ACAP
Association for Community Affiliated Plans

Qualified Health Plan Application

Spring 2015

Introduction

Health plans intending to serve in health insurance Marketplaces established by the Patient Protection and Affordable Care Act (ACA) as Qualified Health Plans (QHP) are required to complete an application in order to operate in the Marketplaces. The application submission process is different for each State-Based Marketplace (SBM) and can also vary by state for plans participating in the Federally-Facilitated Marketplace (FFM).

The FFM, and many SBMs, use a core set of templates released annually by Center for Medicaid and Medicare Services (CMS). Those submitting the application are urged to review the actual FFM template instructions; this guide is intended to serve as a high-level overview of both the submission process and the FFM templates.

This brief is part of a series of briefs that ACAP is developing outlining issuer responsibilities. Other guides in this series include:

- Reporting Requirements (released October 2014)
- Taxes and Fees Requirements (released October 2014)
- Special Enrollment Periods (April 2015)
- Standard Transactions (to be released)
- Member- and HHS-required Notifications (to be released)

These guides focus on the individual market and do not include requirements specific to the small business health options program (SHOP). Furthermore, they do not include state-specific requirements, or requirements specific to the state-based Marketplaces (SBM). These briefs are intended to be comprehensive but may not include all requirements. ACAP will update this guide as changes are made and additional information about these and new responsibilities becomes available.

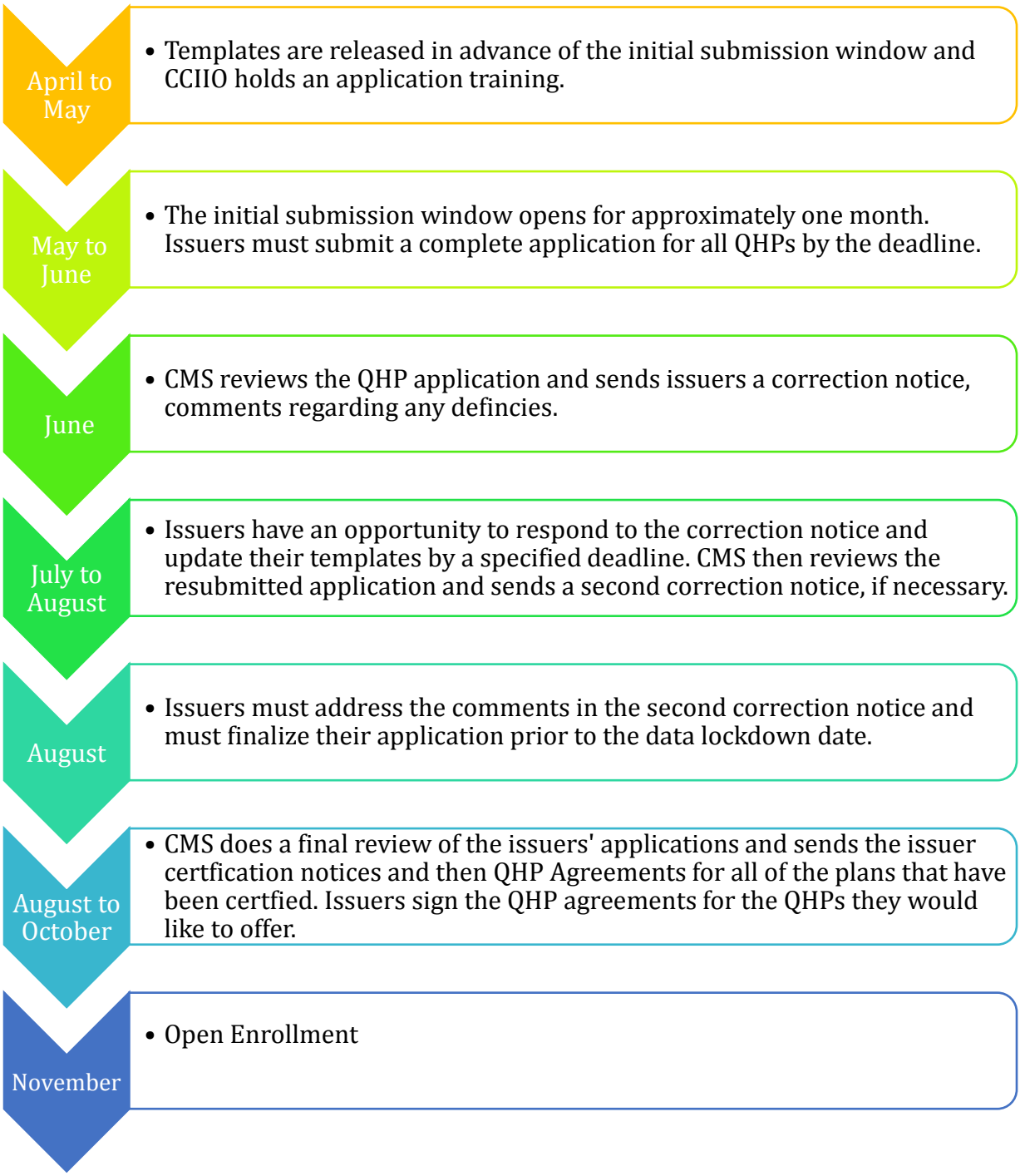
Contents

Using this brief

	Boxes with a lightbulb contain information and resources that will be helpful in completing a successful QHP application.
	Stop signs are cautionary notes where issuers may need to do additional research before taking action.
	Several of the templates use information created in one template to populate another template. The titles of these templates are noted with a puzzle piece.

Qualified Health Plan Application Timeline

The application timeline for FFM issuers, including issuers serving Partnership Marketplaces, is released annually in the Letter to Issuers. SBM QHP certification timelines vary by state. Generally, the FFM submission timeline for issuers participating in non-partnership states works as follows:[1]



[1] This timeline is based on the 2016 QHP Certification timeline, which is subject to change in future years.

QHP Application Preparation

Prior to beginning the QHP application, individuals completing the Marketplace application for their organizations should review all relevant regulations and guidance. All applications are expected to comply with these rules, which include:[2]

- ACA Exchange and Insurance Market Standards for 2015 and Beyond
- Health Insurance Market Rules; Rate Review
- Code of Federal Regulations, Title 45 –
    - Individual and Group Market Requirements: Parts 146, 147, and 148
    - Rate Disclosure and Review: Part 154
    - Essential Health Benefits: Part 156 Subpart B
    - Medical Loss Ratio: Part 158
- The Letter to Issuers* (released annually)
- Additional Regulations and Guidance as released by CMS
- Additional state-specific Regulations and Guidance

Other resources that may be helpful:

- **REGTAP:** collection of FAQs, sub-regulatory guidance, and training materials to help ensure Marketplace compliance.
- **CALT or "Collaborative Application Lifecycle Tool:"** social platform to assist with collaboration for organizations working with CMS.
- **CMSzONE:** social platform where CMS will post templates and technical specifications. Members of the community are also able to share and post information.
- **CMS's Web Site:** regulations, guidance, and FAQs are posted here.
- **Help Desk:** CMS_FEPS@CMS.HHS.GOV or 1-855-267-1515.
- **Account Managers:** point of contact for all non-technical related questions. All issuers with QHPs in the FFM and SBMs using HealthCare.gov's eligibility system are assigned an account manager.

Systems to Know

- **System for Electronic Rate and Form Filing (SERFF):** a system used by some states to collect QHP application data. Issuers should speak to their states about whether a submission in SERFF or another system is required. State Partnership Marketplace (SPM) states often require issuers to submit the application in SERFF.
- **Health Information Oversight System (HIOS):** the system used by CMS to gather QHP application data. CMS also uses HIOS to collect rate data for FFM and SBM plans.

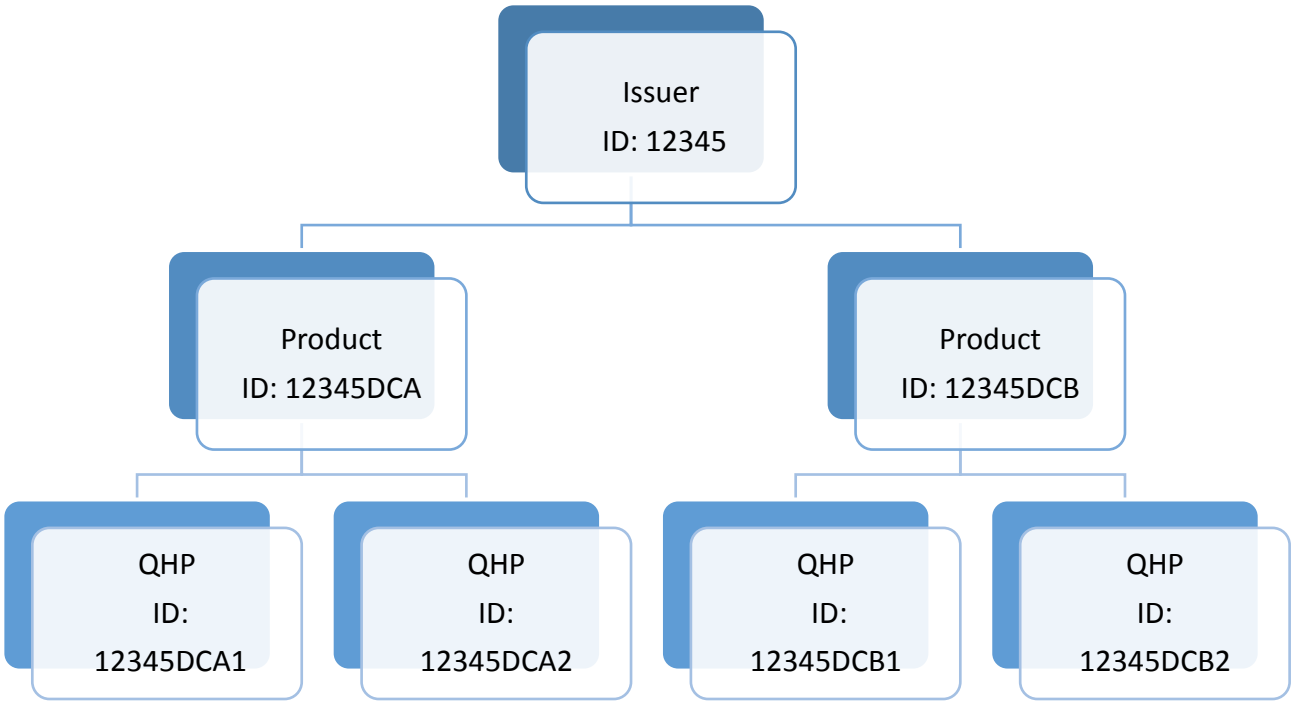
[2] This list was compiled by CMS and can be found in the "QHP Certification Toolkit: Key Resources for Issuers."

Defining Issuers, Products, and Qualified Health Plans

Issuers wanting to participate in the Marketplace are organized by issuer, by product, and by qualified health plan. Each of these levels is a given specific ID, IDs are unique at each level but they build on each other. An explanation of this hierarchy follows. The official definitions are contained in 45 CFR 144.103.

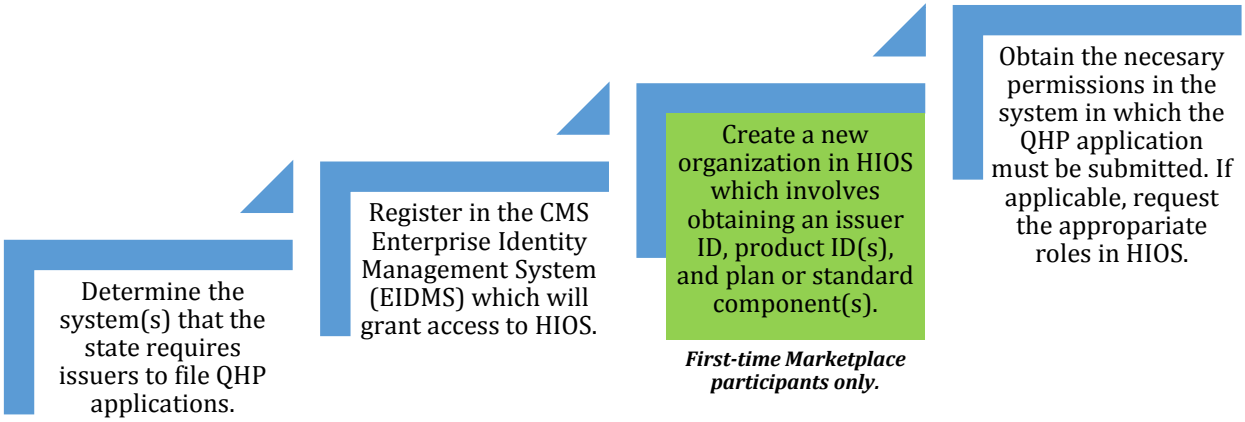
- ***Issuer:*** an organization that is licensed by the state to offer health insurance. Each issuer is required to obtain a five-digit Issuer ID from HIOS. Issuers can create products and plans.
- ***Product:*** the benefit package(s) offered by an issuer using a particular network type (e.g., HMO, PPO, or EPO) within a certain service area. A product consists of all of the plans offered within it.
- ***Plan:*** offered within a product. It is the pairing of benefits with a particular metal level, cost-sharing structure, provider network, and service area.

Below is an example of the hierarchy for an issuer participating in Washington, D.C.



Qualified Health Plan Application Preparation

Individuals must also complete some key steps before they are able to begin submitting the templates including:



For issuers participating for the first time in the Marketplace:

1. Determine the system(s) the state requires issuers to use to file QHP applications.

2. ***All issuers wanting to participate in the Marketplace for the first time—both SBM and FFM issuers—must obtain IDs for their organization through the Health Insurance Oversight System (HIOS).*** To do so, an individual within the organization must register in the CMS Enterprise Identity Management System (EIDMS) which will grant access to HIOS and allow them to create the necessary HIOS IDs.

> *Doing a submission in HIOS?* The system can be confusing. Read CMS's HIOS manual before beginning.

3. Once in HIOS, a new organization must be created which involves obtaining an issuer ID, product ID(s), and plan or standard component IDs.

4. For the issuer ID created in the previous step, the individual(s) working on the application should then request all appropriate roles. Roles must be requested for each of the HIOS modules in order to gain access. Examples of these roles include "Submitter" and "Approver." The HIOS role(s)/module(s) an individual should select varies on the requester's responsibility relative to the application/submission. For example, selecting roles includes requesting access to various modules, such as the "Issuer Module," then selecting a role within that module, such as submitter.

> *If the QHP application must be submitted into HIOS, which modules are required to submit the templates?*
>
> - QHP Issuer Module
> - QHP Benefits & Service Area Module
> - QHP Rating Module
> - HIOS Administrative Section
> - Unified Rate Review Module

HIOS is not just used for QHP application submissions. For example, the Rate and Benefit Information System, or "RBIS," module in HIOS is used to submit a quarterly RBIS report required of all issuers, participating in the SBMs and the FFM. See ACAP's guide on reporting requirements for more information about this submission.

For issuers that have participated in the Marketplace in the past:

1. Determine the system(s) the state requires issuers to use to file QHP applications.

2. Gain access to the applicable system and request the necessary roles to complete the submission.
    a. If the application must be submitted in HIOS, all individuals working on the application must register in EIDMS to obtain access to HIOS.
    b. Once in HIOS, the individual(s) working on the application should then request all of the appropriate roles for the necessary modules(s) associated with the issuer's ID. The HIOS role(s)/module(s) an individual should select varies on the requester's responsibility relative to the application/submission. For example, roles include requesting access to various modules, such as the "Issuer Module," then selecting a role within that module, such as Submitter.

Doing a submission in HIOS? The system can be confusing. Read CMS's HIOS manual before beginning.

HIOS is not just used for QHP application submissions. For example, the Rate and Benefit Information System, or "RBIS," module in HIOS is used to submit a quarterly RBIS report required of all issuers, participating in the SBMs and the FFM. See ACAP's guide on reporting requirements for more information about this submission.

QHP Application Overview

As indicated previously in this brief, issuers participating in SBMs should check with their states to determine which systems issuers need to use to file QHPs. Issuers participating in the FFM must submit their QHP applications using four distinct modules in HIOS. The chart below is a high-level overview of each of the HIOS modules and their associated templates and documentation. The templates are the forms an issuer must complete and the modules are a collection of these forms.

Looking for a complete FFM QHP application checklist?

CMS released a toolkit which includes a checklist with everything needed for a successful QHP submission.

In addition to the requirements listed below, issuers may be required to submit additional justifications and supporting documentation based on an issuer's unique circumstances, which differ for each template. Individuals submitting the application should read all of the QHP application instructions to ensure the application is submitted correctly.

HIOS QHP Issuer Module	HIOS QHP Benefits and Service Area Module	HIOS QHP Rating Module	Unified Rate Review Module	Other
• Administrative Template • Program Attestations • State Licensure Documentation • Good Standing Documentation • Accreditation Template (template differs based on accreditation body) • ECP Template	• Network ID Template • Network Adequacy Template • Service Area Template • Prescription Drug Template • Plans and Benefit Template	• Rates Template • Business Rules Template	• Unified Rate Review Template	• Crosswalk Template

It is important to know that many data elements in the templates are cross-referenced in other templates. There are two templates that require other templates to be completed before they can be finalized:

- Plan and Benefit Template
- Network Adequacy Template

The next section of this report contains a brief explanation of each of the modules listed in the chart above. This document is not official CMS guidance. See the QHP template instructions for detailed information on successfully completing each template.

HIOS QHP Issuer Module

Administrative Template

Purpose: Documenting company-level information and any holding company information.

Description: Issuers are required to complete the template which includes information such as Issuer ID, HIOS product IDs for proposed QHPs, and contact information for company contacts and customer service.

Looking for tips and tricks to avoid the most common errors on each of the templates?

Check out CMS's QHP Certification Toolkit.

Supporting Docs: Not applicable.

Program Attestations

Purpose: An attestation of an issuer's compliance with the FFM QHP standards.

Description: Issuers must respond yes or no to each of the attestations. The attestations occur directly in the HIOS QHP Issuer Module; there is no template to complete and upload. A full list of attestations can be in found in the attestation instructions. Issuers are also required to upload a compliance plan and an organization chart in this module.

Looking for a list of QHP requirements?

The list of attestations is a great review of QHP requirements.

Supporting Docs: If an issuer selects "no" for any of the attestations, a Statement of Detailed Attestation Responses must be completed.

State Licensure Documentation

Purpose: To prove an issuer is licensed to sell health insurance in the service areas and the applicable market(s) in which they are applying to become a QHP.

Description: Issuers must upload a copy of their State License, Certificate of Authority, Certificate of Compliance, or a form equivalent to one of these documents. The issuer also must respond to a series of questions related to state licensure. The documentation upload must occur and questions must be answered directly in the HIOS QHP Issuer Module; there is no template to complete and upload.

Supporting Docs: Not applicable.

Good Standing

Purpose: To provide evidence of the issuer's compliance with state solvency and regulatory requirements for the state(s) and market(s) in which the issuer is applying to be a QHP.

Description: Issuers must respond to questions related to the issuer's good standing. The good standing questions must be answered directly in the HIOS QHP Issuer Module; there is no template to complete and upload.

Supporting Docs: An issuer must upload supporting documentation if the issuer is not considered to be in good standing or is under a corrective action plan.

Accreditation

Purpose: To provide information about an issuer's accreditation status.

Description: Issuers are required to complete the template associated with their accreditor – NCQA, URAQ, or AAAHC. The URAC and NCQA templates are uploaded into the Accreditation section of the HIOS QHP Issuer module.[3] All issuers are also required to respond to questions about their accreditation in this section of the module.

Supporting Docs: The issuer must upload proof of accreditation (the accreditation certificate).

Essential Community Provider Documentation

Purpose: Issuers are required to meet certain requirements related to inclusion in networks of essential community providers (ECP), released annually in the Letter to Issuers. This template demonstrates an issuer's compliance with these requirements.

Where can you find a list of ECPs?

CMS releases a non-comprehensive list of ECPs annually.

Description: Issuers must list all of the ECPs in the issuer's network in the ECP Template, and complete ECP-related attestations.

Supporting Docs: The ECP Supplemental Response must be completed if an issuer does not meet the ECP requirements.

[3] The AAAHC template and supporting documentation cannot be submitted in the Issuer Module; this template must be emailed to Marketplace_Quality@cms.hhs.gov.

HIOS QHP Benefits and Service Area Module

Network ID Template

Purpose: This template generates a Network ID for each of an issuer's provider networks. The network ID(s) are used in other templates.

Requirements: Issuers must input the network(s) name(s),create a Network ID, and provide a link to the network(s) provider directory.

Supporting Docs: Not applicable.

Network Adequacy Template

Purpose: To collect information on all of the providers in an issuer's provider network.

Description: Issuers must list all physicians, facilities, and pharmacies for each of the issuer's provider networks. The Network IDs developed in the Network ID Template are used to link each provider with a network.

Supporting Docs: If upon review of the Network Adequacy Template CMS sends a correction notice describing a deficiency in the network, issuers can resubmit the Network Adequacy template, or submit a network justification explaining how the network would ensure access to enrollees.

Service Area Template

Purpose: To collect all of the geographic service areas an issuer intends to participate in as a QHP.

Description: Service areas are defined as a full county or group of counties where an issuer intends to provide coverage to enrollees. Service areas can be limited to partial counties (e.g., zip codes) but this approach is not recommended and will undergo increased scrutiny during the application review process. The template requires that an issuer select each county in the state(s) in which they intend to participate. The selected county or counties must then be given a Service Area ID. These IDs will be used in other templates in the application.

Supporting Docs: If an issuer would like to participate in partial counties in any of their service areas, a detailed supplemental response must be submitted. Specific requirements of the supplemental response are outlined by CCIIO. More information can be found in the Service Area Instructions.

Prescription Drug Template

Purpose: Report the formulary and the associated cost-sharing information.

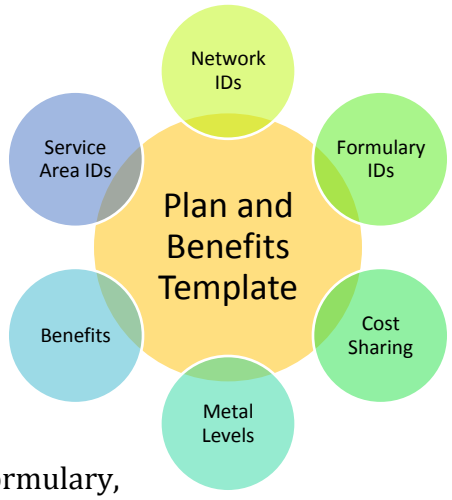
Description: This template requires issuers to input covered drugs using the RxNorm Concept Unique Identifiers (RxCUIs) for each formulary the issuer is intending to offer. The issuer must identify which drugs fall into which tier and the cost-sharing structure for each tier. The issuer must provide a URL that links to a searchable formulary for consumers. Each formulary is also given a Formulary ID which is used in other templates in the application.

What is an RxCUI?

An RxCUI is a unique ID given to all drugs. More about RxCUIs (including access to a full list) is in the Prescription Drug Template Instructions.

Supporting Docs: Several supporting and justification documents that may be required depending on an issuer's specific circumstances, including an Inadequate Category/Class Count justification, a Formulary Outlier Review response, a Formulary Clinical Appropriateness response, and a Formulary Treatment Protocol response.

Plan and Benefit Template



Purpose: To define the QHP by metal level, benefits covered, and cost-sharing structure. This template uses information provided in various other parts of the application to further define a QHP, including the service area, pharmacy benefit, and network.

Description: This template pulls together information from other templates. An issuer must input Plan IDs under each product and link plans to the appropriate network, formulary, and service area using the appropriate IDs.[4] The issuer must also describe covered benefits under the product(s), the plans' metal level, and the associated cost sharing.

Supporting Docs: If an issuer intends to use a unique plan design, meaning the plan does not fit into the Actuarial Value Calculator, then supporting documentation must be filed as part of the application. Also, when an issuer intends to make changes to the benchmark benefits, supporting documentation is required.

What is meant by actuarial value (AV)?

Cost-sharing under each metal level must meet the mandated AV. CCIIO releases an AV calculator annually that calculates the AV of a proposed cost-sharing structure.

[4] Review the QHP Application Preparation section for how to obtain these IDs and the Issuer, Product, Plan Structure section of this document for more information on plans.

HIOS QHP Rating Module

Rates Template

Purpose: To define the premium rate for each QHP.

Description: Issuers are required to submit the premium rate by age, tobacco use (if required by the state), and rating area for each QHP.

Supporting Docs: Not applicable.

Business Rules Template

Purpose: To calculate rates and determine whether individuals are eligible to apply for a plan.

Description: Issuers must answer a series of questions, such as "how are rates for contracts covering two or more enrollees calculated?" for each QHP. This template also requires issuers to select the types of relationships that are acceptable between the primary and the dependent(s). Examples of allowable relationships include: spouse, foster child, and adopted child. The way an issuer answers these questions governs the way in which rates and plans appear on HealthCare.gov.

Supporting Docs: Not applicable.

HIOS QHP Unified Rate Review Module

Unified Rate Review

Purpose: To provide additional information about an issuer's rate development and ensure an issuer's rates comply with all federal and state requirements.

Description: This template is most commonly completed by an actuary. It requires issuers to input information regarding the issuer's market experience, including information needed to review proposed rate increases. An explanation of the actuarial reasoning and justification for the submitted rates, or an Actuarial Memorandum, must also be submitted as part of the Module.

Supporting Docs: Issuers increasing rates are required to complete a rate increase justification.[5]

[5] Rate increases of more than 10 percent are reviewed by CMS in partnership with the state, if the state has an effective rate review program.

Other

Crosswalk Template

Purpose: To provide mapping from QHP(s) offered in the year prior to the proposed QHP(s). This template facilitates automatic re-enrollment.

Description: Issuers must import the previous year's QHPs from the Plans and Benefits Template and Service Area Template, select the level at which the crosswalk is to occur (e.g., Plan ID level), select the reason for the crosswalk, then input the associated 2016 plan IDs. Issuers must also submit evidence from the state that the issuer is authorized to submit the Crosswalk Template.

The Template and evidence of state approval is not submitted in HIOS. It must be emailed to QHP_Applications@cms.hhs.gov.

Supporting Docs: Not applicable.

QHP Issuer Agreement

Issuers are notified of CMS's final certification decisions in the fall and are required to sign QHP agreements for any plans they intend to sell on the Marketplace. This provides issuers one last opportunity to decide not to offer a QHP before being subject to the rules associated with withdrawing from a market.

Issuers are given two agreements, the QHP Privacy and Security Agreement and the Senior Officer Acknowledgement. Issuers are required to complete both agreements for all QHPs that the issuer intends to offer and return them the CMS within the required timeframe.

How can an issuer check an application?

CCIIO provides several data integrity and review tools to aide issuers in checking the templates for compliance. CCIIO requests that all issuers use the tools.

Issuers will also have the opportunity to check the QHPs during Plan Preview. QHPs will be displayed in a format similar to Plan Compare on HealthCare.gov. The Plan Preview User Guide is available on zONE.