may not employ marketing practices that discourage enrollment of individuals with significant health needs.

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

Network Adequacy: Issuers are required to include a sufficient number and type of providers, including providers that treat substance use and mental health conditions, to ensure that all services are available without unreasonable delay (45 CFR 156.230). Issuers are required 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. Issuers need to validate and finalize the template before it is uploaded to SERFF.

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

below:

- Service Areas
 - If an Issuer is not covering an entire rating area, the Issuer must provide which subsets of a rating area are included in the service area or the corresponding product and network.
 - ✓ Rating areas the network covers
 - ✓ Definition of Service Area
 - ✓ List of counties in the service area, by product and plan
- Provider Network
 - This list must be provided for each product and/or network that an Issuer is offering for ACA compliant products. In addition to the list of provider names the following information will be required:
 - ✓ Addresses (physical addresses as opposed to P.O. boxes)
 - ✓ Types and specialties
 - ✓ NPI number(s)
 - ✓ Tax Identification Number (TIN)
 - ✓ Indicator if accepting new patients
 - ✓ Network tier (if there are multiple tiers within a product)
 - Internet website with up to date provider directory which fully denotes which network applies to each plan sold on the Marketplace or a distinct URL for each plan sold
 - Demonstration of 24/7 accessibility
 - ✓ Hours of operation for providers/after-hours access
 - ✓ Urgent care/emergency care hours and listing of providers
- Geographic map with providers marked
- Number of anticipated beneficiaries by county and/or number of actual beneficiaries by 5 digit zip

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

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

The Illinois Department of Public Health (DPH) in conjunction with DOI will review the network adequacy components of HMO QHP recertification/certification applications and provide recommendations to the Department regarding whether HMO applicants meet these standards.

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

<http://cciio.cms.gov/programs/exchanges/qhp.html>. Issuers must:

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

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

- List of Provider names
 - Addresses (physical rather than PO boxes)
 - Categories
 - Identifier if provider is included or not on the list of providers supplied by CCIIO
 - NPI
 - TIN
- Geographic map with providers marked

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

Statewide coverage is not a prerequisite to be recommended for recertification/certification, but a QHP must provide coverage to an entire rating area as defined in this guidance or obtain an exception from the Department. The Issuer must provide service area maps to show compliance.

The service area of a QHP must be, at a minimum, an entire county or group of counties, unless the Department determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and 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. An exception request form must be completed and submitted

the Department for review. The form is attached to these Guidelines. The Issuer must download a Service Area Template from SERFF, complete it and upload it to SERFF. Data points on the Service Area Template include service area ID, service area name, coverage area and zip codes. The Issuer needs to validate and finalize the template with buttons in the upper left corner of the Excel document before it is uploaded to SERFF.

Enrollee Termination: 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).

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 need to download an Accreditation Template in SERFF, complete it and upload it to SERFF. Issuers must select the NCQA, URAC or the AAAHC Template. Data points on the Accreditation Template include Market Types, Accreditation Status, Expiration Date(s) and other specified data. The template must be validated and finalized with buttons in the upper left corner of the Excel document before it is uploaded to SERFF. The Department will be electronically advised of any changes in Issuer accreditation status through SERFF, which will track Issuer accreditation status. Accreditation standards do not apply to stand-alone dental plans.

For the year 2015, the Issuer must have accreditation in any line of business, these being commercial, Medicaid or Marketplace lines of business. DOI will be electronically advised of any changes in Issuer accreditation status through SERFF, which will track Issuer accreditation status. Accreditation standards do not apply to Stand-Alone Dental Plans.

Quality Reporting: All 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 Marketplace 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 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: The Department and DPH 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, Issuers must not employ benefit designs that discourage the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

Segregation of Abortion Funds: Federal funds may not be used for abortion. (45 CFR 156.280). Compliance will be monitored through market conduct reviews, including financial exam auditors verifying that federal premium tax credits and other federal funds are segregated. Additionally, 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 QHPs 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 the Department and provide any necessary documentation to support the limited availability. Issuers must request this limit by noting the issue in the cover letter of the QHP application. Issuers 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 Public Health Service Act section 2702(c) (2) and (45 CFR 147.104).

Reporting: Issuers must submit the following information in a quarterly report to the

Department through SERFF and to CCIIO through HIOS:

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

Corrective Action Plan

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

Plan Decertification

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

Issuer Oversight

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



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 the requirements necessary to comply with federal ACA and associated health care reform legislation, and that the attached completed Recertification/Certification Checklist, the policy forms contained herein and the associated documents and any other reporting requirements conform with the requirements of the Recertification 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 Recertification 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).
- 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: _____



1 | Illinois QHP Submission 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:	

This submission checklist should be included with your QHP Application Checklist to verify you have all required documentation attached to your filing before it is uploaded to SERFF in your QHP Application Binder. The templates may be downloaded at: <http://www.serff.com/hix.htm>

Overview of QHP Templates

Template Name	Template Description	Version	Download
Administrative Template (Updated 4/17/2014)	Collects general company and contact information.	4.0	Administrative Data Template
ECP Template (Updated 4/17/2014)	Collects identifying information for Essential Community Providers.	4.0	Essential Community Providers Template
Plan/Benefit Template (Updated 4/17/2014)	Collects plan and benefit data for medical and dental.	4.0	Plans and Benefits Template Instructions Plans Benefits Template
Plans Benefits Add-In (Updated 4/17/2014)	Collects plan and benefit data, including changes for dental.	4.0	Plans Benefits Add-In
	<p>The updated file corrected discrepancies some issuers encountered between the Benefits Template and the Stand Alone AV Calculator. Also enables issuers to change the Plan Marketing Name in the Benefits Template.</p>		



2 | Illinois QHP Submission Checklist

Prescription Drug Template (Updated 4/17/2014)	Collects formulary data for plans. The updated file corrected a defect for some issuers who need to enter "0" for copays and co-insurance.	4.0	Prescription Drug Template
Network Template (Updated 4/17/2014)	Information identifying a provider's network.	4.0	Network Template
Service Area Template (Updated 4/17/2014)	Information identifying a plan's geographic service area.	4.0	Service Area Template
Rate Data Template (Updated 4/17/2014)	Rating Tables The updated file corrected defect for some issuers who experience problem due to rounding errors for non-tobacco rates.	4.0	Rates Template
Business Rule Template (Updated 4/17/2014)	Supporting business rules	4.0	Business Rules Template
Accreditation Templates (Updated 4/17/2014)	Collects information related to an issuer's NCQA and/or URAC accreditation status.	4.0 4.0	Issuers NCQA Template Issuers URAC Template Issuers AAAHC Template
Unified Rate Review Template (Updated 4/17/2014)	This is a federal data collection template designated to capture information at the market level, consistent with the requirement to set premium rates using a single risk pool.	2.0.2 2.0.2	Part I Unified RR Instructions Unified Rate Review Template

Attestations

The attestations document will need to be downloaded from HIOS, completed and electronically signed.



Plans and Benefits



3 | Illinois QHP Submission Checklist

Please verify the Actuarial Memorandum and template contains an AV Calculator which may be used for cost sharing variances and EHB substitutions.

Department of Insurance Checklists

The DOI checklists may be downloaded from the DOI website at:
http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/IS3_Checklists.asp

- Individual Accident and Health Checklist
- Small Group Accident and Health Checklist
- HMO Small Group Checklist
- HMO Individual Checklist
- Catastrophic Plan Checklist
- Rate Review Checklist-Accident & Health/HMO
 - Verify all documents contained in this checklist are submitted with each rate filing
- Network Adequacy Checklist
 - Verify all spreadsheets and supporting documentation is submitted

Filing Fees

- All appropriate filing fees will need to be paid in SERFF



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 <input type="checkbox"/> Is in good standing		Mark all applicable boxes.	
1.3			DOI will review financial documents and regulated entities database for	



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		compliance. 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.	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><input type="checkbox"/> Cost-sharing shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage.</p> <p>For the plan year beginning in 2015, 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</p>			
2.3	<p><input type="checkbox"/> Offers through the Exchange:</p> <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 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.	
2.4	<p><input type="checkbox"/> If offers a Catastrophic Plan, it is only offered to</p>	42 USC §18022(e)	Please review Catastrophic	



4 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
	<p>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. <input type="checkbox"/> If offered, Catastrophic Plans are offered only in the individual exchange and not in the SHOP. <input type="checkbox"/> If offered, Catastrophic Plan complies with specific requirements for benefits. 		<p>Plan checklist for compliance. The checklist may be found at the DOI Website - http://insurance.illinois.gov/Main/industry.asp</p>	
2.5	<ul style="list-style-type: none"> <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. 	45 CFR §156.200(c)	Please use the checklist of the plan type you are filing.	
2.6	<ul style="list-style-type: none"> <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	<ul style="list-style-type: none"> <input type="checkbox"/> Files rates for review 		DOI will review all rates for the QHP recommendation in	



5 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
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)	<p>accordance with current rate review requirements. The checklist may be found at the DOI Website - http://insurance.illinois.gov/Main/industry.asp</p> <p>Insurance carrier should submit a statement to DOI that addresses these requirements</p>	
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)	<p>Insurance carrier should submit a statement to DOI that addresses these requirements</p>	
<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)	<p>Any rate for an individual policy will be reviewed to verify the rate will not change for the entire benefit year.</p>	
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			
5.1	<input type="checkbox"/> Varies rates only based on: <ul style="list-style-type: none"> <input type="checkbox"/> Geographic area <input type="checkbox"/> Age <input type="checkbox"/> Tobacco use <input type="checkbox"/> Family composition: 	42 U.S.C. 300gg §2701; 45 CFR §156.255	<p>Verify which applicable provisions have been met by marking the appropriate box.</p>	



6 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
<input type="checkbox"/>	<p>Individual; <input type="checkbox"/> Two-adult families; <input type="checkbox"/> One-adult family with child(ren); <input type="checkbox"/> All other families.</p>			
<input type="checkbox"/>	<p>Marketing <input type="checkbox"/> Complies with all Illinois marketing laws & regulations.</p>	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.	
	<p>6.2 <input type="checkbox"/> Marketing practices do not discourage the enrollment of individuals with significant health needs.</p>	45 CFR §156.225(b)		
<input type="checkbox"/>	<p>Network Adequacy Requirements</p>	45 CFR §155.1050; 45 CFR §156.230		
	<p>7.1 <input type="checkbox"/> Complies with Illinois network requirements listed below.</p>		Review the network adequacy requirements in accordance the checklist found at the DOI Website- http://insurance.illinois.gov/Main/industry.asp	
	<p>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</p>	45 CFR §156.230(a)(2)		



7 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
	<p>delay.</p> <p><input type="checkbox"/> Network must include providers that specialize in mental health and substance abuse services.</p>			
7.3	<p><input type="checkbox"/> Has a network with sufficient geographic distribution of providers for each plan.</p>	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	<p><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.</p>	45 CFR §156.230(a)(1) 45 CFR §156.235		
7.5	<p><input type="checkbox"/> Makes its provider directory available:</p> <p><input type="checkbox"/> For publication online in accordance with guidance and</p> <p><input type="checkbox"/> To potential enrollees in hard copy upon request.</p> <p><input type="checkbox"/> Provider directory identifies providers that are not accepting new patients.</p>	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	<p><input type="checkbox"/> 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.</p>			
VIII	<p>Enrollment Periods</p>		QHP Applicant will need to provide a reference for review of these enrollment	



8 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
8.1	<input type="checkbox"/> Provides an initial open enrollment period	45 CFR §155.410(b)	requirements.	
8.2	<input type="checkbox"/> Provides an annual open enrollment period	45 CFR §155.410(e)		
8.3	<input type="checkbox"/> Provides notice prior to the annual open enrollment period.	45 CFR §155.410(d)		
IX	Termination of Coverage of Qualified Individuals	45 CFR §155.430(b) 45 CFR § 156.270	Termination provisions need to be referenced for review.	
9.1	<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 switches 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	45 CFR §155.430(b) 45 CFR § 156.270		



9 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
	receiving advance payments of the premium tax credit and has previously paid at least one month's premium.			
X	Accreditation Standards	45 CFR §1045; 45 CFR § 156.275		
<input type="checkbox"/>	10.1 <input type="checkbox"/> Accredited on the basis of local performance by an accrediting entity recognized by HHS and within required timeline established by HHS.	45 CFR § 156.275(a)(1)	The accreditation template must be completed and sent in SERFF	
10.2	<input type="checkbox"/> Authorizes the accrediting entity to release a copy of its most recent accreditation survey and survey-related information.	45 CFR §156.275 (a)(2)	QHP applicant will need to show compliance with this requirement.	
XI	Quality Assurance Program	45 CFR §156.200(b)(5) 42 U.S.C §13031		
11.1	<input type="checkbox"/> Verify accreditation for deemed status. <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,		QHP applicants will submit plan for review and compliance. The plan must provide proof of accreditation.	



10 | Illinois QHP Application Checklist

	Requirements	Federal Source	DESCRIPTION OF REVIEW REQUIREMENTS	Location of Standard in Filing
	<p>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 			
XII	Segregation of Funds			
12.1	<input type="checkbox"/> Does not use federal funds for abortion.	45 CFR §156.280	QHP applicant will submit statement of compliance. This will be monitored by market conduct and financial exams.	