Network Adequacy

Advisory Council

Plan Year 2018

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Network Adequacy Advisory Council

BRIAN SANDOVAL
Governor

STATE OF NEVADA

BRUCE H. BRESLOW
Director

BARBARA D. RICHARDSON
Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
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June 7, 2016

Dear Council Members,

Congratulations on your appointment to the Commissioner's Network Adequacy Advisory Council. I appreciate your commitment to serve Nevada and your fellow citizens in this exciting and innovative approach to addressing network adequacy for individual and small employer group plans.

The Division has prepared this binder to ensure all Council Members have the same information and resources as you get started on the project. This is important work, and we at the Division are available to help answer questions or address concerns that you may have.

Thank you for your time and attention to this vital matter. I look forward to receiving your recommendations.

Sincerely,

BARBARA D. RICHARDSON
Commissioner of Insurance

Nevada Network Adequacy Council Members

Howard Baron, MD, FAAP Pediatric Gastroenterology & Nutrition Associates	Pediatric Gastroenterologist
Tracey Green, MD University of Las Vegas, School of Medicine	Vice Dean Clinical Affairs
Nancy E. Hook, MHSA Nevada Primary Care Association	Executive Director
Jack Kim United Health Care	Senior Associate General Counsel
Todd Lefkowitz DaVita Healthcare Partners	SVP, Manage Care Operations & Network Development
John Packham, PhD University of Reno, School of Medicine	Director of Health Policy Research
Trevor Rice Access to Healthcare Network	Chief Operating Officer
Pete Sabal Anthem Blue Cross and Blue Shield	Regional Vice President, Provider Solutions
Bill Welch Nevada Hospital Association	President and CEO

Meet the Facilitator

Deborah Loesch-Griffin

Dr. Deborah Loesch-Griffin was born in Detroit, Michigan in 1955 and was raised and educated in Switzerland and Germany. She returned to the United States in the mid-1960s and continues to travel abroad to develop ties with colleagues in other nations.

Loesch-Griffin received her master's degree in counseling from California State University, Fullerton in 1978 and earned her doctorate in educational psychology and child development from Stanford University in 1987. She directed the Research and Educational Planning Center in the University of Nevada-Reno School of Education from 1987 to 1990, and she is currently an adjunct faculty member with the Department of Human Development and Family Studies in the College of Health and Human Sciences at UNR.

Loesch-Griffin has twenty years of school and community program development and evaluation experience. She has served in a wide range of positions throughout pre-K-university systems, including as a high school counselor, site administrator, program manager, teacher, professor, and researcher at CSUF, Stanford University and UNR. She maintains strong community ties and working relationships throughout most of these educational positions, working in a part-time or consultant capacity to community-based organizations and non-profits.

She is partnership facilitator for a statewide service-learning initiative coordinated through the private, non-profit Community Chest, Inc. Since 1988 she has worked as a volunteer, board member, and program development director with Community Chest, Inc. to develop community organizations, programs, and projects in her local town of Virginia City, Nevada, such as:

- Storey County Preschool and Child Care Center (founding organizer and board member, 1988-1993).
- AmeriCorps*VISTA after school programs and support services for families and children (supervisor of volunteers for the development of the program, 1990-1995).
- Storey County Community Council, an advisory group providing input and direction for funding and programming for county residents (founder, 1995).
- Community Center Project, countywide door-to-door census and needs-assessment projects to identify community priorities for projects and funding (organizer and facilitator, 1995-2000).

In 1998 she entered a partnership with UNR to co-sponsor the Center for Partnership Evaluation in the College of Health and Human Sciences. There she began training and mentoring individuals interested in becoming professional evaluators.

Most recently she has been working on the development and evaluation of programs that focus on educational reform and integrated service delivery, working collaboratives, school

SOURCE: http://www.turningpointnevada.com/associatespg.htm

Meet the Facilitator

Deborah Loesch-Griffin

and community partnerships, youth development, and service learning. She has performed statewide evaluations of School to Careers, Nevada's K-12 Learn and Serve programs, and has completed a six-year national Head Start/Public School Early Childhood Transition Demonstration Project study.

Loesch-Griffin has also served as the director and evaluation consultant for regional service-learning evaluations through the Points of Light Foundation's California's Communities as Places of Learning project, East Bay Conservation Corps's Project YES (Youth Engaged in Service), AmeriCorps, Summer of Service, and Charter School Programs, and she has served on CalServe's statewide evaluation advisory team.

She was the primary facilitator for the Pinon Service Project, a Northern Nevada coalition comprised of sixteen partners. This project involved AmeriCorps members from higher education working in local schools and communities in four counties to implement service-learning from 1994-2000. This partnership evolved into the Nevada Service-Learning Partnership (NSLP), for which Dr. Loesch-Griffin wrote and received funding for three years on behalf of the partnership as one of 20 national projects to facilitate and evaluate a statewide service-learning initiative.

On a personal note, Loesch-Griffin views the world as her home and continues to learn from, reach out to, and serve the people of this planet. In 2002, she left with her family on a self-imposed six-month "victory lap" to renew and reframe her lifework. Upon return, she co-founded Global Voice with her sons and daughter and also continued to explore more deeply the religious, cultural, and national divisions that mark the twenty-first century. She believes that she must work to "think differently" about the world, to continue to see it as a place of forgiveness, hope, and light, and to put the four agreements into practice.

SOURCE: http://www.turningpointnevada.com/associatespg.htm

Nevada Division of Insurance

Division of Insurance Contacts

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Council Timeline

June 15th	First official meeting of the Council must occur
	New regulation requires the Council meet at least three times each year
September 15th	Council recommendations must be submitted to Commissioner
October 15th	Commissioner will make decision regarding recommendations of the Council
	Rule making process begins

Network Adequacy Advisory Council
General Operating Procedures and Ground Rules

A. Purpose of Advisory Council

On April 4, 2016, the Secretary of State signed regulation R049-14 which establishes the Network Adequacy Advisory Council ("Advisory Council") for the purpose of recommending additional or alternative standards for determining whether a network plan is adequate. These recommendations must be provided to the Commissioner of Insurance by no later than September 15 of each year.

B. Roles and Responsibilities of Members

1. Meet three times a year at the office of the Division of Insurance.
2. Represent the interests of their respective groups: industry, consumers, and providers.

C. Role of the Facilitator

The facilitator is an impartial individual who guides the process and facilitates meetings. The facilitator's job is to keep the group focused on the agreed-upon agenda, suggest alternative methods and procedures to move forward when necessary, encourage participation by all group members, and halt or redirect dialogue that is disrespectful, off-topic, or dominating the conversation so that others are not able to effectively participate.

The Nevada Division of Insurance ("Division") staff, will prepare agendas, coordinate meeting logistics, and prepare materials for the meetings. These documents and materials will also be posted on the Division's website. The facilitator will prepare meeting summaries. Meeting summaries will briefly summarize the topics discussed, recommendations or options being considered by the Advisory Council, areas of agreement or disagreement, and any decisions made by the Advisory Council. The Facilitator will prepare a final report to the Commissioner by September 15th of the Advisory Council's recommendations.

D. Maintaining and Ensuring Success

An important part of having a successful Advisory Council is to track its accomplishments. The Division Staff will track the following:

a. Specific goals defined and achieved.
b. Minutes
c. Agenda planning with clear closure and transition at the end of each meeting.
d. Attendance

D. Decision-Making and Voting

The Advisory Council will attempt to reach consensus on all decisions and recommendations. If consensus cannot be reached, decision-making will occur by majority voting.

E. Observers

Meetings of the Network Adequacy Advisory Council will be open to the public. At each meeting, a brief public comment period will allow observers to offer comments related to issues at hand, subject to time limits stated on the agenda. In addition, written public comments may be submitted into the record at any Advisory Council meeting.

Division of Insurance Documents

State of Nevada
Department of Business & Industry
Division of Insurance

Protect Consumers
Ensure Solvency

Network Adequacy

Presented to the Legislative Commission on Health
by Alexia Emmermann, Insurance Counsel
Division of Insurance

4/18/2016 2:11 PM

State of Nevada
Department of Business & Industry
Division of Insurance

Protect Consumers
Ensure Solvency

What Is Network Adequacy?

- Measures whether a network plan has sufficient providers to meet member needs

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Department of Business & Industry
Division of Insurance

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Background

- Patient Protection and Affordable Care Act
  - 45 C.F.R. § 156.230
    - Network adequacy standards
  - 45 C.F.R. § 156.235
    - Essential community providers
- Exchange
- AB 425 (2013) - NRS 687B.490

State of Nevada
Department of Business & Industry
Division of Insurance

Protect Consumers
Ensure Solvency

The Regulation

- Division's expertise
- Research
- Outreach
- Discussions
- Workshops
- Hearings

State of Nevada
Department of Business & Industry

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Division of Insurance

R049-14

- March 28, 2016
  - Adopted by Commissioner
- April 4, 2016
  - Passed by Legislative Commission
- April 4, 2016
  - Filed with Secretary of State
- Effective date

State of Nevada
Department of Business & Industry

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Key Concepts

- Applicability
- Advisory Council
- Recommendation
- Standards
- Requirements
- Timing
- Hearing Provisions
- Federal Approval
- Directories
- Application (Justifications)
- Notice to Commissioner
- Corrective Action Plan
- Consequences

State of Nevada
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Network Adequacy Advisory Council

- Nine members appointed by the Commissioner
- Fair representation of the interests of carriers, providers and consumers
- Meeting open to the public
- Council makes recommendation to Commissioner by September 15 of each year

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Department of Business & Industry

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Division of Insurance

Commissioner's Requirements

- Consider recommendation of Council
- Determine requirements for relevant plan year by October 15 each year
- Promulgate regulation for the requirements each year
- In February/March after the Commissioner promulgates regulation for requirements, if CMS standards change or if requirements are not accepted by CMS, Commissioner must revise and promulgate regulation again

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Division of Insurance

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What to Expect for 2017

- Network adequacy reviews
  - 2017 Letter to Issuers
  - Default to CMS standards with State mandates
- Advisory Council set up
  - Invitation to apply
  - Facilitator to run meetings
  - Orientation and guidance manual
  - Meetings start in 2016 for PY 2018

State of Nevada
Department of Business & Industry
Division of Insurance

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PY 2017 DOI Review Timeline

- May 2nd — Network Plan applications due
- May 13th — DOI communicates deficiencies to carrier
- May 27th — Carrier submits revised network plans to correct deficiencies
- June 10th — DOI communicates remaining deficiencies to carrier, if necessary
- June 24th — Carrier submits revised network plans to correct remaining deficiencies
- July 8th — DOI communicates remaining deficiencies to carrier, if necessary
- July 29th — DOI makes final determinations

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PY 2017 Network Adequacy Standards

Type	Specialty	Metro		Micro		Rural		CEAC	
		Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	15	10	30	20	40	30	70	60
	Endocrinology	60	40	100	75	110	90	145	130
	Infectious Diseases	60	40	100	75	110	90	145	130
	Mental Health	45	30	60	45	75	60	110	100
	Oncology - Medical/Surgical	45	30	60	45	75	60	110	100
	Oncology - Radiation/Radiology	60	40	100	75	110	90	145	130
	Rheumatology	60	40	100	75	110	90	145	130
Facility	Hospitals	45	30	80	60	75	60	110	100
	Outpatient Dialysis	45	30	80	60	90	75	125	110

State of Nevada
Department of Business & Industry

Division of Insurance

Protect Consumers
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Nevada County Designations

Rank	Population Density	County / Population	Designation
1	351.5/sq mi	Carson City, NV / 55,274	Metro
2	242.1/sq mi	Clark, NV / 1,951,269	Metro
3	64.4/sq mi	Washoe, NV / 421,407	Metro
4	63.7/sq mi	Douglas, NV / 46,997	Micro
5	25.7/sq mi	Lyon, NV / 51,980	Micro
6	15.2/sq mi	Storey, NV / 4,010	Rural
7	5.0/sq mi	Churchill, NV / 24,877	CEAC
8	2.8/sq mi	Elko, NV / 48,818	CEAC
9	2.4/sq mi	Nye, NV / 43,946	CEAC
10	1.7/sq mi	Humboldt, NV / 16,528	CEAC
11	1.3/sq mi	Mineral, NV / 4,772	CEAC
12	1.1/sq mi	White Pine, NV / 10,030	CEAC
13	1.1/sq mi	Pershing, NV / 6,753	CEAC
14	1.0/sq mi	Lander, NV / 5,775	CEAC
15	0.5/sq mi	Lincoln, NV / 5,345	CEAC
16	0.5/sq mi	Eureka, NV / 1,987	CEAC
17	0.2/sq mi	Esmeralda, NV / 783	CEAC

Conclusion

- Competing Priorities
- Passionate Stakeholders
- Tight Deadlines
- Federal Involvement

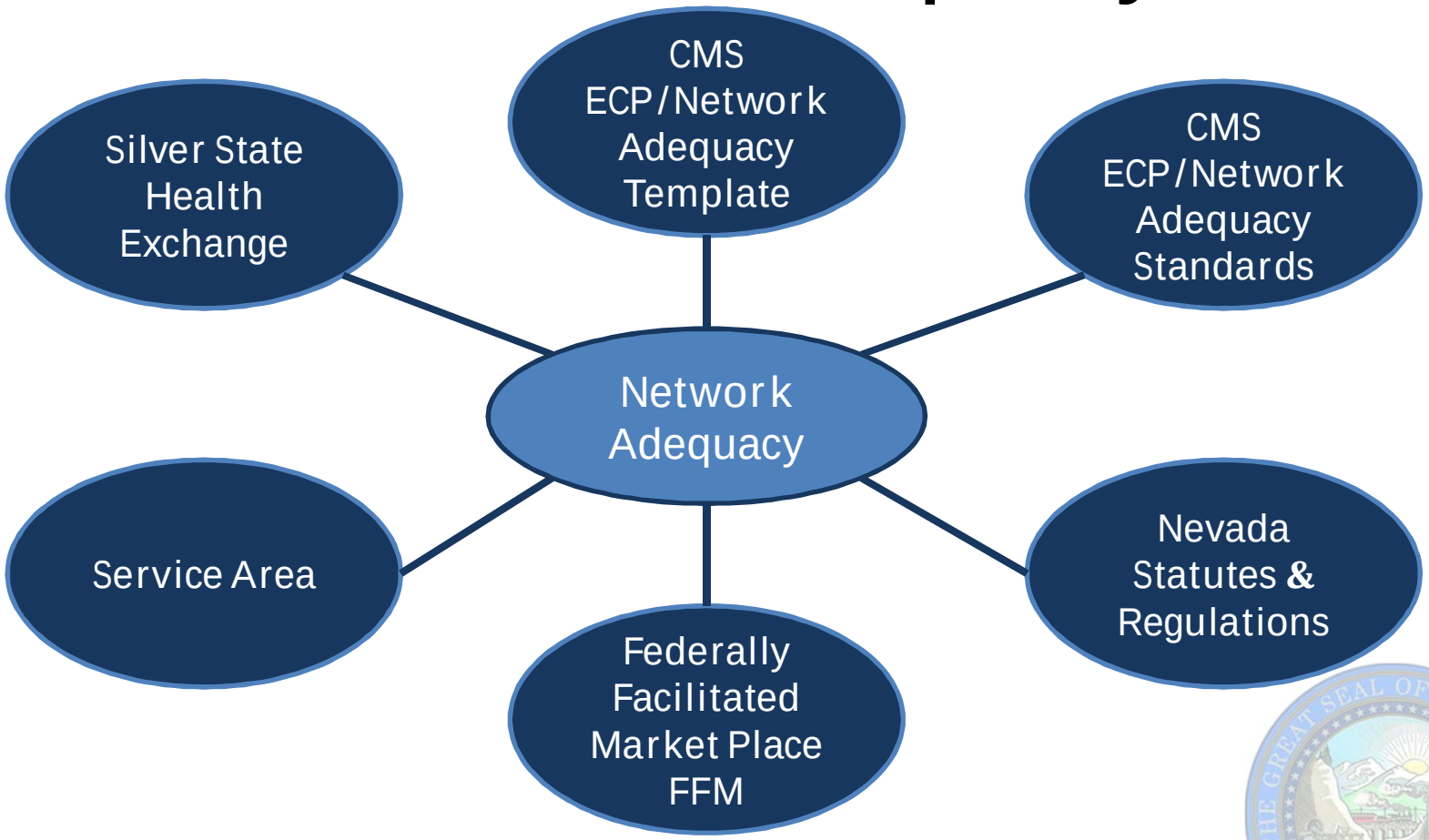
Network Adequacy Advisory Council

Introduction & Overview

Life & Health Contacts

- Kim Everett – Assistant Chief Insurance Examiner
- Jeremey Gladstone – Actuarial Analyst II
- Syed Rahman – Actuarial Analyst II

Network Adequacy



2017 Network Adequacy Standards

Essential Community Providers

- A network plan must contract with at least 30% of available Essential Community Providers (ECP) in each plan's service area
- Offers contracts in good faith to all available Indian health care providers in the service area
- Offers contacts in good faith to at least one ECP in each category in each county in the service area

Essential Community Providers

Category and Provider Types

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

Network Adequacy Defined

- Network

  The facilities, providers, and suppliers a health insurer or plan has contracted with to provide health care services

- Network Adequacy

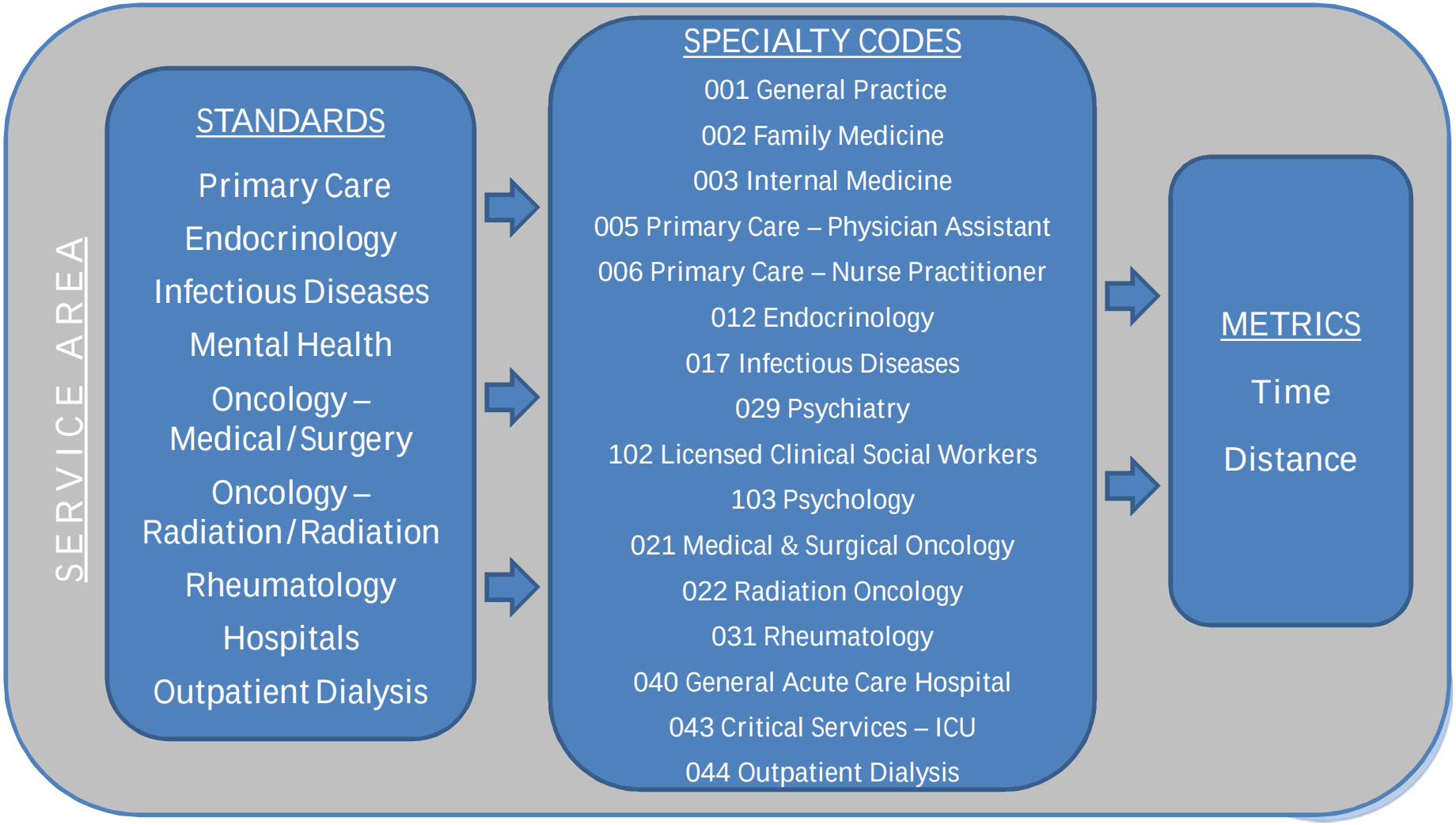
  Maintain a network to assure that all services will be accessible to enrollees without unreasonable delay

2017 Network Adequacy Standards

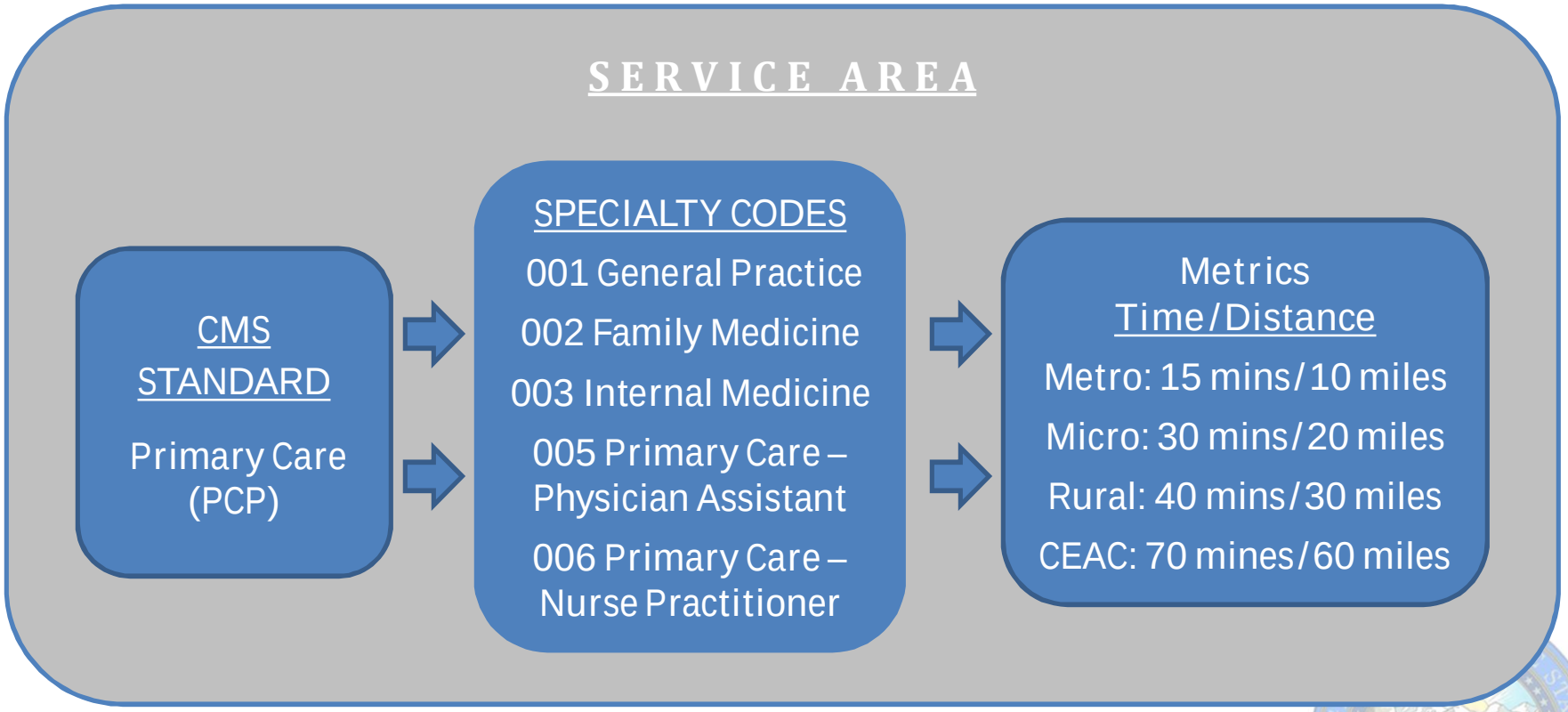
	Specialty	Specialty Codes	Metro		Micro		Rural		CEAC	
			Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	001,002,003, 005, & 006	15	10	30	20	40	30	70	60
Provider	Endocrinology	012	60	40	100	75	110	90	145	130
Provider	Infectious Diseases	017	60	40	100	75	110	90	145	130
Provider	Mental Health	029, 102, & 103	45	30	60	45	75	60	110	100
Provider	Oncology - Medical/Surgical	021	45	30	60	45	75	60	110	100
Provider	Oncology - Radiation/Radiology	022	60	40	100	75	110	90	145	130
Provider	Rheumatology	031	60	40	100	75	110	90	145	130
Facility	Hospitals	040 & 043	45	30	80	60	75	60	110	100
Facility	Outpatient Dialysis	044	45	30	80	60	90	75	125	110

To be adequate 90% of the service area population must at least meet these standards

2017 Network Adequacy



Determining Adequacy



An adequate network for a metro region requires that 90% of the population is within 15 minutes or 10 miles of a PCP

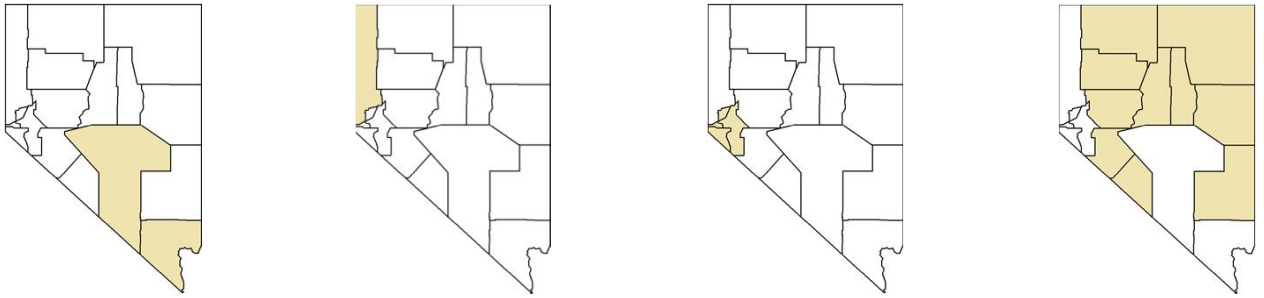
CMS Network Adequacy Template

Included Provider Specialties

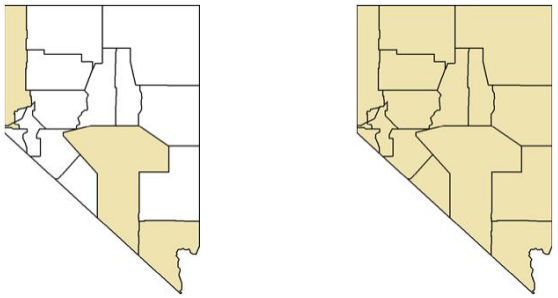
001 General Practice	018 Nephrology	040 General Acute Care Hospital	057 Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology
002 Family Medicine	019 Neurology	041 Cardiac Surgery Program	061 Heart Transplant Program
003 Internal Medicine	020 Neurological Surgery	042 Cardiac Catheterization Services	062 Heart/Lung Transplant Program
004 Geriatrics	021 Medical Oncology & Surgical Oncology	043 Critical Care Services - Intensive Care Units	064 Kidney Transplant Program
005 Primary Care - Physician Assistant	022 Radiation Oncology	044 Outpatient Dialysis	065 Liver Transplant Program
006 Primary Care - Nurse Practitioner	023 Ophthalmology	045 Surgical Services	066 Lung Transplant Program
007 Allergy and Immunology	025 Orthopedic Surgery	046 Skilled Nursing Facilities	067 Pancreas Transplant Program
008 Cardiovascular Disease	026 Physical Medicine & Rehabilitation	047 Diagnostic Radiology	000 OTHER
010 Chiropracty	027 Plastic Surgery	048 Mammography	101 Pediatrics - Routine/Primary Care
011 Dermatology	028 Podiatry	049 Physical Therapy	102 Licensed Clinical Social Workers
012 Endocrinology	029 Psychiatry	050 Occupational Therapist	103 Psychology
013 ENT/Otolaryngology	030 Pulmonology	051 Speech Therapy	Dental - General
014 Gastroenterology	031 Rheumatology	052 Inpatient Psychiatry	Dental - Orthodontist
015 General Surgery	033 Urology	054 Orthotics and Prosthetics	Dental - Periodontist
016 Gynecology (OB/GYN)	034 Vascular Surgery	055 Home Health	Dental – Endodontist
017 Infectious Diseases	035 Cardiothoracic Surgery	056 Durable Medical Equipment	Pharmacy

Service Area

- Plans sold on the Silver State Health Exchange
  - 4 Distinct Service Areas

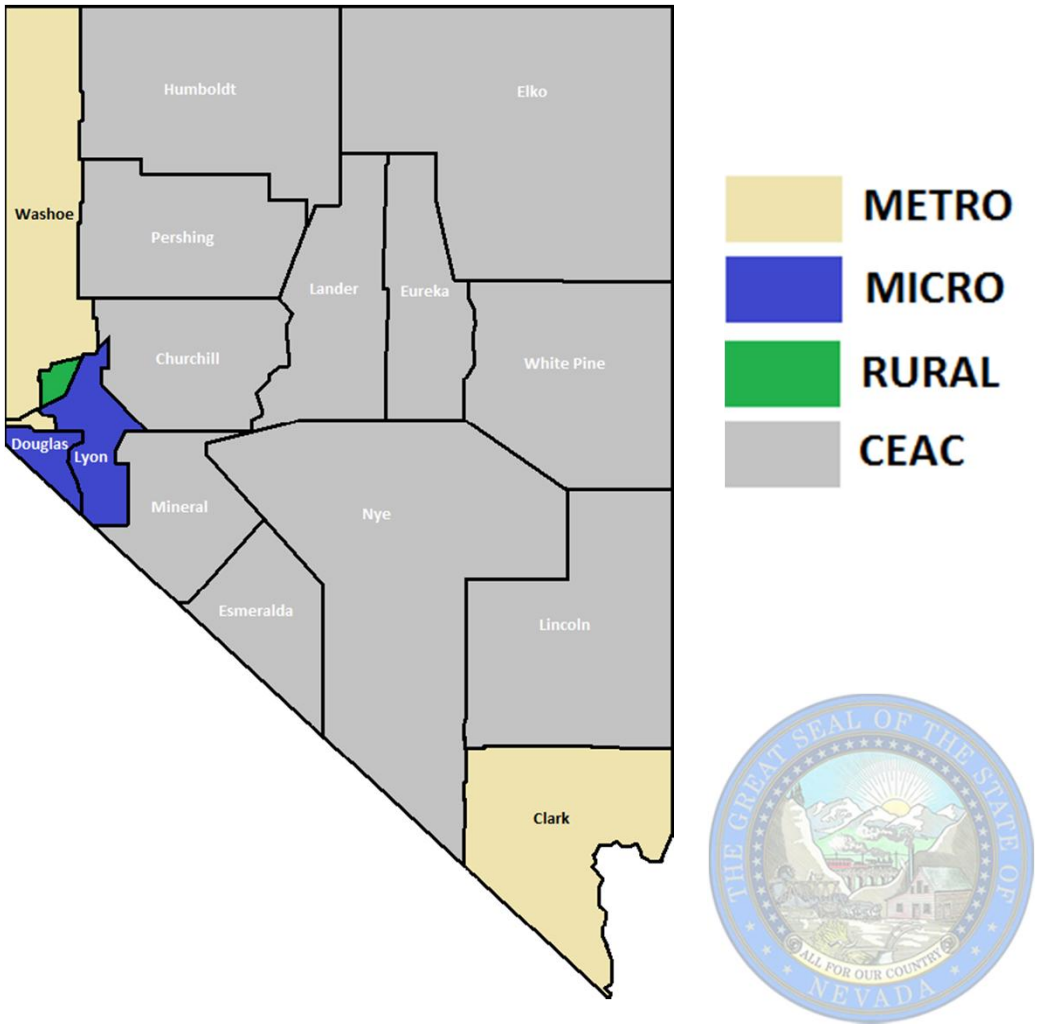


- Off Exchange Plans
  - Defined by carrier



County Designations

- Designations based on methodology designed by Office of Personnel Management (OPM)
- Designations utilized by CMS in setting FFM standards
- Based on population size and population density



Nevada County Designations

Rank	Population Density	County	Population	OPM Designation	Population Weight
1	351.5/sq mi	Carson City, NV	55,274	Metro	2.05%
2	242.1/sq mi	Clark, NV	1,951,269	Metro	72.25%
3	64.4/sq mi	Washoe, NV	421,407	Metro	15.60%
4	63.7/sq mi	Douglas, NV	46,997	Micro	1.74%
5	25.7/sq mi	Lyon, NV	51,980	Micro	1.92%
6	15.2/sq mi	Storey, NV	4,010	Rural	0.15%
7	5.0/sq mi	Churchill, NV	24,877	CEAC	0.92%
8	2.8/sq mi	Elko, NV	48,818	CEAC	1.81%
9	2.4/sq mi	Nye, NV	43,946	CEAC	1.63%
10	1.7/sq mi	Humboldt, NV	16,528	CEAC	0.61%
11	1.3/sq mi	Mineral, NV	4,772	CEAC	0.18%
12	1.1/sq mi	White Pine, NV	10,030	CEAC	0.37%
13	1.1/sq mi	Pershing, NV	6,753	CEAC	0.25%
14	1.0/sq mi	Lander, NV	5,775	CEAC	0.21%
15	0.5/sq mi	Lincoln, NV	5,345	CEAC	0.20%
16	0.5/sq mi	Eureka, NV	1,987	CEAC	0.07%
17	0.2/sq mi	Esmeralda, NV	783	CEAC	0.03%

Advisory Council Recommendation

- Recommendations for provider specialties or metrics need to be accepted by CMS, in addition to including providers required by Nevada law
- May include standards for other types of providers
- May include requirements for a greater number of essential community providers
- Changing time and distance standards (CMS standards are the floor)
- May include Provider to Enrollee Ratios.

Example of Adding Specialty Code 008 - Cardiovascular Disease

Counties	Cardiovascular Distance	Cardiovascular Time
Carson City	1.94%	0.88%
Clark County	70.54%	55.54%
Washoe County	13.80%	9.65%
Douglas County	1.39%	1.12%
Lyon County	0.74%	0.74%
Storey County	0.02%	0.00%
Churchill County	0.46%	0.23%
Elko County	0.45%	0.29%
Nye County	1.18%	0.85%
Humboldt County	0.20%	0.20%
Mineral County	0.14%	0.07%
White Pine County	0.18%	0.14%
Pershing County	0.10%	0.10%
Lander County	0.00%	0.00%
Lincoln County	0.00%	0.00%
Eureka County	0.00%	0.00%
Esmeralda County	0.00%	0.00%
Overall	**91.13%**	**69.80%**

Example of adding Cardiovascular Disease as a requirement with Time and Distance Standard of 10 for all County Designations.

Example of adding Cardiovascular Disease as a requirement with Time and Distance Standards of PCPs.

Counties	Cardiovascular Distance	Cardiovascular Time
Carson City	1.94%	1.22%
Clark County	70.54%	66.23%
Washoe County	13.80%	12.70%
Douglas County	1.73%	1.73%
Lyon County	1.60%	1.60%
Storey County	0.02%	0.02%
Churchill County	0.69%	0.69%
Elko County	1.52%	1.52%
Nye County	1.43%	1.42%
Humboldt County	0.42%	0.22%
Mineral County	0.15%	0.15%
White Pine County	0.36%	0.36%
Pershing County	0.21%	0.21%
Lander County	0.10%	0.10%
Lincoln County	0.00%	0.00%
Eureka County	0.02%	0.02%
Esmeralda County	0.00%	0.00%
Overall	**94.52%**	**88.19%**

Network Adequacy Summary

- Requirements vs Data Collected
  - The 2017 FFM standards only required 7 provider specialties and 2 Facilities
  - The CMS template includes 64 provider and facility codes
- Specialties vs Code Assignments
  - Standards includes specialties which are assigned to specific codes in the CMS ECP/Network Adequacy Template
  - Most specialties are assigned one code however for 2017 3 of the specialties were assigned to multiple codes
- Service Area
  - On Exchange vs Off Exchange
- For each specialty and standard, issuer-submitted data will be reviewed to make sure that the plan provides access to at least one provider, for each provider type, for at least 90 percent of enrollees in the Service Area(s).
  - For example, a plan covering Clark, Washoe and Nye will have to ensure that 90% of the population in all of Clark, Washoe and Nye has access to each of the Specialties, not that 90% of Clark has access, 90% of Washoe has access and 90% of Nye has access, individually

Master Provider List

- A consolidated list of all contracted providers and facilities for the 2017 Plan Year
- Provider list broken out for each specialty captured in the CMS template
- Deficiencies with CMS Standards in Master Provider List
- Enrollee Ratios of Note from Master List using Provider Standards

Requests Specifications

- We can accommodate about 3 – 4 analysis requests per week.
- All requests must be submitted to Kim Everett, who will be the point of contact.
- She will determine reasonableness of the request, before passing it on to us.

Questions

Nevada Statutes and Regulations

NRS 687B.490

NRS 687B.490 Health benefit plans: Carrier required to demonstrate capacity to adequately deliver services; Commissioner to determine capacity; annual summary.

1. A carrier that offers coverage in the group or individual market must, before making any network plan available for sale in this State, demonstrate the capacity to deliver services adequately by applying to the Commissioner for the issuance of a network plan and submitting a description of the procedures and programs to be implemented to meet the requirements described in subsection 2.

2. The Commissioner shall determine, within 90 days after receipt of the application required pursuant to subsection 1, if the carrier, with respect to the network plan:

(a) Has demonstrated the willingness and ability to ensure that health care services will be provided in a manner to ensure both availability and accessibility of adequate personnel and facilities in a manner that enhances availability, accessibility and continuity of service;

(b) Has organizational arrangements established in accordance with regulations promulgated by the Commissioner; and

(c) Has a procedure established in accordance with regulations promulgated by the Commissioner to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner.

3. The Commissioner may certify that the carrier and the network plan meet the requirements of subsection 2, or may determine that the carrier and the network plan do not meet such requirements. Upon a determination that the carrier and the network plan do not meet the requirements of subsection 2, the Commissioner shall specify in what respects the carrier and the network plan are deficient.

4. A carrier approved to issue a network plan pursuant to this section must file annually with the Commissioner a summary of information compiled pursuant to subsection 2 in a manner determined by the Commissioner.

5. The Commissioner shall, not less than once each year, or more often if deemed necessary by the Commissioner for the protection of the interests of the people of this State, make a determination concerning the availability and accessibility of the health care services of any network plan approved pursuant to this section.

6. The expense of any determination made by the Commissioner pursuant to this section must be assessed against the carrier and remitted to the Commissioner.

7. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

(Added to NRS by 2013, 3607)

SOURCE: http://www.leg.state.nv.us/NRS/NRS-687B.html

ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

Effective April 4, 2016

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[**~~omitted material~~**]** is material to be omitted.

AUTHORITY: §§1-9 and 12-18, NRS 679B.130 and 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636; §§10 and 11, NRS 679B.130, 679B.160 and 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636; §19, NRS 679B.130, 695C.130 and 695C.275.

A REGULATION relating to insurance; adopting by reference certain standards for determining the adequacy of a network plan issued by a carrier; establishing the Network Adequacy Advisory Council to make recommendations concerning additional standards for determining the adequacy of such a network plan; requiring a carrier who applies for approval to issue a network plan to submit certain data and documentation to the Commissioner of Insurance; requiring a carrier to take certain actions in response to a change to its network that results in the network not meeting applicable standards of adequacy; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the Commissioner of Insurance to adopt reasonable regulations for the administration of the Nevada Insurance Code and as required to ensure compliance with federal law relating to insurance. (NRS 679B.130) Existing law also requires: (1) a carrier that offers coverage in the group or individual insurance market to demonstrate the capacity to deliver services adequately before making any network plan available for sale; and (2) the Commissioner to promulgate regulations concerning the organizational arrangements of the network plan and the procedure established for the network plan to develop, compile, evaluate and report certain statistics relating to its services. (NRS 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636)

Under federal law, a health insurance exchange is a governmental agency or nonprofit entity established by a state that makes health plans that meet certain requirements available to persons and small employers in the state. (42 U.S.C. §§18031, 18032) **Section 9** of this regulation: (1) adopts by reference certain standards prescribed by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services for determining the adequacy of a network plan offered on a health insurance exchange; and (2) provides that those standards are the standards for determining the adequacy of any network plan offered for sale in

this State, including a plan that is not offered on a health insurance exchange. **Section 9** also provides that if a new version of those standards is issued, the Commissioner will determine whether existing requirements concerning network adequacy conform with the new version of those standards. If the Commissioner determines that existing requirements do not conform with the new version of those standards, **section 9** provides that the Commissioner will hold a hearing concerning possible amendments to existing requirements.

Section 10 of this regulation establishes the Network Adequacy Advisory Council and requires the Council to hold at least three annual meetings. **Section 11** of this regulation: (1) requires the Council to propose to the Commissioner recommendations for additional or alternative standards for determining the adequacy of a network plan; and (2) prescribes the content of the recommendations. **Section 12** of this regulation requires each carrier or other person or entity who applies for approval to issue a network plan to submit to the Commissioner with its annual rate filing sufficient data and documentation to establish that the proposed network plan meets the standards for network adequacy prescribed in regulation.

Section 13 of this regulation requires a carrier to update its directory of providers of health care at least once each month and within 5 business days after a change in a network plan that results in the network plan not meeting the standards for adequacy prescribed in regulation. **Section 14** of this regulation requires a carrier to: (1) notify the Commissioner of any such change to its network plan within 3 business days; and (2) provide to the Commissioner within 10 business days a description of the cause and impact of the change and a summary of the measures that the carrier will take to bring the network plan into compliance with the standards. **Section 15** of this regulation requires a carrier to: (1) submit to the Commissioner for approval a corrective action plan to bring the network plan into compliance with the standards; and (2) take certain actions to ensure that covered persons have access to covered services after such a change. **Section 16** of this regulation allows the Commissioner to determine that a network plan is inadequate pursuant to existing law if the Commissioner does not approve a corrective action plan and the network plan fails to comply with the standards. **Section 17** of this regulation excludes a network plan issued by certain smaller carriers from the requirements of **sections 12-16** of this regulation. **Section 18** of this regulation excludes certain other plans from the provisions of this regulation. **Section 19** of this regulation repeals provisions that: (1) require a health maintenance organization or a provider-sponsored organization to define the geographic area it intends to serve and prescribe requirements concerning that geographic area; and (2) require each applicant for a certificate of authority to submit a list of providers in its health care plan.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 18, inclusive, of this regulation.

Sec. 2. ***As used in sections 2 to 18, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. 3. *"Carrier" means an insurer that makes a network plan available for sale in this State pursuant to NRS 687B.490.*

Sec. 4. *"Council" means the Network Adequacy Advisory Council established by section 10 of this regulation.*

Sec. 5. *"Covered person" means a policyholder, subscriber, enrollee or other person participating in a network plan.*

Sec. 6. *"Network plan" has the meaning ascribed to it in NRS 689B.570.*

Sec. 7. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 8. *"Qualified health plan" has the meaning ascribed to it in NRS 695I.080.*

Sec. 9. *1. For the purpose of determining the adequacy of a network plan made available for sale in this State, the Commissioner hereby adopts by reference the standards contained in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. A copy of the letter may be obtained free of charge at the Internet address https://www.cms.gov/CCIIO/resources/regulations-and-guidance/.*

2. Upon the issuance of a new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will determine whether the requirements of sections 2 to 18, inclusive, of this regulation, including, without limitation, the standards adopted by reference in subsection 1, conform with any similar standards prescribed in the new Letter to Issuers in the Federally-facilitated Marketplaces. If the Commissioner determines that the requirements of sections 2 to 18, inclusive, of this regulation do not conform with any similar standards prescribed in the new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will hold a public hearing concerning possible amendments to sections 2 to 18, inclusive, of this

regulation and give notice of that hearing in accordance with NRS 233B.060 at least 30 days before the date of the hearing.

Sec. 10. *1. The Network Adequacy Advisory Council is hereby established.*

2. The Council consists of nine members appointed by the Commissioner. The members of the Council will be chosen to ensure fair representation of the interests of carriers, providers of health care and consumers of health care. The members of the Council serve at the pleasure of the Commissioner and without compensation.

3. If a vacancy occurs in the membership of the Council, the Commissioner will appoint a qualified person to fill the vacancy. The person appointed to fill the vacancy must represent interests similar to those represented by the member who is being replaced.

4. The Council shall meet at least three times each year. The first meeting of the Council must take place not later than June 15 of each year. Written notice of each meeting of the Council must be given as provided in NRS 241.020, as amended by section 4 of Senate Bill No. 70, chapter 226, Statutes of Nevada 2015, at page 1056, except that the notice must be given at least 5 working days before the meeting.

Sec. 11. *1. The Council shall consider the standards adopted by reference in section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation and may recommend additional or alternative standards for determining whether a network plan is adequate.*

2. The recommendations proposed by the Council to the Commissioner:

(a) Must include quantifiable metrics commonly used in the health care industry to measure the adequacy of a network plan;

(b) Must include, without limitation, recommendations for standards to determine the adequacy of a network plan with regard to the number of providers of health care that:

(1) Practice in a specialty or are facilities that appear on the Essential Community Providers/Network Adequacy Template issued by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and available at the Internet address https://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/qhp.html free of charge, which is hereby adopted by reference; and

(2) Are necessary to provide the coverage required by law, including, without limitation, the provisions of NRS 689A.0435, 689C.1655, 695C.1717 and 695G.1645;

(c) May propose standards to determine the adequacy of a network plan with regard to types of providers of health care other than those described in paragraph (b); and

(d) May, if a sufficient number of essential community providers, as defined in 45 C.F.R. § 156.235(c), are available and willing to enter into an agreement with a carrier to participate in network plans, propose requiring a network plan to include a greater number of such providers than the number of providers of health care of that type that a network plan is required to include pursuant to the standards adopted by reference in section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation.

3. The Council must submit its recommendations to the Commissioner on or before September 15 of each year. On or before October 15 of each year, the Commissioner will determine whether to accept any of the recommendations of the Council and take any action necessary to issue any new requirements for determining the adequacy of a network plan. Any such new requirements will become effective on the second January 1 next ensuing after the adoption of the requirements.

Sec. 12. *1. Each carrier or other person or entity that applies to the Commissioner for approval to issue a network plan pursuant to NRS 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636, shall submit to the Commissioner with its annual rate filing sufficient data and documentation to establish that the proposed network plan meets the standards adopted by reference in section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation.*

2. The data and documentation submitted to the Commissioner pursuant to subsection 1 must be in a format prescribed by the Commissioner.

Sec. 13. *1. Each carrier shall update its directory of providers of health care at least once each month. Except as otherwise provided in this subsection, each update to the directory must include each provider of health care who, as of the previous month, is no longer in the network plan or has stopped accepting new patients. A carrier shall not be deemed to have violated the provisions of this subsection if a provider of health care fails to provide information to the carrier which the provider of health care is contractually obligated to provide to the carrier.*

2. If a change occurs to the network plan of a carrier that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, the carrier must update its directory of providers of health care not later than 5 business days after the effective date of the change and include in the directory a clear description of the change.

3. The directory of providers of health care and each update to the directory must be:

(a) Posted to a publicly available Internet website maintained by the carrier not later than 5 business days after the update is completed;

(b) Posted in a manner that allows a person who is not enrolled in any plan offered by the carrier to view the directory; and

(c) Made available in a printed format to any person upon request.

4. As used in this section:

(a) "Directory of providers of health care" means a list of physicians, hospitals and other professionals and organizations that provide health care services, including, without limitation, through telehealth, as part of a network plan.

(b) "Telehealth" has the meaning ascribed to it in section 3 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 621.

Sec. 14. *A carrier shall:*

1. Within 3 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, notify the Commissioner in writing of the change; and

2. Within 10 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, provide to the Commissioner a written description of the cause of the change, the impact of the change on the network plan and a summary of the measures that the carrier will take to bring the network plan into compliance with those standards and requirements.

Sec. 15. *1. A carrier shall, within 60 days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive,*

of this regulation, submit to the Commissioner for approval a written corrective action plan to bring the network plan into compliance with those standards and requirements.

2. Except as otherwise provided in subsection 3, during the period in which the network plan does not meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, the carrier shall, at no greater cost to the covered person:

(a) Ensure that each covered person affected by the change may obtain any covered service from a qualified provider of health care who is:

(1) Within the network plan; or

(2) Not within the network plan by entering into an agreement with the nonparticipating provider of health care pursuant to NRS 695G.164; or

(b) Make other arrangements approved by the Commissioner to ensure that each covered person affected by the change is able to obtain the covered service.

3. The provisions of subsection 2 do not apply to services received from a nonparticipating provider of health care without the prior authorization of the carrier unless the services received are medically necessary emergency services, as defined in subsection 3 of NRS 695G.170.

Sec. 16. *If a network plan does not meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation and the Commissioner does not approve the corrective action plan submitted pursuant to section 15 of this regulation, the Commissioner may:*

1. For a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of NRS 687B.490; or

2. For any network plan other than a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of NRS 687B.490 and require the carrier to submit a statement of network capacity to the Commissioner demonstrating that the carrier meets the conditions described in 42 U.S.C. § 300gg-1(c)(1)(B).

Sec. 17. *The provisions of sections 12 to 16, inclusive, of this regulation do not apply during any calendar year to a network plan that:*

1. Is issued by a carrier that has been authorized to transact insurance in this State pursuant to chapter 680A of NRS;

2. Had a statewide enrollment of not more than 1,000 persons during the immediately preceding calendar year;

3. Has an anticipated statewide enrollment of not more than 1,250 persons during the next succeeding calendar year; and

4. Is not a qualified health plan.

Sec. 18. *The provisions of sections 2 to 18, inclusive, of this regulation do not apply to:*

1. A network plan issued pursuant to NRS 422.273 for the purpose of providing services through a Medicaid managed care program on behalf of the Department of Health and Human Services;

2. A network plan issued for a health benefit plan that is regulated pursuant to chapter 689B of NRS and is not available for sale to small employers, as defined in NRS 689C.095;

3. A grandfathered plan, as defined in NRS 679A.094; or

4. A plan issued pursuant to Medicare, as defined in NAC 687B.2028, or a Medicare Advantage plan, as defined in NAC 687B.2034.

Sec. 19. NAC 695C.160 and 695C.200 are hereby repealed.

TEXT OF REPEALED SECTIONS

695C.160 Geographic area of service: Definition. (NRS 679B.130, 695C.130, 695C.275)

1. An organization shall clearly define the geographic area it intends to serve which:

(a) In a county having a population of 100,000 or more, must have a radius of not more than 25 miles between the subscriber or individual enrollee and a primary physician and the hospital used by the organization. This subsection does not apply to services rendered pursuant to Medicaid or Nevada Check Up.

(b) In any other county, must be defined by the organization under a plan for the provision of health care services if the organization receives the written approval of the Division for such a geographic area by:

(1) Demonstrating the availability and accessibility of services to its enrollees, including reasonable access to primary physicians, a hospital and to medically necessary services or services in an emergency; and

(2) Submitting a statement concerning the standards within that community regarding the availability and accessibility of other health care services and demonstrating that the organization will meet the community's standards for such services.

2. As used in this section, "Nevada Check Up" has the meaning ascribed to it in NAC 442.688.

695C.200 List of providers: Submission; changes; extension of submission date; excessive reduction. (NRS 679B.130, 695C.070, 695C.275)

1. Each applicant for a certificate of authority shall:

(a) Submit a list of the providers in its health care plan and a description of the type of providers based upon a projected number of enrollees;

(b) Sufficiently describe its list of providers to demonstrate the accessibility and availability of health care to its enrollees; and

(c) Describe a plan for increasing the number of providers based upon increased enrollment.

2. The organization shall notify:

(a) For a health maintenance organization, the Division and the State Board of Health in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the health maintenance organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(b) For a provider-sponsored organization, the Division in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the provider-sponsored organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(c) An enrollee in writing of the disassociation of his or her primary physician from the organization not later than 30 working days after such disassociation.

3. Based upon the current list of providers of an organization, an overall reduction of more than 30 percent in the number of primary physicians in a geographic area of service or a material change in the panel of specialists shall be deemed by the Division to jeopardize the ability of the organization to meet its obligations to its enrollees, and the Division will so notify the organization, and for a health maintenance organization, the Division will also notify the State Board of Health. The organization may rebut this presumption by providing written information to the Division within 14 days after the notice is sent to the organization.

4. The provisions of subsection 3 do not apply if the organization:

(a) Notifies the Division in writing;

(b) Submits information concerning the number of persons enrolled in the organization and the reasons for any reductions; and

(c) Obtains the approval of the Division in advance for the reduction.

CMS Documentation

CMS Template Specialty Codes	
Individual Provider (MD/DO) Specialty Types	Facility, Pharmacy, and Other Non-MD/DO Specialty Types
001 General Practice	Pharmacy
002 Family Medicine	040 General Acute Care Hospital
003 Internal Medicine	041 Cardiac Surgery Program
004 Geriatrics	042 Cardiac Catheterization Services
005 Primary Care - Physician Assistant	043 Critical Care Services - Intensive Care Units (ICU)
006 Primary Care - Nurse Practitioner	044 Outpatient Dialysis
007 Allergy and Immunology	045 Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)
008 Cardiovascular Disease	046 Skilled Nursing Facilities
010 Chiropracty	047 Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)
011 Dermatology	048 Mammography
012 Endocrinology	049 Physical Therapy (individual physical therapists providing care in Free-standing; hospital outpatient and ambulatory health care facilities)
013 ENT/Otolaryngology	050 Occupational Therapist
014 Gastroenterology	051 Speech Therapy
015 General Surgery	052 Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
016 Gynecology (OB/GYN)	054 Orthotics and Prosthetics
017 Infectious Diseases	055 Home Health
018 Nephrology	056 Durable Medical Equipment
019 Neurology	057 Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology
020 Neurological Surgery	061 Heart Transplant Program
021 Medical Oncology & Surgical Oncology	062 Heart/Lung Transplant Program
022 Radiation Oncology	064 Kidney Transplant Program
023 Ophthalmology	065 Liver Transplant Program
025 Orthopedic Surgery	066 Lung Transplant Program
026 Physical Medicine & Rehabilitation	067 Pancreas Transplant Program
027 Plastic Surgery	000 OTHER
028 Podiatry	
029 Psychiatry	
030 Pulmonology	
031 Rheumatology	
033 Urology	
034 Vascular Surgery	
035 Cardiothoracic Surgery	
101 Pediatrics - Routine/Primary Care	
102 Licensed Clinical Social Workers	
103 Psychology	
000 OTHER	
Dental - General	
Dental - Orthodontist	
Dental - Periodontist	
Dental - Endodontist	

User Control Section

2017 ECP/Network Adequacy Template v6.10

User Control & Details for Template

Issuer Information

Issuer ID:*	
Source System:*	
Market:*	
Dental Only:*	
State:*	
Is this an Alternate ECP Standard Issuer?*	No

Notes & Instructions

*1. Enter all **Issuer Information**, then create a new tab using the buttons below to enter data*

2. Ensure automatic calculation is turned on. Formulas -> Caculation Options -> Automatic

3. Data can be entered manually or Copy & Pasted into each tab

4. All fields with an asterisk (*) are required

*5. Validate data (using the **"Validate"** button below) after entering in all information*

Actions

1. Create New Provider Tab

Please enter all Issuer Information above before creating a new tab.

A. New Individual Provider (MD/DO) Tab

B. New Facility, Pharmacy, Non-MD/DO Tab

2. Import Network IDs

Click the Import Network IDs button to import a list from the Network ID template.

3. Validate Data

Validate information entered into all tabs. Warning: Depending on data size, validation may take several minutes.

4. Create Supporting Documents

Perform data validation & export data to XML files.

5. Delete an Exisiting Tab?

Refer to Column P on this tab if you would like to delete an existing tab.

Exporting Data:

1. Data must pass all validation checks before being exported. Any invalid entries will be displayed in the 'Errors' and must be corrected.

*2. Click **"Create Documents"** to export data from all provider tabs.*

3. When prompted, select the folder in which you wish to save the files.

4. All files will be saved as XML files.

***Warning**: Files larger than 50mb cannot be uploaded to HIOS/SERFF. Please ensure that each exported text file is less than 50mb. On average,tabs with less than 300,000 records should be okay.*

Validation Status
Incomplete

Current Tabs	Number of Rows per Tab	Number of Validation Errors	Delete Tab? If you would like to delete a provider tab please click 'Delete' for the corresponding tab. WARNING!: Deleted tabs cannot be recovered.
Facility ECPs	0	0	
Individual ECPs	0	0	

Select ECPs Section
Columns A-J

	A	B	C	D	E	F	G	H	I	J
2	Add ECP?	Row Number	Site Name	Organization Name	National Provider Identifier	ECP Category (General ECP Standard Issuers Only)	Number of authorized MDs, DOs, PAs, and NPs	Number of authorized DMDs and DDSs	Site Street Address 1	Site Street Address 2
3		201700002	Adak Medical Clinic	EASTERN ALEUTIAN TRIBES, INC. (EAT)	1285796094	Community Mental Health Centers, Dental Providers, Family Planning Providers, Federally Qualified Health Centers, Rural Health Clinics, Ryan White Providers, Sexually Transmitted Disease Clinics, Tribal Health Program operated under P.L. 93-638	8	1	2105 Main St	PO Box 2105
4		201700003	Akhiok Village Clinic	KODIAK AREA NATIVE ASSOCIATION (KANA)	1205883907	Dental Providers, Federally Qualified Health Centers, Indian Health Service, Rural Health Clinics	1	1	3rd Ave	
5		201700004	Yukon-Kuskokwim Health Corporation Akiachak Clinic	Yukon-Kuskokwim Health Corporation	1447477815	Indian Health Service, Tribal Health Program operated under P.L. 93-638	1	0	Main St	PO Box 51089
6		201700005	Yukon-Kuskokwim Health Corporation Akiak Clinic	Yukon-Kuskokwim Health Corporation	1447477815	Indian Health Service, Tribal Health Program operated under P.L. 93-638	1	0	148 Post Rd	PO Box 216
7		201700006	ANESIA KUDRIN MEMORIAL CLINIC	Eastern Aleutian Tribes, Inc.	1558423392	Community Mental Health Centers, Dental Providers, Family Planning Providers, Federally Qualified Health Centers, Rural Health Clinics, Ryan White Providers, Tribal Health Program operated under P.L. 93-638	1	1	113 Main St	PO Box 113
8		201700007	Yukon-Kuskokwim Health Corporation Alakanuk Clinic	YUKON-KUSKOKWIM HEALTH CORPORATION	1447477815	Indian Health Service, Tribal Health Program operated under P.L. 93-638	1	0	Anderson Street Clinic Drive	PO Box 288
9		201700008	ALATNA HEALTH CLINIC	Tanana Chiefs Conference (DENA' NENA' HENASH)	0000000000	Federally Qualified Health Centers, Indian Health Service	99999	99999	PO Box 10	
10		201700009	ALLAKAKET HEALTH CLINIC	Tanana Chiefs Conference (DENA' NENA' HENASH)	1821201278	Community Mental Health Centers, Dental Providers, Federally Qualified Health Centers, Indian Health Service, Rural Health Clinics, Tribal Health Program operated under P.L. 93-638	1	1	Koyokuk River Junction	
11		201700010	Ambler Clinic	MANIILAQ ASSOCIATION	0000000000	Federally Qualified Health Centers, Indian Health Service	99999	99999	110 Main Street	
12		201700011	SVT Health & Wellness	SELDOVIA VILLAGE TRIBE	1336178847	Federally Qualified Health Centers	1	0	34361 Old Sterling Hwy	
13		201700012	Alaskan AIDS Assistance Association	Alaskan AIDS Assistance Association	0000000000	Ryan White Providers	99999	99999	1057 W Fireweed Ln Ste 102	
14		201700013	APIAI	Aleutian/Pribilof Islands Association, Inc. (APIAI)	0000000000	Indian Health Service	99999	99999	1131 E International Airport Rd	
15		201700014	SCF Cleveland Home	Southcentral Foundation (SCF)	0000000000	Indian Health Service	99999	99999	1701 Cleveland Ave	
16		201700015	Quyana Club House	Southcentral Foundation	1144274986	Community Mental Health Centers, Tribal Health Program operated under P.L. 93-638	1	0	225 Eagle St	
17		201700016	SCF Head Start Northway Mall	Southcentral Foundation (SCF)	0000000000	Indian Health Service	99999	99999	301 Penland Pkwy	

Select ECPs Section
Column K-W

	K	L	M	N	O	P	Q	R	S	T	U	V	W
2	Site City	Site State	Site Zip Code	Site County	Org Street Address 1	Org Street Address 2	Org City	Org State	Org Zip Code	Org County	POC 1 Name	POC 1 Title	POC 1 Phone #
3	Adak	AK	99546-2105	Aleutians West	3380 C Street, Ste.100		Anchorage	AK	99503	Aleutians East	Jennifer Harrison	Executive Director	907-277-1440
4	Akhiok	AK	99615	Kodiak Island	3449 East Rezanof Drive		Kodiak	AK	99615	Kodiak Island	Amy Durand	Grants Coordinator	907-486-9890
5	Akiachak	AK	99551-0089	Bethel	700 Chief Eddie Hoffman Hwy	PO Box 528	Bethel	AK	99559	Bethel	Rahnia Boyer	VP of Village Health	907-543-6240
6	Akiak	AK	99552	Bethel	700 Chief Eddie Hoffman Hwy	PO Box 528	Bethel	AK	99559	Bethel	Rahnia Boyer	VP of Village Health	907-543-6240
7	Akutan	AK	99553-0113	Aleutians East	3380 C Street, #100		Anchorage	AK	99503	Aleutians East	Jennifer Harrison	Executive Director	907-277-1440
8	Alakanuk	AK	99554-0288	Wade Hampton	700 Chief Eddie Hoffman Hwy	PO Box 528	Bethel	AK	99559	Bethel	Rahnia Boyer	VP of Village Health	907-543-6240
9	Alatna	AK	99720	Yukon Koyukuk	122 First Avenue, Suite 600		Fairbanks	AK	99701		Crystal L Stordahl		907-452-8251
10	Allakaket	AK	99720	Yukon Koyukuk	122 First Avenue, Suite 600		Fairbanks	AK	99701	Fairbanks North Star	Crystal L Stordahl	Director	907-452-8251
11	Ambler	AK	99786	Northwest Arctic	733 2nd Ave Ferguson Bldg		Kotzebue	AK	99752		Timothy Schuerch	President/CEO	907-442-7615
12	Anchor Point	AK	99556-9500	Kenai Peninsula	880 E End Rd		Homer	AK	99603	Kenai Peninsula	Emily Read	SVTHW Director	907-226-2208
13	Anchorage	AK	99503-1760	Anchorage									907-269-8061
14	Anchorage	AK	99518	Anchorage	1131 E International Airport Rd		Anchorage	AK	99518-1408		Dimitri Philemonof	President/CEO	907-276-2700
15	Anchorage	AK	99517-2689	Anchorage	4501 Diplomacy Dr		Anchorage	AK	99508-5919		Doug Eby	VP. Medical Services	907-729-3250
16	Anchorage	AK	99501-2626	Anchorage	4501 DIPLOMACY DR		ANCHORAGE	AK	99508-5919	Anchorage	Jim Lamb	Director of Revenue Cycle	907-729-5453
17	Anchorage	AK	99508	Anchorage	4501 Diplomacy Dr		Anchorage	AK	99508-5919		Doug Eby	VP. Medical Services	907-729-3250

Select ECPs Section
Columns X-AF

	X	Y	Z	AA	AB	AC	AD	AE	AF
2	POC 1 Phone Ext	POC 1 Email	URL 1	POC 2 Name	POC 2 Title	POC 2 Phone #	POC 2 Phone Ext	POC 2 Email	URL 2
3		jenniferh@eatribes.net	www.eatribes.org	Edgar Smith	Director of Operations	907-277-1440		edgars@eatribes.net	www.eatribes.org
4		amy.durand@kodiakhealthcare.org		Andy Teuber	President/CEO	907-486-9800			
5		rahnia_boyer@ykhc.org							
6		rahnia_boyer@ykhc.org							
7		jenniferh@eatribes.net		Edgar Smith	Director of Operation	907-277-1440		edgars@eatribes.net	www.eatribes.org
8		rahnia_boyer@ykhc.org							
9				Victor Joseph	President/Chairman	907-452-8251			
10		crystal.stordahl@tananachiefs.org		Victor Joseph	President/Chairman	907-452-8251			
11				Paul J Hansen		907-442-7150		phansen@maniilaq.org	
12		eread@svt.org		Thelma Pepion	Billing Supervisor	907-226-2228		tpepion@svt.org	
13			www.alaskanaids.org/						
14									
15									
16		JLamb@SouthcentralFoundation.com		Ronald L. Olson	VP FInance	907-729-4939		lolson@SouthcentralFoundation.com	
17									

	A	B	C	D	E	F	G	H
2	**Remove ECP?**	**Row Number**	**National Provider Identifier (NPI)***	**Facility Name***	**Facility Type***	**Provider Name***	**ECP Category (General ECP Standard Issuers Only)***	**Street Address***

Facility ECPs Section
Columns A-H

	I	J	K	L	M	N	O	P
2	**Street Address 2**	**City***	**State***	**County***	**Zip***	**Network IDs***	**Number of Contracted MDs, DOs, PAs, and NPs***	**Number of Contracted DMDs and DDSs***

Facility ECPs Section
Columns I-P

	A	B	C	G	I	J	K	L
2	**Remove ECP?**	**Row Number**	**National Provider Identifier (NPI)***	**Name of Provider***	**Physician/Non Physician***	**Specialty Type (area of medicine)***	**Provider Entity Name***	**ECP Category (General ECP Standard Issuers Only)***

Individual ECPs Section
Columns A-L

	M	N	O	P	Q	R	S	T	U
2	**Street Address***	**Street Address 2**	**City***	**State***	**County***	**Zip***	**Network IDs***	**Number of Contracted MDs, DOs, PAs, and NPs***	**Number of Contracted DMDs and DDSs***

Individual ECPs Section
Columns M-U

Specialty Type Section

Instructions for populating the Specialty/Facility Types without using the drop-down menu

The lists below show the specialty/facility & pharmacy types that can be entered in the ECP/Network Adequacy template. Column C shows the available specialty types that can be entered for Individual Provider (MD/DO). Column D shows the available types that can be entered for Facility, Pharmacy, and Other Non-MD/DOs. If you would like to enter more than 1 specialty/facility type for a record, please comma separate each type. For example if you would like to assign 001 General Practice and 002 Family Medicine specialty types to a provider, please enter the the types as "001 General Practice, 002 Family Medicine". Entering multiple specialty/facility types using any other convention will result in a validation error. The same comma separation technique can be used to assign multiple Network IDs to the same provider. For example, an issuer in Virginia with 3 Network IDs could assign network 1 and network 3 to the same provider by entering "VAN001, VAN003".

Individual Provider (MD/DO) Specialty Types	Facility, Pharmacy, and Other Non-MD/DO Specialty Types
001 General Practice	Pharmacy
002 Family Medicine	040 General Acute Care Hospital
003 Internal Medicine	041 Cardiac Surgery Program
004 Geriatrics	042 Cardiac Catheterization Services
005 Primary Care - Physician Assistant	043 Critical Care Services - Intensive Care Units (ICU)
006 Primary Care - Nurse Practitioner	044 Outpatient Dialysis
007 Allergy and Immunology	045 Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)
008 Cardiovascular Disease	046 Skilled Nursing Facilities
010 Chiropracty	047 Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)
011 Dermatology	048 Mammography
012 Endocrinology	049 Physical Therapy (individual physical therapists providing care in Free-standing; hospital outpatient and ambulatory health care facilities)
013 ENT/Otolaryngology	050 Occupational Therapist
014 Gastroenterology	051 Speech Therapy
015 General Surgery	052 Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
016 Gynecology (OB/GYN)	054 Orthotics and Prosthetics
017 Infectious Diseases	055 Home Health
018 Nephrology	056 Durable Medical Equipment
019 Neurology	057 Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology
020 Neurological Surgery	061 Heart Transplant Program
021 Medical Oncology & Surgical Oncology	062 Heart/Lung Transplant Program
022 Radiation Oncology	064 Kidney Transplant Program
023 Ophthalmology	065 Liver Transplant Program
025 Orthopedic Surgery	066 Lung Transplant Program
026 Physical Medicine & Rehabilitation	067 Pancreas Transplant Program
027 Plastic Surgery	000 OTHER
028 Podiatry	
029 Psychiatry	
030 Pulmonology	
031 Rheumatology	
033 Urology	
034 Vascular Surgery	
035 Cardiothoracic Surgery	
101 Pediatrics - Routine/Primary Care	
102 Licensed Clinical Social Workers	
103 Psychology	
000 OTHER	
Dental - General	
Dental - Orthodontist	
Dental - Periodontist	
Dental - Endodontist	

County Names used in the ECP/Network Adequacy Template

The list below shows the county names that are used and accepted in the ECP/Network Adequacy template. If you aren't using the drop-down menus, please ensure that your county names match the names below. A different version of a county name will result in a validation error. The county names below are the same as those in the Service Area template. Only include the county name in the county field, do not include the FIPS code.

State	County Name	FIPS Code
NV	Carson City	32510
NV	Churchill	32001
NV	Clark	32003
NV	Douglas	32005
NV	Elko	32007
NV	Esmeralda	32009
NV	Eureka	32011
NV	Humboldt	32013
NV	Lander	32015
NV	Lincoln	32017
NV	Lyon	32019
NV	Mineral	32021
NV	Nye	32023
NV	Pershing	32027
NV	Storey	32029
NV	Washoe	32031
NV	White Pine	32033

Health Professional Shortage Area Zip Code Listing

Zip Code	State
89001	NV
89003	NV
89004	NV
89007	NV
89008	NV
89009	NV
89010	NV
89011	NV
89013	NV
89014	NV
89015	NV
89016	NV
89017	NV
89018	NV
89019	NV
89020	NV
89021	NV
89022	NV
89023	NV
89024	NV
89025	NV
89027	NV
89028	NV
89029	NV
89030	NV
89031	NV
89032	NV
89033	NV
89034	NV
89036	NV
89037	NV
89039	NV
89040	NV
89041	NV
89042	NV
89043	NV
89045	NV
89046	NV
89047	NV
89048	NV
89049	NV
89054	NV
89060	NV
89061	NV
89067	NV
89070	NV
89077	NV
89081	NV
89086	NV
89087	NV
89101	NV
89102	NV
89103	NV
89104	NV
89105	NV
89106	NV
89107	NV
89108	NV
89109	NV

Health Professional Shortage Area Zip Code Listing

89110	NV
89111	NV
89112	NV
89114	NV
89115	NV
89116	NV
89118	NV
89119	NV
89120	NV
89121	NV
89122	NV
89125	NV
89126	NV
89127	NV
89128	NV
89132	NV
89133	NV
89136	NV
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89161	NV
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89180	NV
89185	NV
89191	NV
89193	NV
89195	NV
89199	NV
89310	NV
89314	NV
89316	NV
89318	NV
89319	NV
89402	NV
89403	NV
89405	NV
89406	NV
89407	NV
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89409	NV
89412	NV
89414	NV

89415	NV
89418	NV
89419	NV
89420	NV
89421	NV
89422	NV
89424	NV
89425	NV
89427	NV
89428	NV
89429	NV
89430	NV
89431	NV
89432	NV
89433	NV
89440	NV
89442	NV
89444	NV
89446	NV
89447	NV
89450	NV
89452	NV
89496	NV
89501	NV
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89510	NV
89512	NV
89513	NV
89515	NV
89520	NV
89555	NV
89557	NV
89570	NV
89595	NV
89599	NV
89701	NV
89705	NV
89706	NV
89711	NV
89712	NV
89713	NV
89714	NV
89721	NV
89820	NV
89821	NV
89825	NV
89826	NV
89830	NV
89831	NV
89832	NV
89833	NV
89834	NV
89835	NV
89883	NV

Below are the validation errors that were identified in the submitted data. Please correct these errors. You must have a valid template before you can export data to text files. Select the Cell address that is underlined and highlighted in blue to navigate to the specified error.

Important Note: If one or more rows are deleted in a provider tab or data is reorganized, cell hyperlinks in that tab may no longer be accurate. Please re-run the data validation on the 'User Control' tab to refresh the hyperlinks if this occurs.

Tab	Cell	Validation Error Message

Errors Section

Department of Health & Human Services

Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: February 29, 2016

From: Center for Consumer Information and Insurance Oversight (CCIIO),

Centers for Medicare & Medicaid Services (CMS)

Title: 2017 Letter to Issuers in the Federally-facilitated Marketplaces

The Centers for Medicare & Medicaid Services (CMS) is releasing this final 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Letter). This Letter provides issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Marketplaces (FFMs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs) with operational and technical guidance to help them successfully participate in any such Marketplace℠[1] in 2017. Unless otherwise specified, references to the FFMs include the FF-SHOPs.

Throughout this Letter, CMS identifies the areas in which States performing plan management functions in the FFMs have flexibility to follow an approach different from that articulated in this guidance. CMS also describes how parts of this Letter apply to issuers in State-based Marketplaces on the Federal Platform (SBM-FPs). CMS notes that the policies articulated in this Letter apply to the certification process for plan years beginning in 2017.[2]

Previously published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Marketplace-related topics are set out in 45 CFR Subtitle A, Subchapter B. CMS provided additional standards in the final rule titled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule" (2017 Payment Notice), CMS 9937-F, which went on public display on February 29, 2016.[3] CMS expects issuers to consult all applicable regulations, in conjunction with the final version of

[1] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.

[2] Plan years in the FF-SHOPs will not always align with calendar year 2017.

[3] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule; CMS-9937-F (February 29, 2016).

this Letter, to ensure full compliance with the requirements of the Affordable Care Act. Throughout the plan year, QHP issuers may be required to correct deficiencies identified in CMS's post-certification activities, as a result of the investigation of consumer cases, oversight by State regulators or by CMS, or an issuer's own industry-standard internal compliance and risk management program. QHP issuers in the FFMs may also be subject to other requirements for plan years beginning in 2017, as indicated in future rulemaking.

Unless otherwise indicated, regulatory references in this Letter are to Title 45 of the Code of Federal Regulations (CFR).

CONTENTS

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

The Affordable Care Act and applicable regulations establish that health plans, including SADPs, must meet a number of standards in order to be certified as QHPs. Several of these are market-wide standards that apply to plans offered in the individual and small group markets both inside and outside of the Marketplaces established by the Affordable Care Act. The remaining standards are specific to health plans seeking QHP certification from the Marketplaces.

This chapter provides an overview of the QHP certification process in all FFM States. This includes 1) a State performing plan management functions and making QHP certification recommendations to CMS, 2) a State where CMS is performing all plan management functions and certifying QHPs while the State is enforcing the market-wide standards under the Affordable Care Act, and 3) a direct enforcement State where CMS is performing plan management functions and enforcing market-wide standards under the Affordable Care Act (but the State continues to enforce State law requirements with which issuers must be in compliance).[4] The QHP certification process CMS will conduct in calendar year 2016 for plan year 2017 maintains many aspects of the process that CMS conducted in calendar year 2015 for plan year 2016. CMS intends to incorporate some modified review standards as well as operational changes for the QHP certification process for plan year 2017, as noted in this Letter.

As was the case for prior benefit years, CMS expects to rely on States' reviews of policy forms and rate filings submitted by issuers for market-wide standards as part of its QHP certification process, provided that States review for compliance with Federal laws and regulations and complete the reviews in a manner consistent with FFM operational timelines.[5] States that have Effective Rate Review[6] programs should also consult forthcoming guidance from CMS regarding timelines for rate filing for 2017 plan year coverage. CMS must receive confirmation that, in addition to complying with Affordable Care Act requirements, all QHP issuers, including

[4] SBM-FPs should transfer plan data to CMS in accordance with the QHP application submission deadlines as specified in this Letter.

[5] States are the primary regulators of health insurers and are responsible for enforcing the market reform provisions in title XXVII of the Public Health Service (PHS) Act both inside and outside the Marketplaces. Under sections 2723 and 2761 of the PHS Act and existing regulations, codified at 45 CFR Part 150, CMS is responsible for enforcing the provisions of Parts A and B of title XXVII of the PHS Act in a State if the State notifies CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the provisions, or if CMS determines that the State is not substantially enforcing the requirements. As necessary, CMS will provide additional information on enforcement. In direct enforcement States (currently, direct enforcement States are Alabama, Missouri, Oklahoma, Texas, and Wyoming), CMS enforces the market-wide provisions. Issuers in these States should work with CMS in instances in which this guidance references the "State," but should be aware that they will still generally continue to have some obligations under State law.

[6] See 45 CFR 154.301 for a list of criteria that CMS considers when evaluating whether a State has an Effective Rate Review Program.

SADP issuers, are licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage, and confirmation that they are in compliance with all applicable State laws that are conditions of offering health insurance in the State. Therefore, to certify QHPs in the FFMs, CMS must receive confirmation that issuers receive applicable form and rate filing approval from the appropriate State regulatory authority. Issuers should follow State guidance regarding compliance with the processes, criteria, and timeline for reviews conducted by States.

States performing plan management functions must provide CMS with State recommendations for QHP certification along the timeline specified by CMS in order for CMS to consider the recommendations and certify QHPs, or deny certification to QHPs, including SADPs. States are encouraged to provide CMS with feedback regarding certification of QHPs, as well as the status of issuers and plans in relation to State guidelines separate from Affordable Care Act certification requirements, as early in the certification process as practicable. For CMS to ensure this information is taken into account for certification, States must provide all of their recommendations and relevant information to CMS in a timely manner and no later than the State final plan recommendation deadline in Table 1.1. CMS will provide States with detailed guidance regarding the process for submitting plan approval recommendations to CMS prior to the start of and throughout the QHP certification cycle.

Similar to the QHP certification process for plan years beginning in 2016, States can opt to conduct reviews of QHP applications and provide QHP certification recommendations to CMS for plan years beginning in 2017. CMS will review the State's recommendations or findings to confirm that they are consistent with Federal regulatory standards.

Each of the following sections describes CMS's planned approach for evaluating QHPs against the certification standards when CMS is performing plan management functions for plan years beginning in 2017. States performing QHP certification reviews may exercise reasonable flexibility in their application of CMS's QHP certification standards, provided that the State's application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP certification in States that are performing plan management functions should continue to refer to State direction in addition to this guidance.

Section 1. QHP Application and Certification Process

This section describes how CMS will conduct QHP certification for plan years beginning in 2017.

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

For certification of a plan as a QHP effective beginning in 2017, issuers must submit a complete QHP application for all plans they intend to offer on an FFM. QHP certification must be completed annually. In the case of an FF-SHOP QHP certification, the QHP retains its certification through the end of any plan year beginning in the calendar year for which the QHP was certified, even if the plan year ends after the calendar year for which the QHP was certified.

CMS will review all QHP applications for all current and new issuers applying for QHP certification in an FFM. CMS expects States performing plan management functions in an FFM also to review QHP applications from all issuers applying for certification of a QHP for plan years beginning in 2017.

Issuers are expected to adhere to the QHP certification timeline. CMS requires issuers, including SADP issuers, to submit complete QHP applications by the initial submission deadline on May 11, 2016, and make necessary updates to the QHP application prior to the last deadline for issuer submission on August 23, 2016. Issuers that fail to meet these deadlines or have consistently failed to meet these deadlines in past certification years may have their QHP application denied. Issuers whose applications are not accurate after the deadline for issuer submission of changes to the QHP application or that have consistently submitted inaccurate data in past certification years may have their QHP application denied.[7] Table 1.1. Key Dates for QHP Certification in the FFMs, Including in States Performing Plan Management Functions.[8]

[7] Regulations at 45 CFR 155.1000 provide Marketplaces with broad discretion to certify QHPs that otherwise meet the QHP certification standards specified in Part 156, and afford Marketplaces the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the "interest" of qualified individuals and qualified employers. The preamble to the 2017 Payment Notice Final Rule clarifies that HHS will continue to focus denials of certification in the FFMs based on the "interest of the qualified individuals and qualified employers" standard which may include cases involving the integrity of the FFMs and the plans offered through them.

[8] The submission deadlines apply to all QHP application submissions, including those submitted by issuers directly to CMS via HIOS, those transferred to CMS via SERFF by States performing plan management functions, and those transferred to CMS via SERFF by SBM-FPs.

Note: All dates are subject to change.

Activity		Dates (Approximate)
QHP Application Submission and Review Process	Initial QHP Application Submission Window[9]	4/11/2016 – 5/11/2016
	CMS Reviews Initial QHP Applications as of 5/11/16	5/12/2016 – 6/10/2016
	CMS Sends First Correction Notice	6/15/2016 – 6/16/2016
	Deadline for Submission of Revised QHP Data	6/30/2016
	CMS Reviews Revised QHP Data as of 6/30/16	7/01/2016 – 8/02/2016
	CMS Sends Second Correction Notice	8/08/2016 – 8/09/2016
	Deadline for Issuer Submission of Changes to QHP Applications; Deadline for All Risk Pools with QHPs to be in "Final" Status in the Unified Rate Review (URR) System[10]	8/23/2016
	CMS Reviews Final QHP Data Received as of 8/23/16	8/24/2016 – 9/09/2016
	States Send CMS Final Plan Recommendations	9/08/2016[11]

[9] Unified Rate Review Template (URRT) and Form Filing submissions to CMS in States in which CMS is either the Effective Rate Reviewer or direct enforcer of Federal law follow the same Initial Submission Window and Deadline as the Initial FFM QHP application Submission Window. This submission deadline applies to URRT and Form Filing submissions for QHPs and non-QHPs. CMS is separately issuing guidance describing the timeline for URRT submissions in States that have an Effective Rate Review Program.

[10] There are three final submission statuses in HIOS. See Unified Rate Review Instructions for more information regarding HIOS submission statuses, available at: https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Review_of_Insurance_Rates.

[11] Separate from Correction Notices, CMS will send plan lists for confirmation to States with an FFM, including in States performing plan management functions, or SBM-FP. CMS requires responses to that State outreach by September 8, 2016, including if plans were transferred in error or a State otherwise recommends against certification

Activity		Dates (Approximate)
QHP Agreement, Plan Confirmation, and Final Certification	CMS Sends Certification Notices to Issuers	9/15/2016 – 9/16/2016
	Issuers Send Agreements and Plan List to CMS	9/19/2016 – 9/23/2016[12]
	CMS Sends Validation Notice to Issuers	10/03/2016 – 10/04/2016
Open Enrollment		11/01/2016 – 1/31/2017

i. Registration and QHP Application

To offer QHPs in the FFMs for plan years beginning in 2017, issuers must register in the CMS Enterprise Identity Management System (EIDM) to gain access to the Health Insurance Oversight System (HIOS) where they request user roles (QHP Issuer Submitter or Validator) and obtain HIOS user IDs.[13] Issuers must obtain HIOS product and plan IDs.

CMS expects that between April 11, 2016, and May 11, 2016, issuers applying to offer QHPs in FFMs will access the QHP application in HIOS to submit all information necessary for certification of health plans and SADPs as QHPs. Issuers in States performing plan management functions in the FFMs are to submit QHP applications in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF) in accordance with State and CMS review deadlines. Each State will define the relevant submission window for State-level reviews as well as dates and processes for corrections and resubmissions.

of a plan. States must communicate that information to CMS in order for the information to be incorporated into certification decisions and Certification Notices.

[12] This is the final opportunity for issuers to withdraw QHPs from the certification process for the 2017 plan year.

[13]Additional information on HIOS registration is available in the HIOS Portal User Manual, available at: https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Content_Requirements_for_Plan_Finder.

CMS will use the QHP application to collect both issuer-level information and plan-level benefit and rate data,[14] largely through standardized data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 CFR Parts 155 and 156, and provide requested supporting documentation. Based on the requirement set forth in 45 CFR 156.340 that QHP issuers maintain responsibility for the compliance of their delegated and downstream entities, these attestations will also cover the adherence of the vendors and contractors of the issuer to applicable requirements.

Issuers seeking to offer QHPs must also submit the Unified Rate Review Template (URRT) to CMS via HIOS. Issuers in a State with an Effective Rate Review program[15] must submit proposed rate filings for single risk pool coverage (for both QHPs and non-QHPs) on a date set by the State, so as long as the date is no later than July 15, 2016. Issuers should enter their submissions into the HIOS Rate Review Module for both their single risk pool QHPs and non-QHPs at the same time. In addition to the initial submission period, issuers will be able to make corrections to their URRT and upload supplemental materials needed to complete the review in direct enforcement States. If a State requires an issuer to make changes and the single risk pool rate filing is altered, causing a change to the URRT, the issuer must revise its URRT in HIOS, ensuring that both the State and CCIIO have matching URRTs. Issuers do not need to submit URRTs for SADPs.

ii. Issuer Data Collection and Coordination with States

CMS expects States to review plans seeking QHP certification for compliance with all applicable requirements under State law, as well as market-wide standards established by the Affordable Care Act such as essential health benefits (EHB) and actuarial value (AV) standards, among others.[16] State regulators may request access to QHP data templates to facilitate review of these plans.

CMS expects that States will establish the timeline, communication process, and resubmission window for any reviews conducted under State authority. As noted previously, issuers should comply with any State-specific guidelines for review and resubmission related to State review standards. CMS notes that issuers may be required to submit data to State regulators in addition

[14] Issuers in FFMs and SBM-FPs are required to submit their QHP Rates Table Template by May 11, 2016 even if their Rate Filing Justification is not due until a later date.

[15] See 45 CFR 154.301 for a list of criteria that CMS considers when evaluating whether a State has an Effective Rate Review Program.

[16] CMS notes that, because SADP issuers are only required under Federal law to adhere to pediatric dental EHB requirements for SADPs offered through a Marketplace, CMS does not have the same expectation of State review for SADPs offered through the Marketplace if such standards are otherwise not applicable under State law. Accordingly, CMS reviews SADPs for compliance with applicable Affordable Care Act standards.

to that required for QHP certification through the FFMs, if required by a State, and must comply with any requests for resubmissions from the State or from CMS in order to be certified. CMS will coordinate with States to ensure that any State-specific review guidelines and procedures are consistent with applicable Federal law and operational deadlines. In addition, CMS will work with all State regulators near the end of the QHP certification cycle to confirm that all potential QHPs meet applicable State and Federal standards, and are approved for sale in the State. Issuers must meet all applicable obligations under State law to be certified for sale on the FFMs.

Direct Enforcement States

Issuers in direct enforcement States will also be required to comply with any CMS requirements related to form filing, in addition to any applicable State requirements. Issuers may contact the CMS Form Filing Team at formfiling@cms.hhs.gov for details. Additionally, issuers in direct enforcement States will be required to submit rate filings for Federal compliance review. Issuers in those States must submit proposed rate filings for single risk pool coverage (for both QHPs and non-QHPs) on a date set by the State, so long as the date is no later than May 11, 2016. Issuers may contact the CMS Rate Review team at ratereview@cms.hhs.gov for details.[17] Issuers will also have obligations under State law, and should consult with their State for details on any State-specific guidelines or requirements.

FFMs (Excluding States Performing Plan Management Functions)

Issuers applying for QHP certification in FFMs, excluding those in States performing plan management functions, will submit their QHP applications in HIOS. Issuers may also be required to submit data to their State. Some States in which there are FFMs use SERFF to collect plan data, which may include copies of the QHP templates, but any data submitted by issuers applying for QHP certification in FFMs into SERFF will not be transferred to CMS. Issuers should ensure that changes to plan data are submitted to both CMS (in HIOS) and their State.

States Performing Plan Management Functions

In FFMs where the State is performing plan management functions, issuers will work directly with the State to submit all QHP issuer application data in accordance with State guidance.[18] States performing review of QHP applications use SERFF to collect QHP applications from issuers.

[17] Additional information on the CMS requirements for rate and form filings in direct enforcement States is available at: http://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#Health Insurance Market Reforms.

[18] CMS will work with States performing plan management functions in an FFM to ensure that such guidance is consistent with Federal regulatory standards and operational timelines.

In States performing plan management functions, the State will review QHP applications for compliance with the standards described in this guidance and will provide a certification recommendation for each plan to CMS. CMS will review the State's QHP certification recommendations, make final QHP certification decisions, and load certified QHP plans on the Marketplace website. CMS will work closely with States that are performing plan management functions to coordinate this process.

The SERFF data transfer deadlines will align with the HIOS submission deadlines, as was the case for plan year 2016 submissions. These State transfers should include all plans submitted to the State for certification, including SADPs for off-Marketplace sale.[19] CMS understands that all State reviews might not be complete by the submission deadlines, but, as stated above, requires State confirmation of approval of QHPs for sale prior to CMS certification.

iii. FFM Review of QHP Applications

Issuers applying for QHP certification in the FFMs, including issuers in States performing plan management functions, will submit complete and accurate QHP applications through HIOS or SERFF by May 11, 2016. CMS will not consider plans for which QHP applications are received after this date. CMS will not conduct QHP certification reviews of plans that are submitted for offering only outside of the FFMs except for SADPs seeking off-Marketplace certification. Additionally, if an issuer changes its application to indicate that plans will only be offered outside of the FFMs, those plans will no longer be eligible for certification.

CMS expects to review QHP applications in two rounds. Following each review period, CMS will send applicants notices summarizing any need for corrections identified during CMS's review. Issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to CMS's feedback until August 23, 2016.

After reviewing final application data submitted by August 23, 2016, CMS will make final certification decisions. CMS will send certification notices to issuers and States by September 16, 2016.

iv. Data Changes

Issuers applying for QHP certification will be able to view plan data in the Plan Preview environment in order to identify and correct data submission errors before the final QHP application data submission deadline. Issuers should use the Plan Preview environment to verify that their plan display reflects their State-approved filings. Discrepancies between the issuer's

[19] SBM-FPs should not transfer off-Marketplace SADPs.

QHP application and approved State filings may result in a plan not being certified or a compliance action if CMS has already certified a plan as a QHP.

Issuers in States performing plan management functions in the FFMs will be able to view their plan data after the State transfers QHP data from SERFF to HIOS. Issuers in these States will be able to review plan data and make any necessary corrections in SERFF according to the timeline established by the State. Changes will be reflected once the State retransfers plan data from SERFF to HIOS.

During the certification process for plan years beginning in 2017, CMS will allow issuers to make changes to their QHP application based on the guidelines below. These changes are in addition to any corrections that CMS has identified during its review of QHP applications. Table 1.2 presents a high-level overview of key dates during the QHP data change process for FFMs. Each phase of the process is described in greater detail in the subsections that follow Table 1.2.

Table 1.2. Key Dates for QHP Data Changes in the FFMs

Note: All dates are subject to change.

Activity	Allowed Changes	Dates (Approximate)
Initial Application Submission	Issuers will submit QHP applications including recertification for 2016 QHPs, including SADPs, and new 2017 QHPs and SADPs. Issuers may make any changes to their data without State or CMS authorization.	4/11/16-5/11/16
QHP Review and Modification	No new plans may be submitted. Issuers may not change plan type. Child-only value cannot be changed for QHPs. Petition to CMS required for changes to service area. Issuers must submit petitions by August 9, 2016. Issuers may submit plan withdrawal requests. For all other changes, issuers are not required to submit petitions or document State authorization to CMS.	5/12/16-08/23/16

	CMS will monitor all data changes and contact issuers if there are concerns about changes made.	
After Final Application Submission	No further data changes allowed prior to certification. Issuers will have a final opportunity to withdraw plans during the plan confirmation process. CMS may allow issuers to make critical post-certification data corrections in order to: • Correct data display errors on HealthCare.gov, and • Align QHP plan display with products and plans approved by the State. Post-certification data corrections require data change petitions and State and CMS approval. Allowed changes will occur during periodic, scheduled limited data correction windows.	8/24/16 - onward

Initial Application Submission

As described in Section 1 of Chapter 1, issuers will submit their initial QHP applications between April 11, 2016, and May 11, 2016. This includes applications for SADPs to be offered on and off the FFMs. Issuers that intend to include new QHPs must submit their 2017 QHP application data during this submission window. Issuers that are requesting recertification of 2016 QHPs must follow the guidelines in Chapter 1, Section 3 for recertification for 2017. Issuers may make changes to their QHP application until the deadline for initial application submission without State or CMS authorization. Applications must be cross-validated and complete by May 11, 2016.

QHP Review and Modification

After the close of the initial QHP application submission window, issuers will be able to upload revised data templates on an as-needed basis until the final data submission deadline of August 23, 2016.

After May 11, 2016, issuers cannot add new plans to a QHP application or change an off-Marketplace plan to both on- and off-Marketplace. Issuers also may not change plan type(s). QHPs (excluding SADPs) may not be changed from a child-only plan or to a child-only plan.

An issuer may submit a petition to make service area changes during this period. For further information about what constitutes a change to an issuer's service area, please review Chapter 2, Section 2 "Service Area." Issuers must submit petitions for all changes to service area, including responding to a correction CMS identified during CMS application reviews. Issuers are required to submit evidence of State approval for service area changes. For QHPs in direct enforcement States, the CMS Form Filing team, instead of the State, must authorize data changes. The petition process will require a signed data change request form, justification for the change, and evidence of State approval. Requests must be submitted with evidence of State approval by August 9, 2016 in order to allow CMS sufficient time for review. Issuers must submit approved changes to QHP applications prior to the final data submission deadline of August 23, 2016.

An issuer may submit a plan withdrawal request to withdraw one or more plans from its QHP application during this period. SADP issuers seeking to change on-Marketplace to off-Marketplace plan certification must submit a plan withdrawal request. CMS expects to allow issuers to withdraw plans as needed prior to QHP Certification Agreement signing

For all other changes, issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to State or CMS feedback until the final data submission deadline. The issuer's State must authorize all data changes, though evidence of State approval is only required for petitions. CMS will monitor all data changes made by issuers during this period. If there are concerns about changes made, CMS will contact the issuer to determine next steps. CMS reviews will be based on the issuer's QHP data as of the specific due dates as listed in Table 1.1.

Issuers must ensure plans that are being recertified will still be considered the same plan even with data changes, as outlined in 45 CFR 144.103, and further discussed in Chapter 1, Section 2, "Recertification for 2017."

After Final Application Submission

After August 23, 2016, HIOS will close and no additional QHP data changes will be allowed until CMS completes its certification decisions and issuers sign the QHP Privacy and Security Agreement and Senior Official Acknowledgement. Issuers will have a final opportunity to

withdraw plans during the plan confirmation process, as described in Subsection V, "Plan Confirmation and QHP/SADP Certification, Privacy and Security Agreement, and Senior Officer Acknowledgement."

After this occurs, CMS may offer data correction windows, during which issuers will not be allowed to make further changes to QHP data unless changes are pre-approved by CMS and the State. For QHPs in direct enforcement States, the CMS Form Filing team instead of the State must authorize data changes.

During a data correction window, issuers may request to make changes necessary to correct data display errors or align QHP data with products and plans as approved by the State, or from a limited list of changes that do not impact certification, such as URLs and plan marketing names. Issuers will be required to provide a justification for any requested changes and submit a signed data change request form and evidence of State approval. Issuers are responsible for ensuring that requested changes are in compliance with Federal QHP certification standards set forth in the Affordable Care Act, Federal regulations, and all other guidelines discussed in this Letter.

A request for a data change after August 23, 2016, excluding administrative changes, may indicate the presence of inaccuracies or the incompleteness of a QHP application, and may result in compliance action. Discrepancies between the issuer's QHP application and approved State filings may result in a plan not being certified or a compliance action if CMS has already certified a plan as a QHP. Issuers that request to make changes that affect consumers may have their plans removed from display on HealthCare.gov until the data are refreshed for consumer display. Additional requirements may apply, and CMS intends to release further instructions about this process.

v. Plan Confirmation and QHP/SADP Certification, Privacy and Security Agreement, and Senior Officer Acknowledgement

As with the certification process for plan years beginning in 2016, issuers intending to offer QHPs or SADPs in the FFMs, including issuers in States performing plan management functions, will be required to validate their final plan list, and sign and submit to CMS a QHP Certification Agreement and Privacy and Security Agreement (the QHP Certification Agreement) and a Senior Officer Acknowledgement.

Issuers will submit these signed agreements along with a final list of QHPs and SADPs they intend to offer on the FFMs. Among other things, the QHP Certification Agreement will include provisions for safeguarding the privacy of plan applicant and participant data in the FFMs and standards for issuer testing prior to the beginning of open enrollment. An officer of the legal entity who has legal authority to contractually bind the issuer must sign the QHP Certification Agreement. The Senior Officer Acknowledgment includes provisions confirming that a senior officer of the issuer has knowledge of the content of the issuer's plans, as well as the content of the completed attestations and this Letter.

With the certification notice, CMS sends to each issuer a list of plans received during the QHP application process which is preliminarily approved for certification. The list includes on and off-Marketplace SADPs and on-Marketplace QHPs.[20] QHP issuers are asked to review the list and must respond to CMS with a final plan confirmation list that will confirm whether or not CMS's list is accurate. Submission of the final plan confirmation list to CMS is the last opportunity a QHP issuer has to withdraw a plan from the Marketplace for the upcoming plan year.

CMS will review the QHP Certification Agreement, the Senior Officer Acknowledgment, and the final plan confirmation list and, if they are accurate and complete, sign and return the QHP Certification Agreement to issuers. QHP issuers' receipt of a QHP Certification Agreement with CMS signature and final plan list validated by CMS completes the certification process for the upcoming plan year. CMS will not sign or return the Senior Officer Acknowledgement.

The documents will apply to all of the QHPs offered by a single issuer in an FFM at the HIOS Issuer ID level or designee company.

Issuers should ensure that the legal entity information listed in HIOS under the Issuer General Information section is identical to the legal entity information that will be used when executing the documents.

vi. Sale of Ancillary Products on the FFMs

FFMs will not display ancillary insurance products and health plans that are not QHPs (e.g., stand-alone vision plans, disability, or life insurance products). The FFMs will only offer QHPs, including SADPs.

Section 2. Recertification for 2017

i. Policy and Process for Recertification

For plan years beginning in 2017, CMS's process for recertifying a QHP, including an SADP, which was certified for the 2016 benefit year will mirror the process for certification of a plan. Issuers seeking recertification will submit all information required under the 2017 QHP application for plans that were QHPs, including SADPs, in 2016.

To be eligible for recertification for plan years beginning in 2017, a QHP, including an SADP, certified by an FFM must be the same "plan," as defined in 45 CFR 144.103, as the plan that was certified for plan years beginning in 2016. The same definition of "plan" also will apply to

[20] Plan confirmation tables in SBM-FPs will not include off-Marketplace SADPs. Plan confirmation tables in States where CMS certifies SADPs will include both on and off-Marketplace SADPs.

reenrollment of current enrollees into the same plan, pursuant to §155.335(j). A QHP, including an SADP, recertified for plan year 2017 is expected to use the same HIOS plan identification numbers that it used for its certification for plan year 2016.

If an issuer chooses to not recertify a plan in the Marketplace, it is subject to the standards outlined in 45 CFR 156.290.

ii. Plan ID Crosswalk

Previously, CMS developed and released a Plan ID Crosswalk Template for issuers to complete and submit to CMS for the individual market. The submission process applies to all issuers that offered individual market QHPs through an FFM in 2016 – including issuers in States performing plan management functions in an FFM and issuers in SBM-FPs. For the FFMs, this template cross-walked prior year QHP plan ID and service area combinations (e.g., Plan ID and county combinations) to a current QHP plan ID. This data facilitated enrollment transactions from CMS to the issuer for those individual market enrollees who had not actively selected a different QHP during open enrollment at that time.

CMS expects to implement a similar approach for automatic re-enrollment from 2016 to 2017 QHPs in the FFMs. As a result, issuers that offered plans on the individual market FFMs in plan years beginning in 2016, including QHPs and SADPs, should submit Plan ID Crosswalk data.

To note, SADPs, as excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106. However, as CMS has indicated in previous guidance, it again aims to apply the hierarchy set forth at 45 CFR 155.335(j) and the business rules established for the 2017 Plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for re-enrollment plan years beginning in 2017.

For a submission process, CMS expects that issuers will submit the template to a CMS email address, which is the same method that was used for plan years beginning in 2016.

CMS will conduct an overall data integrity review of submitted Plan ID Crosswalk data. This will include, but not be limited to an evaluation for compliance with 45 CFR 155.335(j). This will also include a review for consistency with submitted Service Area and Plans and Benefits Template data for both 2016 and 2017.

Section 3. OPM Certification of Multi-State Plan (MSP) Options

This section provides additional guidance for health insurance issuers seeking to offer Multi-State Plan (MSP) options in FFMs and State-based Marketplaces (SBMs).

The U.S. Office of Personnel Management (OPM) is responsible for implementing the MSP Program as required under section 1334 of the Affordable Care Act. In accordance with section

1334(d) of the Affordable Care Act, MSP options offered by MSP issuers under contract with OPM are deemed to be certified by a Marketplace.

OPM anticipates that the process for MSP issuers to participate in a Marketplace for the 2017 benefit year will largely mirror that used for 2016. Issuers seeking to offer MSP coverage must apply to participate via OPM's online application portal. OPM will evaluate issuer applications and determine which issuers are qualified to become MSP issuers. OPM works closely with States in reviewing benefits and rates to achieve its goals of offering more choices for consumers and maintaining a level playing field for all issuers within a State.

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

For more information on requirements for MSP issuers, issuers should visit http://www.opm.gov/healthcare-insurance/multi-state-plan-program/issuer/. OPM will post specific instructions regarding the 2017 application when available.

Section 4. Standardized Options

In the 2017 Payment Notice Final Rule, we finalized standardized options at each of the bronze, silver (including the three silver cost-sharing reduction plan variation levels), and gold metal levels—a total of 6 standardized options (see Table 9 in the 2017 Payment Notice Final Rule), which issuers will have the option to offer starting in the 2017 plan year. This does not apply to SADPs. We made minor changes to the standardized options proposed in the 2017 Payment Notice Proposed Rule.[21] In making these changes, we ensured that the QHPs more closely reflect the average copayment rates in the most popular QHPs in the 2015 FFMs (weighted by enrollment).

Issuers have the option of offering a standardized option at one level of coverage without offering a standardized option at the other levels of coverage, except that if an issuer offers a silver standardized option, the issuer must also offer the standardized silver cost-sharing reduction plan variation levels. For instance, an issuer may offer a silver standardized option (including the cost-sharing reduction plan variations) without offering a bronze or gold standardized option. We encourage issuers to offer at least one standardized option in 2017, particularly at the silver level of coverage (including the silver cost-sharing reduction plan variation levels). We believe that standardized options will allow consumers to more easily

[21] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Proposed Rule; 80 Federal Register 75488 (December 2, 2015).

compare plans offered by different issuers. Each standardized option is standardized in terms of in-network cost sharing: deductible; annual limitation on cost sharing; and copayment or coinsurance for a key set of EHB that comprise a large percentage of the average enrollee's total spending. Each standardized options has the four drug tiers currently utilized in our consumer-facing applications—generic, preferred brand, non-preferred brand, and specialty drug tiers—with the option for issuers to offer an additional lower-cost generics drugs tier. The standardized options do not have more than one in-network provider tier.

Issuers may also offer more than one standardized option at each level of coverage. For instance, an issuer could offer more than one standardized option at each metal level by varying network, additional benefits covered, or other features. The meaningful difference requirements discussed in Section 12 of Chapter 2 of this Letter apply uniformly across all QHPs, including standardized options.

Finally, we are conducting consumer testing to determine appropriate modifications in display in our consumer-facing plan comparison features in order to readily allow consumers to identify standardized options and distinguish them from non-standardized plans. We also anticipate providing information to explain the standardized option concept to consumers.

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

Section 1. Licensure and Good Standing

This section describes issuer requirements for licensure and good standing and how CMS will review prospective QHPs and SADPs for compliance with these standards in the FFMs. States performing plan management functions may use a similar approach. This approach is the same approach used in 2016.

The following is a summary of key points:

- Each QHP issuer must be licensed and in good standing in each State in which it applies to offer QHPs for the applicable market, product type, and service area (see 45 CFR 156.200(b)(4)).

- CMS interprets "good standing" to mean that an issuer faces no outstanding sanctions imposed by a State's department of insurance (DOI). Therefore, the specific violations or infractions that would jeopardize standing may vary by State. Issuers must be in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage, and in compliance with all applicable State laws that the State imposes as conditions of offering health insurance in the State provided that the applicable laws are in accordance with Federal law. In addition, an issuer is not considered to be in good standing if it is not licensed.

- Issuers must provide one of the following supporting documents as part of the QHP application: State license, certificate of authority, certificate of compliance, or an equivalent form or document for the product(s) in the service area(s) in which the issuer intends to offer a QHP.

- Issuers applying for QHP certification must be able to demonstrate State licensure by no later than 90 days prior to open enrollment.

Section 2. Service Area

This section describes requirements for an issuer's service area(s) and how CMS will conduct its review for compliance with this standard in the FFMs. States performing plan management functions may use a similar approach. This approach is the same approach used for certification for the 2016 plan year and applies to both QHPs and SADPs.

The Marketplace must ensure that each service area of a QHP covers a minimum geographic area that is at least the entire geographic area of a county, or a group of counties defined by the Marketplace, unless the Marketplace determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers (see 45 CFR 155.1055(a)). The Marketplace must also ensure that the service area of a QHP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations (see 45 CFR 155.1055(b)). CMS considers the service area of a plan to be the county or set of counties (or partial counties) that is covered by that particular plan. CMS will review requests for service areas that serve a geographic area smaller than a county (i.e., a partial county request) to ensure that each service area meets the above regulatory standards.

QHP issuers will not be allowed to change their plans' service area after their initial data submission except via petition to CMS. This includes any changes to the Service Area Template (including changing the name of the service area) as well as changing the service area ID associated with a plan on the Plans and Benefits Template. Any change to the list of counties associated with a particular plan is considered a change in the service area, even if the issuer offers other plans or products in the counties (or partial counties) in question. Issuers should note that a change in service area is not always directly related to changes made to the Service Area Template. That is, a change to the Plans and Benefits Template may also potentially impact service area. For example, changing the service area ID associated with a plan from S001 to S002 constitutes a change to service area. Petitions for service area changes must follow a CMS-prescribed format that will be detailed in future guidance and will only be allowed with State approval. Changes to service areas will only be approved under very limited circumstances. CMS will not allow changes to service area after the final data submission date. For additional information on the data change process, please see Chapter 1, Section IV.

Section 3. Network Adequacy

This section includes information on network adequacy evaluation and network provider directory requirements.

i. Network Adequacy Standard

This section describes how CMS will conduct its network adequacy review for plan year 2017 QHP certification, including for SADPs. Pursuant to 45 CFR 156.230(a)(2), an issuer of a QHP that uses a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." All issuers applying for QHP certification will need to attest that they meet this standard as part of the certification process. The 2017 Payment Notice Final Rule did not finalize policies concerning network adequacy time and distance standards as proposed; therefore, we are not finalizing all of the policies proposed in the Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces. We are continuing to use the reasonable access standard so that States have time to adopt the NAIC Network Adequacy Model Act provisions.

As was done during the 2015 and 2016 certification processes, for 2017 plan year certification, CMS will assess provider networks using a "reasonable access" standard in order to identify networks that fail to provide access without unreasonable delay, consistent with requirements specified at 45 CFR 156.230(a)(2). We are also providing more transparency and detail for QHP issuers in an FFM regarding how CMS will review QHP network data collected as part of the certification process to determine if plans provide reasonable access.

ii. CMS 2017 Certification Review Criteria

While CMS is not finalizing network adequacy time and distance standards, this section provides clarity on the criteria that CMS has previously used and will use as part of the certification process to review network provider data to determine if plans provide reasonable access to covered services. For 2017, as in 2016, CMS will review provider data with a focus on the following specialties, which have historically raised network adequacy concerns: Hospital systems, Dental providers (if applicable), Endocrinology, Infectious Disease, Mental Health, Oncology, Outpatient Dialysis, Primary Care, and Rheumatology. CMS will not review SADPs for non-dental provider types.

Specifically, in order to determine whether plans provide reasonable access for these specialties, we will review the provider data using the maximum time and distance standards detailed in the table below.

Table 2.1. Specialties and Standards for Marketplace PY17 Certification.[22]

Specialty Area	Maximum Time and Distance Standards (Minutes/Miles)				
	Large	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Primary Care	10/5	15/10	30/20	40/30	70/60
Dental	30/15	45/30	80/60	90/75	125/110
Endocrinology	30/15	60/40	100/75	110/90	145/130
Infectious Diseases	30/15	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	20/10	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	30/15	60/40	100/75	110/90	145/130
Mental Health (Including Substance Use Disorder Treatment)	20/10	45/30	60/45	75/60	110/100
Rheumatology	30/15	60/40	100/75	110/90	145/130
Hospitals	20/10	45/30	80/60	75/60	110/100
Outpatient Dialysis	30/15	45/30	80/60	90/75	125/110

For each specialty and standard listed in the table, we will review the issuer-submitted data to make sure that the plan provides access to at least one provider in each of the above-listed provider types for at least 90 percent of enrollees. For example, for Endocrinology in a Large

[22] The full definitions for each of the county types listed can be found on page 12 of the following document - https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2016_MA_HSD_Network_Criteria_Guidance.pdf.

county type, at least 90 percent of enrollees must have at least one provider within 15 miles or 30 minutes.

As in past years, in addition to permitting issuers to add additional providers, we will use a justification process when CMS determines that an issuer's network is inadequate under the reasonable access review standard. The justification process requires that QHP issuers detail patterns of care and other relevant information that explain why the issuer provides reasonable access to enrollees in the identified area(s). The justification must specifically address how issuers meet the reasonable access standard, despite not meeting the time and distance standards.

We have analyzed QHP issuer network data submitted as part of the 2016 certification cycle against the metrics set forth above, and, based on that analysis, over 90 percent of issuers passed for each of these metrics. We anticipate that the vast majority of QHPs today would pass these time and distance standards, either numerically or based upon justifications.

CMS will use any updated provider data and written justification submitted as part of the certification process in assessing whether the issuer meets the regulatory requirement, prior to making the certification decision. CMS will share information about its analysis and coordinate with States that are conducting network adequacy reviews. CMS will continue to monitor network adequacy throughout the year and will coordinate with State Departments of Insurance should it be necessary to remedy potential deficiencies.

iii. Provider Transitions

This section discusses the provider transitions policy established in the 2017 Payment Notice Final Rule. To align with the policy finalized in the 2017 Payment Notice Final Rule, the provisions under §156.230(d) are not intended to, and do not, preempt State provider transition notices or continuity of care requirements and we defer to a State's enforcement of substantially similar or more stringent requirements.

First, we finalized a standard that a QHP in an FFM be required to make a good faith effort to provide written notice of termination of a discontinued provider 30 days prior to the effective date of the change or otherwise as soon as practicable to all enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. To identify enrollees who see a provider who is terminating, we expect the issuer to work with the provider to obtain the list of affected patients, use its claims data system to identify enrollees who see the affected providers, or use another reasonable method. The issuer does not need to use more than one method. We understand that there are certain situations that cannot be anticipated, and in those cases, we would expect the issuer to send the notice to the enrollee as soon as practically possible. For the written notice, we encourage issuers to notify enrollees of other comparable in-network providers in the enrollee's service area, provide information on how the enrollee could access the

plan's continuity of care coverage, and encourage the enrollee to contact the plan with any questions.

Second, we finalized at 45 CFR 156.230(d)(2) a provision to ensure continuity of care for enrollees in cases where a provider is terminated without cause. Specifically, we require the issuer, in cases where the provider is terminated without cause, to allow an enrollee in active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. Additionally, we defined active course of treatment as meaning:

(1) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

(2) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(3) The second or third trimester of pregnancy, through the postpartum period; or

(4) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

For the purposes of the active course of treatment definition, an ongoing course of treatment includes treatments for mental health and substance use disorders that fall within the definition of active course of treatment. If the enrollee has successfully transitioned to a participating provider, if the enrollee has met or exceeded benefit limitations of the plan, or if care is not medically necessary, §156.230(d)(2) would no longer apply to the enrollee. Any QHP issuer decision made for a request for continuity of care must be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

While we expect issuers to negotiate with a provider for payment of services under §156.230(d)(2), issuers would only be responsible for paying to a provider what was previously being paid under the same terms and conditions of the provider contract, including any protections against balance billing, if the provider agrees to provide care under §156.230(d)(2). We cannot require non-contracted provider to accept a particular payment rate under §156.230(d)(2). Therefore, nothing under §156.230(d)(2) would prohibit balance billing for non-contracted providers in accordance with Section 1302(c)(3)(B) of the Affordable Care Act and §155.20.

QHP issuers in the FFMs are required to update internal processes and procedures to implement these requirements for plan years beginning on and after January 1, 2017.

iv. Network Transparency

This section discusses how CMS intends to label each QHP network's breadth as compared to other QHP networks on HealthCare.gov. This information will be available to consumers when they are considering which plan to enroll in, and would include a designation that indicates the network's relative breadth. We intend to further consider how we will display this breadth information as we continue consumer testing. The purpose of the labeling is to provide increased transparency to enrollees about the type of provider network in the coverage they are selecting.

Each network's breadth will be compared to the network breadth of other QHPs available in the same geographic area. CMS will identify network breadth based on analysis of QHP provider and facility data submitted as part of the 2017 certification process. This analysis will compare an issuer's contracted providers to the number of specific providers and facilities included across all QHP networks available in a county. The rating will focus on hospitals, adult primary care, and pediatric primary care with either a separate classification for each of the three categories or a composite overall classification that reflects the overall network for all three of the indicated specialties. CMS will make a final determination to use a separate or composite rating based on the results of consumer testing, and intends to provide this information as part of the 2017 QHP certification instructions. These specialty areas were chosen based on consumer feedback that access to specific hospitals and preferred primary care physicians is important to potential enrollees when comparing plans.

We plan to provide the classifications of network breadth for each plan at the county level. These classifications will be determined by calculating the percentage of providers in a plan's network, compared to the total number of providers in QHP networks available in a county. We will divide the number of each QHP's servicing providers at the issuer, network, county, and specialty combination level by the total number of all available QHP servicing providers for that county, including Essential Community Providers (ECPs). This number is the Provider Participation Rate (PPR). As a baseline standard, networks that are within one standard deviation of the mean PPR will be classified as Standard. Those with a PPR that is more than one standard deviation above the mean PPR will be classified as Broad. Those with a PPR that is more than one standard deviation below the mean PPR will be classified as Basic. Applying this methodology to 2016 QHP issuer provider data, we found that approximately 68 percent of the plans would have been categorized as Standard, about 16 percent would have been classified as Basic, and about 16 percent would have been classified as Broad. We will conduct an analysis of QHP 2017 provider data using the same methodology to determine each plan's classification. These calculations will be based on the network provider data that each QHP issuer submits as part of QHP certification and would be updated annually.

In future years, we may expand these classifications to additional specialties and facility types.

Section 4. Essential Community Providers

This section describes how CMS plans to conduct reviews of the ECP standard for QHP and SADP certification for plan years beginning in 2017. States performing plan management functions in the FFMs may use a similar approach.

ECPs include providers that serve predominantly low-income and medically underserved individuals, and specifically include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. In the 2016 Payment Notice Final Rule,[23] we clarified that ECPs may also include not-for-profit or State-owned providers that are entities described in section 340B of the PHS Act but do not participate in the 340B Program, as these providers satisfy the same 340B eligibility requirements and therefore meet the definition of ECPs by virtue of the following description in section 1311(c)(1)(C) of the Affordable Care Act – "health care providers defined in section 340B(a)(4) of the PHS Act and providers in section 1927(c)(1)(D)(i)(IV) of the Act." For the same reasons described above, not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act also qualify as ECPs. Furthermore, Indian health care providers are included among other ECPs, as reflected in Table 2.1. At 45 CFR 156.235, CMS established requirements for inclusion of ECPs in QHP provider networks and provided an alternate standard for issuers that provide a majority of covered services through physicians employed by the issuer or a single contracted medical group.

i. Evaluation of Network Adequacy with respect to all ECPs

Because the number and types of ECPs available vary significantly by location, and consistent with the approach in prior years, CMS intends to evaluate QHP applications for sufficient inclusion of ECPs for plan years beginning in 2017 against the ECP inclusion standard described below.

General ECP Standard

Similar to 2016, for plan years beginning in 2017, CMS will use a general ECP enforcement standard whereby it will consider the issuer to have satisfied the regulatory standard if an application demonstrates satisfaction of the following criteria:

- Contracts with at least 30 percent of available ECPs in each plan's service area to participate in the plan's provider network;

[23] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 Federal Register 10750 (February 27, 2015).

- Offers contracts in good faith to all available Indian health care providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, applying the special terms and conditions necessitated by Federal law and regulations as referenced in the recommended model QHP Addendum[24] for Indian health care providers developed by CMS; and

- Offers contracts in good faith to at least one ECP in each ECP category (see Table 2.2) in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type.

To be offered in good faith, an issuer should offer contract terms comparable to terms that it offers to a similarly-situated non-ECP provider, except for terms that would not be applicable to an ECP, such as by virtue of the type of services that an ECP providers. CMS expects issuers to be able to provide verification of such offers if CMS requests to verify compliance with the policy.

As in previous years, issuers will indicate which ECPs are included in their provider network(s) by populating a template as part of the QHP application. CMS will provide application materials with detailed instructions to support issuers in completing the template.

To assist issuers in identifying these providers, CMS has published an updated list of available ECPs based on data maintained by CMS and other Federal agencies, as well as provider data that CMS received directly from providers through the ECP petition process for the 2017 plan year.[25] CMS has included on the HHS ECP list for the 2017 plan year those providers that submitted an ECP petition during the ECP petition window that closed on January 15, 2016 and met the definition of an ECP under 45 CFR 156.235 through satisfaction of the following criteria:

- Provider consents to be added to or remain on the HHS ECP list for the 2017 plan year.

- Provider is either A) eligible for or participating in the 340B program or is a Rural Health Clinic or is an Indian Health Care Provider; or B) located in a low-income ZIP code or Health Professional Shortage Areas (HPSA).[26] The provider could also have been included in one of the verified datasets from HRSA, the Indian Health Service (IHS), or

[24] The model QHP Addendum for Indian health care providers is available at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

[25] The Final Non-exhaustive HHS List of ECPs for Plan Year 2017 is available at: http://cciio.cms.gov/programs/exchanges/qhp.html"Other Qualified Health Plan Application Resources under "Other Qualified Health Plan Application Resources."

[26] Based on the HHS Low-Income and Health Professional Shortage Area (HPSA) ZIP Code Listing, available at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

the Office of the Assistant Secretary for Health/Office of Population Affairs (OASH/OPA), and appears on the Draft 2017 ECP List, or the provider is a not-for-profit or governmental family planning service site that does not receive Federal funding under Title X of the PHS Act or other 340B-qualifying funding (see 45 CFR 156.235(c)).

- Provider accepts patients regardless of ability to pay and offers a sliding fee schedule, unless the provider has been included in one of the verified datasets from HRSA, IHS, or OASH/OPA and appears on the Draft 2017 ECP List, or the provider is a not-for-profit or governmental family planning service site that does not receive Federal funding under Title X of the PHS Act or other 340B-qualifying funding (see 45 CFR 156.235(c)).
- Provider accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.).
- Provider agrees to be listed in a consumer-facing directory of ECPs.
- Provider consists of one or more MDs, DOs, PAs, NPs, DMDs, or DDSs authorized by the State to independently treat and prescribe within the listed facility.
- Provider lists the number of executed contracts and good faith contract offers rejected.
- Provider completes any missing data from critical data fields on the HHS ECP list, such as the National Provider Identifiers (NPIs), points of contact (POCs), ECP category, provider site and organization addresses, and the number of full-time equivalent MDs, DOs, PAs, NPs, DMDs, and DDSs authorized by the State to independently treat and prescribe within the listed facility.

For plan year 2017 QHP certification, CMS will credit issuers for providers that the issuer selects from the final HHS ECP list and includes on the issuer's ECP template toward satisfaction of the 30 percent ECP threshold requirement.

On December 9, 2015, HHS launched its ECP petition initiative to give providers an opportunity to request to be added to our ECP list, update their provider data on our ECP list, and provide missing provider data. The web-based ECP petition link is available at https://data.healthcare.gov/cciio/ecp_petition. Given the ECP petition process designed to add qualified ECPs to the 2017 HHS ECP list, including providers that issuers may have included as ECP write-ins in previous years, CMS will offer a conditional ECP write-in process for plan year 2017. In previous years, an issuer's ECP write-ins counted toward satisfaction of the ECP standard for only the issuer that wrote in the ECP on its ECP template, resulting in a variation of the available identified ECPs for a given service area based on the number of ECP write-ins a specific issuer included on its ECP template. To ensure that the HHS ECP list more accurately reflects the universe of qualified available ECPs in a given service area, CMS intends to maintain an ongoing initiative to collect more complete provider data directly from providers through the

ECP petition process so that all issuers are held to a more uniform ECP standard in future years. CMS will allow issuers to count their qualified ECP write-ins toward satisfaction of the 30 percent ECP standard for plan year 2017 as long as the issuer arranges that the written-in provider has submitted an ECP petition to CMS by no later than August 22, 2016. CMS acknowledges that an issuer cannot force a provider to submit an ECP petition.

For plan year 2017, CMS will determine issuer satisfaction of the 30 percent ECP standard using the following calculation methodology:

- The denominator of available ECPs consists of any ECPs on the non-exhaustive final plan year 2017 HHS ECP list located within the plan's service area and any qualified ECP write-ins that the issuer has chosen to list on its ECP template, on the condition that the issuer arranges that such written-in providers have submitted an ECP petition by no later than August 22, 2016.

- The numerator of the issuer's contracted ECPs consists of any ECPs that the issuer has listed from the non-exhaustive final plan year 2017 HHS ECP list located within the plan's service area and any qualified ECP write-ins that the issuer has chosen to list on its ECP template, on the condition that the issuer arranges that such written-in providers have submitted an ECP petition by no later than August 22, 2016.

- Applicable to both the numerator and denominator, multiple providers at a single street location will count as one ECP toward the available ECPs in the plan's service area and toward the issuer's satisfaction of the ECP participation standard to ensure a sufficient number and geographic distribution of ECPs as required under 45 CFR 156.235(a).

If an issuer's application does not satisfy the 30 percent ECP standard as well as the requirement to offer contracts in good faith to all available Indian health care providers in the service area, and at least one ECP in each ECP category in each county in the service area, as described above, the issuer will be required to include as part of its application a satisfactory narrative justification describing how the issuer's provider network(s), as presently constituted, provides an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider network(s) in future years. Issuers that submit a narrative justification will do so as part of the issuer application for QHP certification.

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

- The number of contracts offered to ECPs for plan years beginning in 2017;

- The number of additional contracts that an issuer expects to offer for plan years beginning in 2017 and the timeframe of those planned negotiations;

- The names of the ECP hospitals, Federally Qualified Health Centers (FQHCs), Indian health care providers, Ryan White providers, family planning providers, and providers in the other ECP categories listed in Table 2.2 to which the issuer has offered contracts in good faith, but an agreement with the providers has not yet been reached; and

- Contingency plans for how the issuer's provider network, as currently designed, will provide adequate care to enrollees who might otherwise be cared for by relevant ECPs. For example, if available FQHCs, Indian health care providers, Ryan White HIV/AIDS Program providers, or family planning providers are missing from the network(s), the application must explain how its target populations will be served.

Table 2.2. 2017 ECP Categories and Provider Types in the FFMs.

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

Alternate ECP Standard

Issuers that qualify for the alternate ECP standard articulated in 45 CFR 156.235(a)(2) and (b) must demonstrate a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the plan's service area, in accordance with the Marketplace's network adequacy standards. CMS interprets this standard as being met if the issuer complies with the ECP standard described above, based on employed or contracted providers located in HPSAs or 5-digit low-income zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty line (FPL).

For plan year 2017, CMS will determine issuer satisfaction of the 30 percent ECP standard for issuers that qualify for the alternate ECP standard using the following calculation methodology:

- The denominator of available ECPs consists of any ECPs on the non-exhaustive final plan year 2017 HHS ECP list located within the plan's service area and any qualified ECP write-ins that the issuer has chosen to list on its ECP template (i.e., including providers employed by the issuer or providers of its contracted medical group), on the condition that the issuer arranges that such written-in providers have submitted an ECP petition by no later than August 22, 2016.

- The numerator of the issuer's employed or contracted ECPs consists of any ECPs that the issuer has listed from the non-exhaustive final plan year 2017 HHS ECP list located within the plan's service area and any qualified ECP write-ins that the issuer has chosen to list on its ECP template (i.e., including providers employed by the issuer or providers of its contracted medical group), on the condition that the issuer arranges that such written-in providers have submitted an ECP petition by no later than August 22, 2016.

- Applicable to both the numerator and denominator, multiple providers at a single street location will count as one ECP toward the available ECPs in the plan's service area and toward the issuer's satisfaction of the ECP participation standard to ensure a sufficient number and geographic distribution of ECPs as required under 45 CFR 156.235.

CMS will count allowable ECP write-ins toward satisfaction of the ECP standard for issuers that qualify for the alternate ECP standard for only those providers that are employed by the issuer or providers of its single contracted medical group that are located in a low-income ZIP code or Health Professional Shortage Area (HPSA), given that such providers generally would not appear on the HHS ECP list. In addition, such providers that the issuer writes in must not limit their practice on the basis of a particular source of coverage (e.g., Medicare, Medicaid, CHIP, private health insurance, etc.), unless limited to only the employed or contracted issuer's coverage.

To ensure that consumers experience equal access to covered benefits, regardless of whether they are enrolled in plans offered by issuers that qualify for the general or the alternate ECP standard, issuers that qualify for the alternate ECP standard must provide access to the same categories of services provided by entities in each of the ECP categories in each county in the plan's service area as issuers that qualify for the general ECP standard. In accordance with §156.235(b)(2)(ii), issuers that qualify for the alternate ECP standard must provide within the issuer's integrated delivery system all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard; or otherwise offer a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area that can provide those services to low-income, medically underserved individuals. Issuers that qualify for the alternate ECP standard

are not reviewed for compliance with the additional general ECP standard requirement of offering contracts in good faith to all available Indian health care providers.

As with the general ECP standard, an application that does not demonstrate compliance with the 30 percent ECP standard must include a narrative justification describing how the issuer's provider network(s) complies with the regulatory standard. In the context of issuers that qualify for the alternate ECP standard, an issuer's explanation in the ECP Supplemental Response Form would address how the issuer intends to ensure coverage to low-income populations residing in HPSAs or low-income zip codes in the service area(s). The explanation should describe the extent to which the issuer's provider sites are accessible to, and have services that meet the needs of, specific underserved populations, including:

- Individuals with HIV/AIDS (including those with co-morbid behavioral and mental health conditions);
- American Indians and Alaska Natives (AI/AN);
- Low-income and underserved individuals seeking women's health and reproductive health services; and
- Other specific populations served by ECPs in the service area.

CMS provides issuers with a database of zip codes listed as HPSAs or low-income areas where 30 percent or more of the population falls below 200 percent of the FPL. The database is available at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html. Issuers that qualify for the general or alternate ECP standard would use this same HPSA and low-income zip code database as well as the same template to complete the ECP section of the application.

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

ii. Evaluation of Network Adequacy with respect to dental ECPs

For plan years beginning in 2017, CMS will utilize a general ECP enforcement standard for SADPs whereby it will consider the issuer to have satisfied the regulatory standard if an application demonstrates satisfaction of the following criteria:

- Offers a contract in good faith to at least 30 percent of available ECPs in each plan's service area to participate in the plan's provider network; and
- Offers a contract in good faith to all available Indian health care providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, applying the special terms and conditions necessitated by Federal

law and regulations as referenced in the recommended model QHP Addendum[27] for Indian health care providers developed by CMS.

To be offered in good faith, a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted. CMS expects issuers to be able to provide verification of such offers if CMS requests to verify compliance with the policy.

As in previous years, issuers will indicate which ECPs are included in their provider network(s) by populating a template as part of the QHP application. CMS will provide application materials with detailed instructions to support issuers in completing the template.

For the same reasons described above for medical QHPs, CMS intends to maintain for SADPs an ongoing initiative to collect more complete dental provider data directly from dental providers through the ECP petition process so that all issuers are held to a more uniform ECP standard. CMS will offer a conditional ECP write-in process that will allow issuers to count their qualified ECP write-ins toward satisfaction of the 30 percent ECP standard for plan year 2017 on the condition that the issuer has arranged that the written-in dental provider has submitted an ECP petition to CMS by no later than August 22, 2016.

For plan year 2017, CMS will determine SADP issuer satisfaction of the 30 percent ECP standard using the following calculation methodology:

- The denominator of available dental ECPs consists of any ECPs on the non-exhaustive final plan year 2017 HHS ECP list located within the plan's service area and any qualified ECP write-ins that the issuer has chosen to list on its ECP template, on the condition that the issuer has arranged that such written-in providers have submitted an ECP petition by no later than August 22, 2016.
- The numerator of the issuer's contracted dental ECPs consists of:
    - Any ECPs that the issuer has listed from the non-exhaustive final plan year 2017 HHS ECP list located within the plan's service area;
    - Any qualified ECP write-ins that the issuer has chosen to list on its ECP template, on the condition that the issuer has arranged that such written-in providers have submitted an ECP petition by no later than August 22, 2016; and
    - The number of good faith contract offers extended to dental ECPs on the HHS ECP list located in the plan's service area that were rejected by the provider and identified by the issuer within its narrative justification.

[27] The model QHP Addendum for Indian health care providers is available at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

- Applicable to both the numerator and denominator, multiple dental providers at a single street location will count as one ECP toward the available ECPs in the plan's service area and toward the issuer's satisfaction of the ECP participation standard to ensure a sufficient number and geographic distribution of ECPs as required under 45 CFR 156.235.

If an issuer's application does not satisfy the 30 percent ECP standard based on its contracted providers listed on its ECP template as well as the requirement to offer contracts in good faith to all available Indian health care providers in the service area, CMS will require the issuer to include as part of its application a satisfactory narrative justification that consists of a listing of good faith contract offers extended to dental ECPs on the HHS ECP list located in the plan's service area that were rejected by the provider. The issuer's justification should describe how the issuer's provider network(s), as presently constituted, provides an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider network(s) in future years.

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

- The number of contracts offered to ECPs for plan years beginning in 2017;
- The number of additional contracts that an issuer expects to offer for plan years beginning in 2017 and the timeframe of those planned negotiations;
- The names of the dental ECPs to whom the issuer has offered contracts in good faith, but an agreement with the providers has not yet been reached; and
- Contingency plans for how the issuer's provider network, as currently designed, will provide adequate care to enrollees who might otherwise be cared for by relevant ECPs.

An SADP issuer that submits a narrative justification would do so as part of the issuer's application for QHP certification.

iii. Requirements for Payment to FQHCs

We reiterate the importance of issuers complying with 45 CFR 156.235(e) regarding payment to FQHCs. For covered services provided by an FQHC, QHP issuers must pay an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service, as specified in section 1302(g) of the Affordable Care Act. Section 156.235(e) does allow the QHP issuer and FQHC to agree upon payment rates other than those that would have been paid to the FQHC under section 1902(bb) of the Social Security Act, as long as such agreed upon rates are at least equal to the generally applicable payment rates of the issuer. We note that State law may define covered services for closed-panel HMO plans to be limited to those services provided by in-network providers. In such cases, this requirement would not apply to non-covered services, which would include non-

emergent out-of-network services if provided by FQHCs if such services are not treated under State law as covered services. Otherwise, we would expect issuers to pay FQHCs for covered services in accordance with section 1902(bb) of the Social Security Act. We encourage issuers and FQHCs, as well as other ECPs, to develop mutually beneficial business relationships that promote effective care for medically underserved and vulnerable populations. We intend to assess available data to understand the degree to which such patients are cared for effectively and to inform our future regulatory approach.

Section 5. Accreditation

This section describes how CMS will conduct a review of the accreditation standards necessary for QHP certification. States performing plan management functions in the FFMs may use a similar approach. This section does not apply to SADPs.

45 CFR 155.1045(b) establishes the timeline by which QHP issuers offering coverage in the FFMs must be accredited. In 2017, CMS is continuing its phased approach to accreditation for QHP issuers in an FFM. The accreditation requirements for QHP issuers entering their fourth year of certification are described in 45 CFR 156.275(a), which State that QHP issuers must be accredited on the basis of local performance of its plans based on clinical quality measures, patient experience ratings, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.

As previously stated, QHP issuers in their second or third year of certification must be accredited. The accreditation requirements for QHP issuers entering their third year of certification are provided under 45 CFR 155.1045(b)(2) and are described further in the 2016 Letter to Issuers. The accreditation requirements for QHP issuers entering their second year of certification are provided under 45 CFR 155.1045(b)(2) and are described further in the 2015 Letter to Issuers. Issuers entering their initial year of QHP certification for plan years beginning in 2017 (i.e., issuers that did not offer a QHP a previous year) must meet the requirement at 45 CFR 155.1045(b)(1), but may submit accreditation information for display if they have existing accreditation. CMS reviews issuers that crosswalk enrollees to a new HIOS ID for accreditation based on their cumulative years of certification.

As CMS required in 2016, QHP issuers that are required to be accredited must attest that they meet the standards under 45 CFR 155.1045 (b)(2) and authorize the release of their accreditation information as stated in 45 CFR 156.275 (a)(2). CMS will apply the timeline in 45 CFR 155.1045(b) by looking at the issuer’s accreditation status 90 days prior to open enrollment. CMS will not consider an issuer accredited if the accreditation review is scheduled or in process.

In addition to the attestations noted above, issuers must provide information about their accreditation status to determine if the standard in 45 CFR 155.1045(b) is met, including information on their accrediting entity and status. This information will be verified with the

indicated accrediting entity. The National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC) have been recognized by CMS as accrediting entities for the purpose of QHP certification. The issuer will be asked for information related to accreditation of their commercial, Medicaid, or Marketplace products, if appropriate, to show compliance with 45 CFR 155.1045(b).

CMS will consider issuers in their first, second or third year of QHP certification accredited if the QHP issuer is accredited with the following status: by AAAHC with "Accredited" status; by NCQA with "Excellent," "Commendable," "Accredited," "Provisional," or "Interim" status; or by URAC with "Full," "Provisional," or "Conditional" status.

CMS will consider issuers in their fourth year of QHP certification accredited if the QHP issuer is accredited with the following status: by AAAHC with "Accredited" status; by NCQA with Marketplace accreditation and "Excellent," "Commendable," "Accredited," or "Provisional," status; or by URAC with Marketplace accreditation and "Full" or "Conditional" status.

Section 6. Patient Safety Standards for QHP Issuers

This section describes how CMS will review issuer compliance with the patient safety standards for purposes of QHP certification. States performing plan management functions may use a similar approach. SADP issuers will not be reviewed for patient safety standards compliance in 2017. For 2017, we finalized proposals to strengthen the patient safety standards for QHP issuers, which are detailed in the 2017 Payment Notice Final Rule.

As outlined in 45 CFR 156.1110(a)(2), there are new standards for QHP issuers to demonstrate compliance with the patient safety standards for coverage beginning on or after January 1, 2017. Specifically, the regulatory amendments direct QHP issuers that contract with a hospital with more than 50 beds to verify that the hospital utilizes a patient safety evaluation system as defined in 42 CFR 3.20[28] and has implemented a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient.

If the applicable network hospital does not have a current agreement, or other information demonstrating a partnership with a Patient Safety Organization (PSO), based on the reasonable exceptions provision that CMS finalized in 45 CFR 156.1110(a)(2)(ii), a QHP issuer may verify that the hospital has implemented an evidence-based initiative to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination. In this case if a contracted hospital is implementing an evidence-based initiative other than working with a PSO,

[28] A patient safety evaluation system is defined as "the collection, management, or analysis of information for reporting to or by a Patient Safety Organization (PSO)."

a QHP issuer is required to collect and maintain documentation such as hospital attestations or current agreements to partner with a Hospital Engagement Network (HEN) or a Quality Improvement Organization (QIO). In addition, CMS strongly supports hospital tracking of patient safety events using the Agency for Healthcare Research and Quality (AHRQ) Common Formats[29] whether a hospital chooses to work with a PSO as described in proposed 45 CFR 156.1110(a)(2)(i)(A) or implements the alternative approach proposed in 45 CFR 156.1110(a)(2)(ii).

As part of the certification for plan years beginning in 2017, QHP issuers are required to demonstrate compliance with the patient safety standards that are finalized in the 2017 Payment Notice along with the QHP application affirming they have collected and are maintaining the required documentation from their network hospitals.

Section 7. Quality Reporting

This section describes how CMS will review QHP issuer compliance with the quality reporting standards related to the Quality Rating System (QRS) and the QHP Enrollee Experience Survey (QHP Enrollee Survey) for purposes of QHP certification. For the QRS and QHP Enrollee Survey requirements, States performing plan management functions in State Partnership States may use a similar approach. Child-only plans and SADPs are not subject to these quality reporting standards at this time.[30] CMS will continue to monitor the number of child-only QHPs in Marketplaces. A limited number of child-only QHPs and enrollees may prohibit reliable child-only QRS rating calculations and QHP Enrollee Survey results. CMS will continue to monitor child-only and SADP plan types and will consider developing a quality rating system and QHP Enrollee Survey for these in the future.

i. QHP Issuer Data Collection and Reporting Requirements

QHP issuers that meet participation criteria are required to comply with standards and requirements related to quality reporting for QHPs offered on Marketplaces through implementation of the QRS pursuant to 45 CFR 156.1120, and the QHP Enrollee Survey pursuant to 45 CFR 156.1125.[31] Consistent with 45 CFR 156.200(b)(5), QHP issuers will be

[29] See https://www.pso.ahrq.gov/common.

[30] A limited number of child-only QHPs and enrollees may prohibit reliable child-only QRS calculations and QHP Enrollee Survey results. CMS will continue to monitor child-only and SADP plan types in Marketplaces and will consider developing a quality rating system and a QHP Enrollee Survey for them in the future.

[31] See Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, 79 Federal Register 30240 (May 27, 2014); codified at 45 CFR Parts 144, 146, 147, et al.

required to attest that they comply with the specific quality reporting and implementation requirements related to the QRS and QHP Enrollee Survey as part of certification process for the 2017 plan year. QHP issuers offering coverage through the Marketplaces must collect and submit validated clinical quality measure data and QHP Enrollee Survey response data, on a timeline and in a standardized form and manner specified by CMS, to support the calculation of QRS ratings.[32] QHP issuers are also required to contract with and authorize an HHS-approved QHP Enrollee Survey vendor to collect and submit QHP Enrollee Survey response data on their behalf. CMS anticipates issuing technical guidance at least annually that will detail requirements for the QRS and QHP Enrollee Survey including the standards related to data collection, validation and submission, as well as the minimum enrollment and other participation criteria. CMS anticipates issuing technical guidance for 2017 data submissions in the fall of 2016.

Using the QHP issuer's validated QRS clinical measure data and QHP Enrollee Survey response data submitted in the 2016 calendar year, CMS will use the QRS rating methodology to calculate 2016 QRS ratings (on a 5-star scale) and 2016 QHP Enrollee Survey results for each reporting unit.[33] CMS will assign these 2016 ratings to each QHP issuer's product type offered through a Marketplace during the individual market open enrollment period for 2017. QHP issuers will have an opportunity to review their QRS and QHP Enrollee Survey results and submit inquiries during an established preview period each year prior to public display of results. In addition, CMS intends to work with QHP issuers to provide appropriate technical assistance and will issue further information on the timelines for release of QRS ratings.

QHP issuers may reference their respective QRS scores and ratings, as well as QHP Enrollee Survey results, in a manner specified by CMS.[34,35] A QHP issuer that elects to include QRS

[32] 45 CFR 156.1120 and 45 CFR 156.1125

[33] For 2016 reporting, QHP issuers were required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data by product type (i.e., EPO, HMO, POS, PPO, indemnity), with separate submissions by State, for each product type offered through a Marketplace in 2016 that was also offered in 2015 and that had more than 500 enrollees as of July 1, 2015. Therefore, the reporting unit for the 2016 QRS and QHP Enrollee Survey data submissions is defined by the unique State-product type for each QHP issuer. For further details on the 2016 QRS and QHP Enrollee Survey requirements, please see the "Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016," available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-and-QHP-Enrollee-Experience-Survey-Technical-Guidance-for-2016.pdf.

[34] 45 CFR 156.1120(c) and 156.1125(c).

[35] QHP issuers may not use QRS and QHP Enrollee Survey 2015 beta test results in marketing materials. QHP issuers may begin including 2016 QRS and QHP Enrollee Survey results in marketing materials for 2017 plan year coverage.

and/or QHP Enrollee Survey results in its 2017 plan year marketing materials must do so in a manner that does not mislead consumers and in accordance with all applicable Federal and State requirements. Additional CMS guidelines related to the use of the 2016 QRS and/or QHP Enrollee Survey results in 2017 plan year marketing materials are included in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016*.

ii. Marketplace Oversight & Display Requirements

Consistent with 45 CFR 155.200(d), Marketplaces are required to oversee the implementation of the QRS and QHP Enrollee Survey. Beginning in the 2016 calendar year, and on an annual basis thereafter, all Marketplaces must prominently display QHP quality rating information (e.g., QRS and QHP Enrollee Survey results) on their respective websites, as calculated by CMS and in a form and manner specified by CMS.[36] Guidance related to the Marketplace display requirements for 2016 QRS and QHP Enrollee Survey results during the individual market open enrollment period for 2017 is included in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016*.

Beginning in the 2016 calendar year, CMS will publicly display QHP quality rating information on HealthCare.gov to help consumers compare QHPs in time for the individual market open enrollment period for 2017. CMS will display QRS rating information in a clear, understandable manner that has been consumer-tested. In addition, appropriate language (e.g., Not Rated) will be displayed if there is insufficient data for public reporting. CMS will display the 2016 QRS global rating and is considering displaying additional QRS rating information (i.e. summary indicator ratings) for each QHP offered through HealthCare.gov. This includes SBM-FPs. SBMs that do not rely on the Federal Platform are also required to display QHP quality rating information calculated by CMS, and in a form and manner specified by CMS, on their respective websites in the 2016 calendar year to facilitate consumer shopping for the 2017 plan year.

Section 8. Quality Improvement Strategy Requirements

This section describes how CMS will review QHP issuer compliance with the quality reporting standards related to the Quality Improvement Strategy (QIS) for purposes of QHP certification. For the QIS requirements, States performing plan management functions in State Partnership States must evaluate the QIS submissions of the QHP issuers offering coverage through their States using the federal QIS evaluation methodology; however, issuers should contact their States for additional details.

Section 1311(c)(1)(E) of the Affordable Care Act specifies that, to be certified as a QHP for participation through a Marketplace, each QHP issuer must implement a QIS, as described in section 1311(g)(1) of the Affordable Care Act. The 2016 Payment Notice Final Rule established

[36] 45 CFR 155.1400 and 155.1405.

standards and requirements related to issuer implementation and reporting of a QIS for eligible QHPs in every Marketplace at 45 CFR 156.1130. All issuers offering QHPs through the Marketplaces that meet participation criteria must comply with the QIS requirements as a condition of certification and participation in the Marketplaces. 45 CFR 156.200(b) directs issuers to implement and report on a quality improvement strategy or strategies consistent with the standards in section 1311(g). Consistent with 45 CFR 156.200(b)(5), issuers will attest that they comply with the specific requirements related to the implementation of quality improvement strategies to demonstrate compliance with QIS requirements as part of the certification process for the 2017 plan year. In addition, QHP issuers must submit a QIS to the Marketplace for the 2017 plan year if they meet participation criteria. This aligns with the standards in section 1311(g)(3), which requires periodic reporting to the applicable Marketplace, and 45 CFR 155.200(d), which directs Marketplaces to evaluate quality improvement strategies.

Section 1311(g)(2) of the Affordable Care Act directs the Secretary, in consultation with experts in health care quality and stakeholders, to develop guidelines concerning the implementation and oversight of quality improvement strategies. Based on that authority and building on the regulations outlined in the 2016 Payment Notice Final Rule, CMS published the Quality Improvement Strategy: Technical Guidance and User Guide for the 2017 Coverage Year (QIS Technical Guidance) and the QIS Implementation Plan and Progress Report form on the CMS Marketplace Quality Initiatives website in November 2015.[37] The QIS Technical Guidance provides details about the QIS, including a policy overview, Marketplace oversight responsibilities, issuer participation criteria, reporting requirements and data collection (via the QIS Implementation Plan and Progress Report form), evaluation process and methodology, and a step-by-step guide for issuers on how to complete the data collection form.

As detailed in the QIS Technical Guidance, issuers must submit a QIS to the Marketplace for the 2017 plan year if they offered coverage through the Marketplace in 2014 and 2015, provide family and/or self-only medical coverage, and meet the QIS minimum enrollment threshold. An issuer meets the QIS minimum enrollment threshold if it had more than 500 enrollees within a product type as of July 1, 2015. All eligible QHPs within eligible product types (e.g., HMO, PPO) must be included in a QIS.

The QIS requirements apply to all issuers offering QHPs and MSP options through Marketplaces, whether through the individual Marketplace or through the SHOP Marketplace. At

[37] Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QIS-Technical-Guidance-and-User-Guide.pdf and http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

this time, the QIS reporting requirements do not extend to child-only plans, SADPs, or QHPs that are compatible with HSAs.

To meet the QHP certification standard related to QIS requirements, issuers may choose to either implement one QIS that applies to all of their eligible QHPs in a given Marketplace, or implement more than one QIS to cover all of their eligible QHPs in a given Marketplace. A QIS does not have to address the needs of all enrollees in a given QHP offered through a Marketplace. Depending on the rationale an issuer provides in its QIS submission, a QIS may address a sub-population of a QHP's enrollee population, based on the subpopulation's identified needs.

Issuers applying for QHP certification in the FFMs for the 2017 plan year that meet the QIS participation criteria are expected to submit the QIS Implementation Plan portion of the QIS Implementation Plan and Progress Report form to the relevant Marketplace during the 2017 QHP Certification process, which occurs in calendar year 2016, and then implement the QIS beginning no later than January 2017. An issuer must submit a Progress Report to the FFMs through which it offers QHPs during the QHP Certification process in the year after the issuer submitted its QIS Implementation Plan. The QIS evaluation process for the FFMs will take place annually as part of the QHP Certification process.

All Marketplaces are required to evaluate an issuer's QIS, and issuers must submit separate QIS submissions by State.

- CMS will evaluate the QIS submissions for issuers applying to offer QHPs in FFM States.

- In States performing plan management functions, issuers applying to offer QHPs will undergo a joint review of their QIS submissions by the State and the FFM with final determination being made by the FFM.

- SBMs, including SBM-FPs, will evaluate the strategies of the issuers applying to offer QHPs in their respective Marketplaces. SBMs must comply with the federal minimum reporting requirements. They may establish their own reporting forms and evaluation methodologies that exceed the federal minimum, as well as their own reporting manner and frequency requirements; or they may choose to use those established by CMS for the FFMs.

- OPM will evaluate QIS submissions for MSP products for all Marketplaces and will issue technical guidance to issuers. For more information on requirements for MSP issuers, issuers should visit: http://www.opm.gov/healthcare-insurance/multi-state-plan-program/issuer/. OPM will post specific instructions regarding the 2017 application when available.

Issuers applying to offer QHPs in SBM States should contact the States to confirm timing and whether there are any State-mandated QIS requirements beyond the federal minimum requirements.

Section 9. Review of Rates

This section pertains to QHP rate filings. Additional information is available in 45 CFR Part 154.

As required by 45 CFR 155.1020(a), a Marketplace must ensure that a QHP issuer submits a justification for a rate increase and prominently posts the justification on its website as required under 45 CFR 156.210. In addition, 45 CFR 155.1020(b) requires a Marketplace to consider all rates increases when certifying plans as QHPs. CMS works with States to review rate increases for QHPs seeking certification to participate in the FFM. States performing plan management functions in an FFM may use a similar approach.

As finalized in the 2017 Payment Notice Final Rule, for 2017 plans, a health insurance issuer must submit the Unified Rate Review Template (Part I of the Rate Filing Justification) for all single risk pool plans, including plans with rate increases, rate decreases, no rate change, and new plans. The 2017 Payment Notice also amends 45 CFR 154.200(c)(2) such that a rate increase is subject to review if the average increase, including premium rating factors described in 45 CFR 147.102 for all enrollees, weighted by premium volume for any plan within the product, is 10 percent or more.

When reviewing rate increases, CMS will consider:

- Issuers' data and actuarial justification provided in the Rate Filing Justification;
- Other information submitted as part of a filing under an Effective Rate Review program;
- Recommendations by applicable State regulators about patterns or practices of excessive or unjustified rate increases and whether or not particular issuers should be excluded from participation in the Marketplace; and
- Any excess of premium rate growth outside the Marketplace as compared to growth inside the Marketplace.

CMS does not plan to duplicate reviews by States to enforce State law, and will integrate State and other CMS rate reviews into its QHP certification process, provided that States provide information to CMS consistent with Federal standards and agreed-upon timelines. CMS will post the information contained in Parts I, II, and III of each Rate Filing Justification that is not a

trade secret or confidential commercial or financial information, as defined by HHS Freedom of Information Act regulations.[38]

Section 10. Discriminatory Benefit Design

This section addresses how CMS will review health plans applying to be QHPs or SADPs in the FFMs for compliance with nondiscrimination standards. States performing plan management functions may use a similar approach.

i. EHB Discriminatory Benefit Design

Non-discrimination in benefit design with respect to EHB is a market-wide consumer protection that applies inside and outside of Marketplaces for non-grandfathered health insurance plans offered in the individual and small group markets. As stated in 45 CFR 156.125(a), an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates 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.

Issuers must use the 2017 benchmark plans,[39] which are based on 2014 plans, when designing their plans. CMS continues to caution both issuers and States that age limits may potentially be discriminatory when applied to services that have been found clinically effective at all ages. For example, it might be arbitrary to limit coverage for a hearing aid to enrollees who are 6 years of age and younger since there may be some older enrollees for whom a hearing aid is medically necessary. Although CMS does not enumerate which benefits fall into each statutory EHB category, issuers should not attempt to circumvent coverage of medically necessary benefits by labeling the benefit as a "pediatric service," thereby excluding adults. CMS also cautions issuers to avoid discouraging enrollment of individuals with chronic health needs. For example, if an issuer does not cover a single-tablet drug regimen or extended-release product that is customarily prescribed for HIV patients and is just as effective as a multi-tablet regimen, absent an appropriate reason for the exclusion (such as a substantial difference in the cost of the two regimens), such a plan design might effectively discriminate against, or discourage enrollment by, such HIV patients would benefit from such innovative therapeutic options. As another example, if an issuer places most or all drugs that treat a specific condition on the highest cost formulary tiers, that plan design might effectively discriminate against, or discourage enrollment by, individuals who have those conditions.

[38] 45 CFR 5.65.

[39] More information on the benchmark plans is available at: https://www.cms.gov/cciio/resources/data-resources/ehb.html.

The enforcement of this standard is largely conducted by States. CMS encourages States that are enforcing the Affordable Care Act to consider a number of strategies for assessing compliance with this standard including, but not limited, to analysis of information entered in the "explanations" and "exclusions" sections of the QHP Plans and Benefits Template.

Because the nondiscrimination provisions are related to many requirements under the joint interpretive jurisdiction of the Departments of HHS, Labor, and the Treasury (the Departments), HHS will consult with relevant Federal agencies, such as the Departments of Labor and the Treasury, as necessary in developing new guidance related to discriminatory benefit designs.

As noted previously, we remind issuers that certain other Federal civil rights laws impose non-discrimination requirements. Issuers that receive Federal financial assistance, including in connection with offering a QHP on a Marketplace, are subject to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973, and section 1557 of the Affordable Care Act. The Office for Civil Rights (OCR), which enforces these provisions, published a proposed rule on the requirements of section 1557.[40] Issuers that intend to seek certification of one or more QHPs are directed to that proposed rule and to http://www.hhs.gov/ocr/civilrights for additional information.

ii. QHP Discriminatory Benefit Design

For purposes of QHP certification, CMS will assess compliance with this standard by collecting an attestation that issuers' QHPs will not discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation, consistent with 45 CFR 156.200(e). CMS will continue to assess compliance through issuer monitoring and compliance reviews, including analysis of appeals and complaints.

In addition to complying with EHB non-discrimination standards identified above, QHPs must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs pursuant to 45 CFR 156.225. As in prior QHP certification review cycles, CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance). CMS's outlier analysis will compare benefit packages with comparable cost-sharing structures to identify cost-sharing outliers with respect to specific benefits.

In reviewing a plan's cost-sharing structure, CMS will analyze information contained in the Plans and Benefits Template, including the "explanations" and "exclusions" sections, with the

[40] Nondiscrimination in Health Programs and Activities, 80 Federal Register 54172 (Sept. 8, 2015) (regarding categorical exclusions of coverage for all health services related to gender transition and denials or limitations of coverage for specific health services related to gender transition that result in discrimination against a transgender individual).

objective of identifying discriminatory features or wording. Discriminatory cost sharing language would typically involve reduction in the generosity of a benefit in some manner for subsets of individuals for reasons not clearly based on common medical management practices.

CMS will conduct a review of each QHP to identify outliers based on estimated out-of-pocket costs associated with the standard treatment protocols for medical services and drug regimens needed to treat certain chronic and high cost medical conditions. These protocols are based upon nationally recognized clinical guidelines. The medical conditions included in the 2017 plan year review will include: bipolar disorder, diabetes, HIV, rheumatoid arthritis, and schizophrenia. QHPs with unusually high estimated out-of-pocket costs associated with accessing these required benefits when compared to similar type plans, at the State and national level, will be flagged as outliers. Other medical conditions may be considered as part of future reviews. In addition, CMS cautions issuers that the mere fact that a benefit design is similar to other benefit designs offered in a market does not establish that the benefit design is non-discriminatory. CMS retains the right to identify a benefit design as discriminatory even if it is not flagged in the outlier analysis.

CMS will notify an issuer when it sees an indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices. CMS conducts this examination whenever a plan required to cover EHB reduces those benefits for a particular group. Issuers are expected to impose limitations and exclusions, if any, based on clinical guidelines and medical evidence, and are expected to use reasonable medical management. Issuers may be asked to submit justification with clinical supporting evidence. CMS will review the supporting documentation and determine if the plan design is discriminatory.

Section 11. Prescription Drugs

To help ensure that QHPs are in compliance with 45 CFR 156.125 and 45 CFR 156.225, CMS will conduct the following reviews as part of the 2017 QHP certification process. If CMS identifies a QHP for follow-up based on these reviews, CMS will offer the issuer the opportunity to resolve the identified deficiency as part of the certification process. CMS will offer the issuer the opportunity to submit a justification with supporting documentation or to make a change to its application to address the concern.

i. Formulary Outlier Review

CMS will perform an outlier analysis of each QHP issuer's formulary drug list where plans are compared to other plans seeking certification to be offered through an FFM and flagged when identified as outliers. The outlier calculation includes both State-level and national lower outlier threshold values. CMS requires that QHPs meet or exceed both threshold values. QHPs that are outliers have an unusually high number of drugs that are subject to prior authorization or step

therapy requirements in a particular United States Pharmacopeia (USP) category and class. CMS also encourages States performing plan management functions to implement this type of review.

ii. Clinical Guideline-Based Review of Prescription Drug Coverage

As we have in prior years, based on data submitted by issuers in the prescription drug template, CMS will analyze the availability of drugs recommended by nationally recognized clinical guidelines used in the treatment of specific medical conditions. The medical conditions included in the review include the following: bipolar disorder, breast cancer, diabetes, hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia. In addition to analyzing the appropriate coverage of drugs recommended by the clinical guidelines, the review will also analyze cost-sharing requirements associated with these drugs so that they are not used to dissuade consumers with such conditions from enrolling in the QHP. Other additional medical conditions may be considered as part of future reviews.

iii. Review of Tier Placement of Prescription Drugs Recommended for Treatment of Specific Medical Conditions

CMS is concerned about adverse tiering, which occurs when a formulary benefit design assigns most or all drugs in the same therapeutic class needed to treat a specific chronic, high-cost medical condition to a high cost-sharing tier. Since adverse tiering is potentially discriminatory, this review may examine the tier placement of prescription drugs to determine whether QHPs are also consistently placing drugs used to treat these medical conditions on a high cost-sharing tier.

Section 12. Supporting Informed Consumer Choice/Meaningful Difference

This section describes how CMS plans to conduct reviews of the meaningful difference standard for QHP certification in 2017. States performing plan management functions in the FFMs may use a similar approach. This section does not apply to SADPs.

For 2017, CMS intends to apply more standardized criteria than previous years in assessing whether plans proposed to be offered by potential QHP issuers are meaningfully different from other plans the issuer has submitted for certification. In the 2017 Payment Notice Final Rule, CMS removed the following criteria in assessing whether a reasonable consumer would be able to identify one or more material differences between a plan and other plan offerings: Health Savings Account eligibility, self-only plan offering and non-self-only plan offering.

CMS will consider plans within the same metal level and service area to be meaningfully different on the basis of different plan type or different child-only plan offering status, in accordance with requirements in 45 CFR 156.298. For review purposes, CMS will organize an issuer's proposed QHPs from a given State into subgroups based on plan type, metal level, and child-only plan offering status, and overlapping counties/service areas.

Second, CMS will review each subgroup to determine whether the potential QHPs in that subgroup differ from each other based on the criteria of one or more material differences in cost sharing, provider networks, and covered benefits.

Cost Sharing

For plans to be considered materially different on the basis of cost sharing, QHPs within the subgroup must differ in at least one of the following ways: 1) having an integrated medical and drug maximum-out-of-pocket limit (MOOP); 2) having an integrated medical and drug deductible; 3) having multiple in-network tiers rather than only one; 4) $500 or more difference in MOOP; or 5) $250 or more difference in deductible.

CMS will not consider the following criteria in determining whether plans are meaningfully different: 1) having an in-network deductible rather than only a combined in/out-of-network deductible; and 2) having an in-network maximum-out-of-pocket (MOOP) rather than only a combined in/out-of-network MOOP.

Provider Networks

For plans to be considered materially different on the basis of provider networks, the plans within the subgroup must have different provider network IDs.

Covered Benefits

For plans to be considered materially different on the basis of covered benefits, the plans within the subgroup must differ in the coverage of one or more benefits that display to consumers on the HealthCare.gov website. Plans will be considered meaningfully different if they vary in the coverage of at least one of the following benefits that display on the website: Skilled Nursing Facility; Chiropractic Care; Habilitation Services; Routine Eye Exam (Adult); Routine Dental Services (Adult); Basic Dental Care – Adult; Major Dental Care – Adult; Orthodontia – Adult; Dental Check-Up for Children; Basic Dental Care – Child; Major Dental Care – Child; Orthodontia – Child; Hearing Aids; Infertility Treatment; Private-Duty Nursing; Bariatric Surgery; or Acupuncture. Note that QHPs must cover benefits required to provide EHB based on the applicable benchmark in their State.

If CMS finds that two or more plans within a subgroup do not differ based on at least one of the factors of cost sharing, provider networks or covered benefits as specified above, then those QHPs would be flagged as not being meaningfully different. If CMS flags potential QHPs as not meaningfully different, the issuer would be given the opportunity to amend its submission for one or more of the identified health plans. Alternatively, the issuer would be able to submit a justification to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP.

Section 13. Third Party Payment of Premiums and Cost Sharing

In the 2017 Payment Notice Final Rule, we finalized amendments to 45 CFR 156.1250, governing requirements related to QHP and SADP issuers' acceptance of third party payments of premiums on behalf of enrollees. First, we finalized an amendment to 45 CFR 156.1250(c) to include under "Federal and State government programs," programs of the political subdivisions of the State, namely counties and municipalities. In other words, QHP and SADP issuers in the individual market will be required to accept third party payments from Federal, State, and Local government programs.

We also finalized an amendment to 45 CFR 156.1250. Under a new provision at 45 CFR 156.1250(a)(3), we require that if a Federal, State, and Local government program administers premium and/or cost-sharing assistance through grantees or sub-grantees, then QHP and SADP issuers are required to accept these third party payments from the grantees or sub-grantees on behalf of plan enrollees. In this case, because the source of the premium or cost-sharing assistance is the government program, and administration or distribution of that assistance through grantees and/or sub-grantees is directed by the government program, the requirement for issuers to accept the payments falls under 45 CFR 156.1250.

The same grantee/sub-grantee payment structure is utilized by the Ryan White HIV/AIDS programs, which administer funds through sub-grantees that are not government entities. These programs operate by working with cities, States, and local community-based organizations to provide services in line with their statutory authority. Sections 2604(c)(3)(F), 2612(c)(3)(F), and 2651(c)(3)(F) of the PHS Act authorize Ryan White HIV/AIDS program grantees and sub-grantees to use program funds for premium and cost-sharing assistance. These grantees and sub-grantees must provide the assistance through third-party payments as they are prohibited from making payments directly to patients.

In the Final Rule, we clarified that that while issuers offering individual market QHPs, including SADPs, generally do not collect cost-sharing payments, their downstream entities, or agents of the issuer, are required to accept third party cost-sharing payments made by the entities listed at §156.1250(a) on behalf of QHP enrollees if the downstream entities or agent routinely accept cost-sharing payments from enrollees. We clarified in response to comments, that an agent of the QHP issuer with a mail order pharmacy, such as a PBM with a mail order pharmacy, must accept the third party cost-sharing payments directly from the entities listed at §156.1250(a). With respect to third party payments from entities other than those listed at 45 CFR 156.1250, we refer issuers to our February 7, 2014 FAQ guidance document.

Section 14. Cost-Sharing Reductions

QHP issuers are required under 45 CFR 156.420 to submit three plan variations with reduced cost sharing for each silver level QHP an issuer offers through the Marketplace, as well as zero

and limited cost-sharing plan variations for all metal-level QHPs an issuer offers through the Marketplace. This section does not apply to SADPs, as cost-sharing reductions do not apply to SADPs. In the 2017 certification cycle, CMS will continue to review QHP applications for compliance with Part 156, subpart E.

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

- Meet 2017 AV requirements;
- Do not have an annual limitation on cost sharing that exceeds the permissible threshold for the specified plan variation, as finalized in the 2017 Payment Notice Final Rule. For 2017, the reduced maximum annual limitation for self-only coverage is $2,350 for 94% and 87% plan variations, and $5,700 for the 73% plan variation.
- Are designed such that the cost sharing for enrollees under any silver plan variation for an EHB (or non-EHB, under the non-EHB out-of-pocket policy at 45 CFR 156.420(d)[41]) does not exceed the corresponding cost sharing in the standard silver plan or any other silver plan variation of the standard silver plan with a lower AV. For example, if an enrollee in a 87 percent plan variation pays a $40 co-pay for a specialist visit, the specialist visit co-payment for an enrollee in the associated 94 percent plan variation must be less than or equal to $40.
- Are designed such that no individual member of an enrollment group is charged more cost sharing than the 2017 maximum annual limitation on cost sharing for individuals or, as applicable, the 2017 reduced maximum annual limitation on cost sharing for individuals.
- Are designed such that zero cost-sharing plan variations may not have positive cost sharing for any covered EHB, either in or out-of-network. This includes any copayment, coinsurance, deductible, or application of an annual limitation on cost sharing.[42]
- Are designed such that, for limited cost-sharing plan variations and zero cost-sharing plan variations, the cost-sharing values (for example, copayment and/or coinsurance) for a

[41] To simplify benefit design, issuers may reduce out-of-pocket spending for non-EHB for enrollees in plan variations, so that they no longer equal non-EHB out-of-pocket in the associated standard plan. However, such non-EHB cost-sharing reductions are not eligible for HHS reimbursement.

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

non-EHB are the same or less than the values for the non-EHB under the associated standard plan.

Section 15. Data Integrity Tool

This section describes the Data Integrity Tool and the data integrity reviews that CMS will conduct for 2017 QHP applications.

The Data Integrity Tool is a publicly available Excel-based tool that allows issuers to check that the data contained in their QHP templates is in the correct format and conforms to validity checks that CMS will conduct upon submission. Running the QHP templates through the Data Integrity Tool provides issuers immediate feedback regarding the quality of their templates before uploading the final versions into HIOS or SERFF, potentially reducing the need for rework and resubmission. It should be noted that the tool does not replicate all HIOS and SERFF validations and that the tool contains many checks necessary for correct template submissions that are not performed by either HIOS or SERFF.

CMS expects issuers to use the Data Integrity Tool in 2016 for plan years beginning in 2017 because it is in the best interest of both the issuers and CMS. Issuers that choose not to use the Data Integrity Tool should contact their CMS Account Manager in advance of the QHP submission and discuss why they are not using it. Issuers that do not use the Data Integrity Tool risk that their plan information will not display properly on Plan Compare, including that their plans will not be displayed at all due to data errors.

QHP and SADP issuers can use the Data Integrity Tool, which runs checks specific to individual and SHOP market plans. CMS will release an updated version of the Data Integrity Tool that will incorporate validations specific to the 2017 QHP application templates.

CMS will conduct data integrity reviews on all QHP and SADP applications for plan years beginning in 2017. During each review round, CMS will send issuers notices of data integrity errors that would result in either improper display of plan information to consumers or other irregularities. CMS will send summary data integrity review results to States during each review round. Data integrity notices are different from correction notices, which are generated during the separate process of QHP certification reviews.

CHAPTER 3: DECISION SUPPORT TOOLS

CMS has developed a number of decision support tools to help consumers select plans. Under 45 CFR 156.122(d) and 156.230(b), QHP issuers in the FFMs must submit certain drug formulary and provider directory information to the FFMs in a manner specified by HHS. HHS has required that issuers in the FFMs submit the information in a machine readable format, and update it no less than monthly. With this information, CMS developed a formulary lookup tool and provider lookup tool.

Section 1. Provider Directory Links and Provider Lookup Tool

This section discusses the provider directory links and the provider lookup tool for QHPs. Under 45 CFR 156.230(b), a QHP issuer, including issuers of SADPs, must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the FFMs, CMS, and OPM. CMS will consider a provider directory to be up-to-date if the issuer updates it at least monthly. Additionally, CMS will consider a provider directory to be easily accessible when the general public is able to view all of the current providers for a plan in the provider directory on the issuer's public website through a clearly identifiable link or tab without having to create or access an account or enter a policy number. The general public should be able to easily discern which providers participate in which plans and provider networks. Further, if the health plan issuer maintains multiple provider networks, the plans and provider network(s) associated with each provider, including the tier in which the provider is included, should be clearly identified on the website and in the provider directory. Similar to previous years, QHP issuers must make their provider directories available to the FFM for publication online by providing the URL link to their network directory. CMS will collect QHPs' provider directory URLs as part of the QHP application.

CMS also requires QHP issuers in the FFMs, including issuers of SADPs, to make this provider directory information publicly available on their websites in a machine-readable file and format specified by CMS, to allow the creation of user-friendly aggregated information sources. These machine-readable files increase transparency by allowing CMS and other software developers to access provider data and create innovative and informative tools to assist consumers in understanding plans' provider networks. With this information, CMS developed a provider directory lookup tool on HealthCare.gov. This tool allows consumers to determine if a plan includes a specific provider in its network based on issuer-provided data, and CMS will continue to consider options for improvements to these tools. For this reason, QHP issuers in an FFM must submit data in a manner that complies with the data requirements and specifications in the Information Collection for Machine Readable Data for Provider Network and Prescription Formulary Content for FFM QHPs (CMS-10558),[43] update this information not less than monthly, and submit the machine readable link at: https://marketplace.cms.gov/submission/.

Section 2. Formulary Drug List and Formulary Lookup Tool

This section discusses the issuer formulary drug list and formulary lookup tool. Under 45 CFR 156.122(d), issuers' formulary drug lists are required to be up-to-date, accurate, and include a

[43] Information regarding the data requirements and specifications is available at: http://www.reginfo.gov/public/do/PRAOMBHistory?ombControlNumber=0938-1284.

complete list of all covered drugs. The formulary drug list must include any tiering structure that the plan has adopted and any restrictions on the manner in which a drug can be obtained. For the purpose of 45 CFR 156.122(d), for a formulary drug list to be considered complete, the formulary drug list must list all drugs that are EHB, and list all drug names that are currently covered by the plan at that time. The formulary drug list does not have to list every covered formulation for each covered drug, but the issuer should be prepared to provide information on the specific formulations upon request. Issuers must also include accurate information on any restrictions on the manner in which an enrollee can obtain the drug, including prior authorization, step therapy, quantity limits, and any access restrictions related to obtaining the drug from a brick and mortar retail pharmacy.

Similar to previous years, CMS will collect FFM QHPs' formulary drug list URLs as part of the QHP application and will make formulary drug list links provided by issuers available to consumers on HealthCare.gov. This formulary drug list URL link should be the same direct formulary drug list link for obtaining information on prescription drug coverage in the Summary of Benefits and Coverage, in accordance with 45 CFR 147.200(a)(2)(i)(L). The formulary drug list must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Marketplace, CMS, OPM, and the general public. A formulary drug list is easily accessible when it can be viewed on the plan's public web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and if an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan.

Under section 156.122(d)(2), CMS requires QHP issuers in the FFMs, including SHOP issuers but excluding SADP issuers, to make this formulary drug list information publicly available on their websites in a machine-readable file and format specified by CMS, to allow the creation of user-friendly aggregated information sources. These machine-readable files increase transparency by allowing CMS and other software developers to access formulary data and create innovative and informative tools to assist enrollees in understanding plans' formularies. With this information, CMS developed a formulary lookup tool on HealthCare.gov. This tool allows consumers to determine if a plan covers a specific drug (or drugs) based on issuer-provided data and CMS will continue to consider options for improvements to these tools. As noted in section 1, QHP issuers in the FFMs must submit the data in a manner that complies with the data requirements and specifications in the Information Collection for Machine Readable Data for Provider Network and Prescription Formulary Content for FFM QHPs (CMS-10558), update this information not less than monthly, and submit the machine readable link at: https://marketplace.cms.gov/submission/.

Section 3. Out-of-Pocket Cost Comparison Tool

This section describes the Out-of-Pocket (OOP) Cost Comparison Tool that is available on HealthCare.gov to help consumers make more informed choices about their health insurance coverage and to help them pick a plan that will best meet their needs.

CMS offers an OOP Cost Comparison Tool that can help a potential enrollee evaluate key differences across QHPs available through the FFMs. Using this tool, potential enrollees can see, based on their expected low, medium, or high use of health care services, a total OOP estimate for the costs they could expect to pay throughout the year given the cost sharing design for a particular health insurance plan. The OOP Cost Comparison Tool allows shoppers in the FFMs to see estimates of total spending (including premiums and cost-sharing) across various health insurance plans available through the FFMs. This OOP estimate takes into account key cost-sharing design elements in a plan including but not limited to copayments, coinsurance, deductibles, out-of-pocket maximums and uncovered expenses.

CMS published a bulletin[44] explaining the methodology and implementation of the OOP cost estimator tool for the FFMs. The bulletin discusses the following major inputs to the calculator:

- Utilization and Cost Data
- Plan Benefit Data
- User Input

The OOP Cost Comparison Tool can be accessed at https://www.healthcare.gov/see-plans/.

Section 4. Transparency in Coverage Reporting

The content of this section outlines proposed transparency reporting requirements for all QHP issuers, including SADP issuers, in the FFMs, including in States that are performing plan management functions. Issuers in SBM-FPs will also use the same approach.

CMS's information collection request, CMS-10572, "Transparency in Coverage Reporting by Qualified Health Plan Issuers," will seek additional feedback on these proposed elements for

[44] Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/OOP-Tool-Bulletin-10-29-15.pdf.

transparency reporting upon publication of a notice that will provide the public with a 30-day comment period. Therefore, the proposed data collection elements are subject to change pending approval by the Office of Management and Budget pursuant to the Paperwork Reduction Act of 1995.

We note that an initial notice was posted in the Federal Register at 80 Federal Register 48320, initiating a 60-day comment period from August 12, 2015 that closed on October 13, 2015. We intend to finalize this package soon, so that issuers may provide data for 2017.

CHAPTER 4: STAND-ALONE DENTAL PLANS: 2017 APPROACH

Issuers submitting applications for certification of SADPs will have several unique standards due to their excepted benefit status, and their limited scope of benefits. The charts below (Tables 4.1 and 4.2), are intended to assist issuers in understanding those standards that are applicable to SADPs seeking certification in the FFMs for the 2017 plan year. CMS notes that in addition to the certification standards outlined below, SADP issuers will need to comply with operational processes and standards. The application of QHP standards is addressed throughout the sections of this Letter. Therefore, this section only addresses those standards or evaluations that are unique to SADPs. As previously noted, States that are performing QHP certification reviews have flexibility in their application of QHP certification standards including SADPs, provided that the State's application of each standard is consistent with CMS regulations and guidance.

Table 4.1: Standards and Tools Applicable to SADPs

Standard or Tool Applies (* denotes modified standard)	
Essential Health Benefits*	Actuarial Value*
Annual Limits on Cost Sharing*	Licensure
Network Adequacy*	Inclusion of ECPs*
Non-discrimination	Service Area
Acceptance of Third Party Premium and Cost-sharing Payments	Data Integrity Tool
Rates submission*	Machine Readable* (SADPs must comply with provider directory standards but not drug formulary standards)
Transparency in Coverage Reporting	

Table 4.2: Standards and Tools Not Applicable to SADPs

Standard or Tool Does Not Apply	
Accreditation	Patient Safety
Quality Reporting and Quality Improvement Strategy	Meaningful Difference
Prescription Drugs	Standardized Options
Cost-sharing Reductions	Out-of-Pocket Cost Comparison Tool

Section 1. Stand-alone Dental Plans: 2017 Approach

CMS has previously outlined a process for SADPs to complete the rating template portion of the QHP application. As in previous years, for certification for 2017 plan years, SADP issuers will complete the rating templates in accordance with the associated rating and business rules and to indicate in the 2017 Plan and Benefits Template whether they are committing to charging that rate ("guaranteed" rates) or retaining flexibility to change the rate ("estimated" rates).

Section 2. Intent to Apply

QHP issuers are permitted to offer QHPs that omit coverage of the pediatric dental EHB through a Marketplace if an SADP is offered through the Marketplace in the same service area in which the QHP is offered. For the 2014, 2015, and 2016 plan years, CMS conducted a voluntary reporting process for SADP issuers to communicate their intent to apply for certification to be offered through the Marketplace and is following a similar approach for 2017.

Section 3. SADP Annual Limitation on Cost Sharing

In the 2017 Payment Notice Final Rule, we finalized a new process by which the annual limitation on cost sharing for SADPs would be increased over time. Any increase in the annual limitation would be implemented on plans in years beginning after 2017. Any increase would be based upon the percentage increase in the Consumer Price Index (CPI) for dental services and be made in $25 increments for coverage of one child. We intend to publish any new annual limitations on cost sharing annually in the Notice of Benefit Payment Parameters rule.

Section 4: Display of Adult Dental Benefits Icon

CMS's 2016 Plan Preview User Guide[45] indicates that in order for the "Dental: Child & Adult" icon to display, SADPs must cover three categories of pediatric benefits (i.e., Dental Check-up, Basic, and Major) as well as all three categories of adult benefits (i.e., Routine, Basic, and

[45] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/FFM-PM-User-Guide-Plan-Preview-0515015.pdf.

Major). We believe that a consumer should have the general expectation that an SADP with the "Dental: Child & Adult" icon would cover services typically offered by a dental plan, including preventive care and minor and major dental services. These policies will be carried forward to the 2017 plan year and be replicated in the 2017 Plan Preview User Guide.

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

Section 1. Account Management: 2017 Issues

All issuers participating in the FFMs, including issuers in States that are performing plan management functions, will continue to have an assigned Account Manager. In addition, CMS will assign an Account Manager to issuers participating in SBM-FPs. For issuers offering QHPs through the FFMs for the first time, CMS will assign an Account Manager prior to the start of open enrollment for the 2017 plan year. The Account Managers will serve as issuers' primary point of contact with the FFMs for non-technical QHP and SADP issues and will provide QHP issuers with clarification and other assistance related to issuers' responsibilities and requirements for participating in the FFM. Additionally, the Account Manager will communicate updates to issuers, direct issuers to other resources as appropriate, and coordinate resolution of cross-cutting issues. CMS expects that States, regardless of Marketplace type, will continue to take the lead in addressing market-wide issues, such as complaints related to market conduct.

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

Section 2. QHP Issuer Compliance Monitoring

This section describes how CMS, in its role as operator of the FFMs, will monitor issuer compliance with all applicable Marketplace standards on an ongoing basis throughout plan years beginning in 2017. CMS anticipates adopting the same approach in States that are performing plan management functions.

Pursuant to 45 CFR 155.1010(a)(2), CMS will be monitoring QHP issuers participating in the FFMs for demonstration of ongoing compliance with the certification requirements of 45 CFR 155.1000(c). CMS will evaluate an issuer's performance to determine if making the issuer's health plan(s) available is in the interest of qualified individuals and employers enrolling in coverage through the FFMs. Compliance monitoring will be based on several data sources, at the State and national level, including, but not limited to: complaints data; issuer self-reporting of problems; issuer policies, procedures, and operations; network adequacy analysis; and indicators of customer service and satisfaction. The 2016 Payment Notice Final Rule extended the good

faith compliance policy at 45 CFR 156.800(c) through the 2015 calendar year. The good faith compliance policy ended at the close of the 2015 calendar year. As a general principle, CMS intends to continue providing technical assistance to issuers to assist with understanding applicable Marketplace standards and guidance. CMS expects that by 2016 and 2017, issuers will have gained more experience operating in the FFMs environment, be more familiar with the Marketplace requirements, and have updated their policies and procedures to reflect the applicable standards, guidelines, and operations.

As in prior years, CMS will continue to work with States on oversight activities to prevent unnecessary duplication of effort and/or enforcement actions.

Section 3. QHP Issuer Compliance Reviews

This section describes how CMS, as administrator of the FFMs, will assess QHP and SADP issuer compliance with applicable Marketplace standards and operational performance by performing a limited number of compliance reviews. States performing plan management functions in the FFMs may wish to take a similar approach to assessing issuer compliance with applicable Marketplace standards by choosing to perform selected compliance reviews on issuers in their respective States.

Consistent with CMS's authority under 45 CFR 156.715, CMS will continue to perform these compliance reviews to monitor issuer compliance with applicable Marketplace-specific requirements and operational standards. CMS will conduct compliance reviews throughout the year and issuer notification of selection for a review may occur at any time during the year.

Similar to past years, CMS will generally use a risk-based process, based in part on compliance monitoring (e.g., complaint data) and available performance data, to select issuers for standard[46] compliance reviews. CMS may also select a QHP/SADP or issuer for a compliance review based on a specific issue of potential non-compliance. If CMS selects a QHP/SADP or issuer due to a specific issue of potential non-compliance, CMS may perform a targeted[47] review specific to the area(s) of potential non-compliance and/or conduct the compliance review on an expedited basis.[48] In some cases, due to the potential magnitude of harm to consumers, CMS may conduct limited, expedited compliance reviews of issuers to ensure that potential operational problems can be identified and addressed early on.

[46] Standard reviews include all review areas.

[47] Targeted reviews can include all review areas or just select review areas.

[48] Issuers selected for expedited compliance reviews will be required to submit documentation with a shorter turnaround time.

CMS may conduct either a desk review or an on-site review[49] and the type and location of the review will be included in the issuer selection notification. CMS will review data at both the issuer and the QHP/SADP level. CMS may request, as part of the compliance review process, policies, procedures, and any other applicable documentation[50] reasonably necessary to evaluate and verify compliance with the applicable requirements.

CMS intends to coordinate with the State regulatory entities, when appropriate, in conducting the compliance reviews. At the conclusion of all compliance reviews for the year, CMS will share a summary of the results of the reviews conducted by CMS with States and the lessons learned with issuers, as well as make this information generally available to the public on a CMS website.

Section 4. FFM Oversight of Agents and Brokers

This section describes how CMS will approach oversight of agents and brokers participating in the FFMs. It also provides an overview of accompanying QHP and SADP issuer responsibilities regarding their relationships with and oversight obligations for their affiliated agents and brokers who will be assisting with enrollment in QHPs offered through the FFMs. Unless otherwise noted, references to agents and brokers include web-brokers.[51]

i. QHP Issuer Responsibilities

Pursuant to 45 CFR 156.340, a QHP issuer participating in the FFMs maintains responsibility for ensuring that its delegated and downstream entities, including affiliated agents and brokers, comply with applicable laws and regulations. Accordingly, CMS expects QHP issuers to confirm all affiliated agents' and brokers' licensure statuses, and verify fulfillment of the applicable FFM registration and training requirements[52] before allowing access to the QHP issuers' tools to assist with enrollment through the FFMs and/or providing compensation for Marketplace transactions. QHP issuers may verify agents' and brokers' FFM registration and training status by reviewing the registration completion list on the CMS agent and broker resources page, or the on the

[49] On-site reviews will take place at the issuer's place of business.

[50] Additional documentation could include sample sets of applicable data (i.e., notices, claims, complaints, etc.).

[51] CMS uses the term "web-broker" to refer to agents or brokers who use their own website, or that of another agent or broker, to facilitate enrollment in a QHP through the FFMs in accordance with 45 CFR 155.220(c)(3).

[52] Agents and brokers assisting Marketplace consumers in an SBM-FP must complete FFM registration and training requirements.

Private Issuer Community site of CMSzONE.[53] In addition to verifying registration and training status, QHP issuers are responsible for ensuring that activities related to the FFMs that are conducted on their behalf by affiliated agents and brokers (e.g., enrollment) comply with applicable Federal standards, including those related to privacy and security, conflicts of interest, marketing, and continuing education.

ii. Agent and Broker Agreement

Agents and brokers must comply with all applicable privacy and security requirements, including but not limited to the standards established by HHS pursuant to 45 CFR 155.260, related to the use of personally identifiable information (PII) by non-Marketplace entities.[54] Before assisting consumers in the FFMs, agents and brokers must execute the Individual Market and/or FF-SHOP Privacy/Security Agreement (depending on whether the agent or broker is participating in the FFMs for the Individual Market, the FF-SHOP, or both), which includes further details on the Marketplace privacy and security standards related to the use and disclosure of PII.

Every agent and broker must execute the applicable agreement(s) with CMS as part of the registration process with the FFMs. These agreements include:

- Agent Broker General Agreement for the FFMs Individual Market (General Agreement) — all agents and brokers who wish to assist consumers in the FFMs for the Individual Market must electronically execute this General Agreement.
- Agreement Between Agent or Broker and CMS for the FFMs Individual Market (IM Privacy and Security Agreement) — all agents and brokers who wish to assist individual market consumers in the FFMs must electronically execute this Privacy and Security Agreement.
- Agreement Between Agents and Brokers and CMS for the FF-SHOP (SHOP Privacy and Security Agreement) — all agents and brokers who wish to assist FF-SHOP consumers must electronically execute this Privacy and Security Agreement.

[53] The list on the agent and broker resources page is updated twice monthly and is available at https://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html. The list on the CMSzONE Private Issuer Community is updated weekly and posted by Friday morning at: https://zone.cms.gov/document/agent-and-broker-federally-facilitated-marketplace-ffm-registration-completion-list. More agent and broker guidance is available on the Agent and Broker Resources Page at: http://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html.

[54] These include the eight privacy principles listed at 45 CFR 155.260(a)(3).

- Agreement Between Web-Broker Entity and CMS for the FFMs for the Individual Market (Web-Broker Agreement) — all web-brokers who wish to assist individual market consumers in the FFMs must electronically execute this Web-Broker Agreement.

By signing the applicable agreement(s), agents and brokers attest that they will:

- Comply with Marketplace privacy and security requirements, such as standards for use and disclosure of PII;
- Comply with all applicable State and Federal laws and regulations;
- Maintain valid licensure in all States where they wish to enroll qualified individuals and employers/employees into QHPs through the FFMs; and
- Complete the full FFM registration process in advance of assisting consumers, including taking all applicable training.

iii. Monitoring and Oversight

CMS works with States to coordinate oversight activities related to agents and brokers. CMS may investigate complaints pertaining to agents and brokers in the FFMs, and will monitor QHP issuer activities to confirm they are meeting their responsibilities for oversight of affiliated agents and brokers.

Agents and brokers registered with the FFMs must comply with all applicable privacy and security requirements, including but not limited to the standards established by HHS pursuant to 45 CFR 155.260, related to the use and handling of PII by non-Marketplace entities.[55] Before facilitating enrollments through the FFMs, agents and brokers must execute the IM and/or SHOP Privacy/Security Agreement (depending on whether the agent or broker is participating in the FFMs for the Individual Market, the FF-SHOP, or both), which includes further details on the Marketplace privacy and security standards related to the use and disclosure of PII.

CMS may terminate an agent's or broker's agreement(s) with the FFMs for cause if it determines that a specific finding of noncompliance or a pattern of noncompliance is sufficiently severe (based on which Federal standards have been violated, and factors such as financial impact and number of consumers affected), or if the agent or broker materially breaches any term of the General Agreement, IM Privacy and Security Agreement, SHOP Privacy and Security Agreement, and/or the Web-Broker Agreement, as applicable.[56] A termination would effectively bar the agent or broker from assisting with enrollment through the FFM. Termination can be

[55] These include the eight privacy principles listed at 45 CFR 155.260(a)(3).

[56] 45 CFR 155.220(g).

temporary (e.g., subject to reinstatement upon correction of the noncompliance) or permanent. If an agent's or broker's agreement(s) with the FFMs is terminated (either by the agent or broker or by the FFMs), the agent or broker must continue to protect any PII that was accessed during the term of his or her relationship with the FFMs in accordance with the IM and/or SHOP Privacy/Security Agreement and the applicable requirements under 45 CFR 155.260. We note that termination of the agreement results in the following: termination of registration and removal of the agent's or broker's National Provider Number (NPN) from the Agent and Broker FFM Registration Completion List, which generally bars the agent or broker from being compensated by QHP issuers for FFM enrollments[57]; and removal of the agent/broker role from the FFM User ID, which prevents the agent or broker from logging into the agent/broker landing page on a QHP issuer or web-broker website for direct enrollment, and prevents the agent or broker from logging into the SHOP agent/broker portal.

We finalized 45 CFR 155.220(g)(5) in the 2017 Payment Notice Final Rule to provide that if CMS reasonably suspects that an agent or broker may have engaged in fraud or abusive conduct that may result in imminent or ongoing consumer harm using PII of FFM applicants or enrollees, or in connection with an FFM enrollment or application, CMS may temporarily suspend the agent's or broker's agreement(s) with the FFMs for up to 90 calendar days, with the suspension effective as of the date of the notice to the agent or broker. If there is a finding or determination by a Federal or State entity that an agent or broker engaged in fraud or abusive conduct that may result in imminent or ongoing consumer harm, using PII of FFM enrollees or applicants, or in connection with an FFM enrollment or application, CMS will terminate the agent's or broker's agreement(s) with the FFMs for cause with the termination effective as of the date of the notice to the agent or broker. Agents and brokers who are suspended or terminated may submit evidence to rebut the allegation, according to the instructions provided in the written notice of suspension or termination, in the terms and conditions of the FFM agreements, and as described in §155.2202(g)(5)(i)(B) or §155.220(h), respectively. Such evidence must be submitted within 90 calendar days of the date of the written notice from CMS. In the event of termination, a CMS reconsideration entity will provide the agent or broker with a written notice of the reconsideration decision within 30 calendar days of the date it receives the request for reconsideration; this decision will constitute CMS's final determination. During the suspension period and following termination of the agreements under section, the agent or broker will not be registered with the FFMs, or be permitted to facilitate enrollments through an FFM, or be permitted to assist individuals with applying for advance payments of the premium tax credit (APTC) or cost-sharing reduction (CSRs).

We note that this suspension and termination authority pertains only to agents' and brokers' agreements and registration with the FFMs to assist consumers with enrollments through the

[57] See vi. under this section for information on the one exception to this general rule.

FFMs; this does not preempt any State authority to regulate agents or brokers who are licensed to do business in their jurisdiction. Only States can license or certify agents and brokers; the FFMs enter into agreements with agents and brokers, which include registration and training requirements,[58] only with respect to facilitating enrollments through an FFM. In the 2017 Payment Notice Final Rule, we finalized that CMS will notify the State DOI or equivalent State producer licensing authority in cases of suspensions or terminations of the agent's or broker's agreements and registration with an FFM effectuated under §155.220(g). CMS will also coordinate with impacted QHP issuers to the extent that it will not impede any State or Federal law enforcement investigation and as otherwise permitted under applicable Federal or State law. CMS currently works with States and law enforcement to investigate and resolve suspected incidents of fraud or abusive conduct, and we will continue to coordinate with State and Federal agencies (including law enforcement) if CMS were to take suspension or termination action as appropriate. In order to alert States, QHP issuers, as well as members of the public of the agents and brokers that have been suspended or terminated, CMS will publish on its website a "Registration Termination List" that includes impacted NPNs and effective dates for the termination or suspension action.[59] QHP issuers who suspect that an agent, broker, or web-broker is engaging in fraudulent or abusive conduct related to enrollments through the FFMs should report the incident or activity to the State DOI as well as their CMS Account Managers.

In the 2017 Payment Notice Final Rule, we also finalized in 45 CFR 155.220(j) the requirement that agents and brokers participating in the FFMs comply with FFM standards of conduct to protect consumers and ensure the proper administration of the FFMs. These include the requirement to provide the FFMs with correct information under section 1411(b) of the Affordable Care Act; and to obtain the consent of the individual, employer, or employee prior to assisting with or facilitating enrollment through an FFM, or assisting the individual in applying for insurance affordability programs. Finally, as part of the 2017 Payment Notice Final Rule, we finalized in paragraph (k) of §155.220 that CMS may deny the agent or broker the right to enter into an agreement(s) with the FFMs in future years and/or impose civil money penalties under 45 CFR 155.285 for non-compliance with requirements under 45 CFR 155.220.

iv. *Web-brokers*

CMS regulations establish additional requirements that apply when an agent or broker uses his or her own website, or that of another agent or broker, to facilitate enrollment in a QHP through the

[58] Agents and brokers who assist small group employers and employees through the SHOP are strongly encouraged, but not required, to complete annual training.

[59] The list on the agent and broker resources page is updated twice monthly and is available at https://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html. The list on the CMSzONE Private Issuer Community is updated weekly and posted by Friday morning.

FFMs.[60] CMS uses the term "web-broker" to refer to such agents or brokers who use a non-FFM website to assist consumers in the QHP selection and enrollment process as described in 45 CFR 155.220(c)(3).

To the extent permitted by a State, CMS works with web-brokers that meet all applicable requirements to provide an alternate option to help consumers select and enroll in individual market QHPs[61] (including SADPs[62]) through the FFMs online, alongside traditional agents and brokers who assist consumers with enrollment through the Marketplaces. This enrollment pathway through a web-broker is referred to as "direct enrollment."

Regulations at 45 CFR 155.220(c)(3)(i) generally require web-brokers to disclose and display all QHP information provided to them by the FFMs or directly by QHP issuers. To the extent that not all information required under 45 CFR 155.205(b)(1) is displayed on the web-broker's website, the web-broker must prominently display a standardized disclaimer provided by CMS stating that information required under 45 CFR 155.205(b)(1) for the QHP is available on HealthCare.gov, and provide an operational link to HealthCare.gov. This disclaimer is in addition to the requirement, each web-broker must prominently display a standardized disclaimer on its website to inform consumers that the website is not an official FFM website, and provide an operational link to HealthCare.gov.

In the 2016 Payment Notice Final Rule, CMS specified that a web-broker's existing obligation under 45 CFR 155.205(c)(2)(i) to provide oral interpretation services includes making available telephonic interpreter services in at least 150 languages. This standard applies to web-brokers beginning November 1, 2015, or one year after a web-broker registers with the FFM, whichever date is later.

CMS also specified language access requirements for web-brokers pertaining to taglines and translation of website content which will become applicable beginning with the first day of the open enrollment period for the individual market Marketplace for the 2017 benefit year, or one year after a web-broker registers with the FFMs, whichever date is later. First, under 45 CFR 155.205(c)(2)(iii)(B), we specified that a web-broker's existing obligation to include taglines in

[60] 45 CFR 155.220(c)(3)-(4).

[61] Pursuant to 45 CFR 155.220(i), beginning January 1, 2015, SHOPs may permit agents and brokers, in States that permit such activity under State law, to use a QHP issuer or web-broker website to provide assistance to employers and facilitate enrollment of employees in SHOP QHPs, subject to the requirements of 45 CFR 155.220(c)(3). The FF-SHOPs may elect to implement this functionality for future plan years.

[62] As detailed in the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Federal Register 18310 (March 27, 2012), with some limited exceptions, SADPs are considered a type of QHP. We expect agents, brokers, and web-brokers registered with the FFMs to comply with applicable rules and requirements in connection with SADPs, just as they must comply with those rules in connection with medical QHPs.

non-English languages specifically includes providing taglines on website content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by individuals with limited English proficiency (LEP) in the relevant State, as determined in HHS guidance. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by State or Federal law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Second, under 45 CFR 155.205(c)(2)(iv)(C), we specified that a web-broker must translate website content that is intended for a qualified individual, applicant, qualified employer, qualified employee, or enrollee on a website maintained by the web-broker into any non-English language that is spoken by a LEP population that reaches 10 percent or more of the population of the relevant State, as determined in HHS guidance. We intend to publish data identifying the non-English languages that are triggered by these standards for each State as well as sample taglines in March 2016.

In prior years, CMS has supported direct enrollment integration between the web-broker's website and HealthCare.gov using secure redirect and Application Programming Interface (API) mechanisms. The direct enrollment pathway enables a consumer to initiate his or her shopping experience on the web-broker's website, connect securely to HealthCare.gov to complete the eligibility application and determination process, and return securely to the web-broker's site to compare plans and enroll in a QHP.

In the 2017 Payment Notice Proposed Rule, we solicited comments on an expanded direct enrollment pathway option that CMS may offer at a later date under which an applicant could remain on the web-based entity's (WBE's)[63] website to complete the application and enroll in coverage, and the WBE website would obtain eligibility information from the Marketplace to support the consumer in selecting and enrolling in a QHP with the financial assistance (as applicable). The intent is to have this information exchange occur through a Marketplace-approved web service, while offering WBEs more operational flexibility to expand front-end, consumer-facing channels for enrollment through a seamless consumer experience. This expanded direct enrollment pathway option for WBEs will not be operational for 2017 coverage. CMS continues to consider this option for the open enrollment period for 2018 coverage. CMS will further consider enhancements to privacy and security protections of the information transmitted by WBEs, and we note that is important for WBEs to have robust cyber-security systems. CMS is also considering how to ensure that consumers understand that they are applying for Marketplace coverage, such as through specific branding or wording requirements if

[63] A WBE maintains an API connection with the Marketplace to support the direct enrollment pathway. WBEs can be web-brokers or QHP issuers.

a non-FFM front-end website is used for the entire application and enrollment process. Until CMS has identified the Marketplace-approved web services under §155.220(c)(1) that can be used to support the enhanced direct enrollment process and created a pre-approval process under §155.220(c)(4)(i)(F), the current direct enrollment approach and all associated guidance must be followed.

v. Compensation

Agents and brokers are compensated directly by QHP issuers under the terms of their QHP issuer contracts for assisting consumers enrolling in QHPs through an FFM. Compensation includes commissions, fees, or other incentives as established in the relevant contract between a QHP issuer and the agent or broker. An agent or broker must be affiliated or have a contractual relationship with the respective issuer, in accordance with applicable State law, and must complete the applicable FFM registration requirements in order to be paid by an issuer for a Marketplace transaction.[64] The FFMs do not set compensation levels or pay commissions to agents or brokers. CMS does not require QHP issuers to offer contracts to agents and brokers, including offering compensation for enrollment in QHPs through the FFMs. QHP issuers should compensate only affiliated agents and brokers that are compliant with applicable Federal requirements, including those for registration with the FFMs.[65] CMS believes that withholding compensation from affiliated agents and brokers that fail to comply with FFM registration and other applicable Federal requirements would generally be required for an issuer to demonstrate compliance with 45 CFR 156.340 as it relates to oversight of affiliated agents and brokers.

The FFMs transmit the identifying information of agents and brokers (e.g., NPN) to QHP issuers on the 834 enrollment transactions (834). In cases where an FFM-registered agent or broker receives compensation through a third party entity such as an agency or brokerage that is registered with the FFMs, the agent or broker may work with the QHP issuer to appropriately direct compensation based on the NPN included on the 834. The QHP issuer has the discretion to comply with the agent's or broker's request for direction or manner of payment according to the terms of his or her compensation arrangement and applicable State law.

If an FFM-registered agent or broker has a reason to believe that his or her NPN (or agency/brokerage NPN) should have been included on the 834 but was not, the agent or broker may contact the respective QHP issuer directly to discuss the situation. CMS expects that a QHP issuer would issue compensation to an FFM-registered agent or broker with whom the QHP is affiliated if it is determined from the issuer's, agent's, or broker's records that the agent or broker did in fact assist the consumer, but the NPN was erroneously left off of the 834. Those records

[64] See vi. under this section for information on the one exception to this general rule.

[65] See i. under this section and 45 CFR 156.340.

may include a consent form from the consumer, an issuer's broker of record form, or similar documentation to demonstrate that the consumer was the agent's or broker's client for the enrollment in question.

Agents and brokers who are acting as Navigators, certified application counselors, and/or (in FFMs and States performing plan management functions) non-Navigator assistance personnel may not receive any direct or indirect compensation from health insurance or stop loss insurance issuers, in connection with the enrollment of any individuals or employees in a QHP or non-QHP. All agents and brokers should follow State standards with respect to charging consumers directly for services provided, including any requirements for disclosure of the amount being charged directly to the consumer for providing assistance.

The FFMs do not play a role in setting compensation levels or making appointments between issuers and agents and brokers, and the FFMs are not a party to the contract between the QHP issuer and the agent or broker. However, Federal regulations require QHP issuers to provide the same compensation to agents and brokers for QHPs offered through the FFMs as they do for similar health plans offered in the State outside the Marketplaces.[66] This compensation approach is a required participation standard for QHP issuers offering coverage in the FFMs, including both the Individual Market and SHOP. We note that in determining whether a health plan offered in the State outside of the Marketplace is similar to a QHP offered through the FFMs, we would consider whether the plan has a similar cost sharing and benefit structure, covers a majority of the same service area, and covers a majority of the same provider network as compared to the QHP.[67] A compensation arrangement in which an issuer pays no commission for sale of a QHP through an FFM, but does pay commission for sale of a similar plan outside of the FFM, would violate this FFM standard for agent and broker compensation.

vi. Registration Requirements for Initial Enrollment and Re-enrollment Transactions

Agents or brokers who are assisting consumers with enrollment in QHPs offered through the FFMs must meet all applicable State and Federal requirements, including those for State licensure and FFM registration, at the time they are providing assistance.[68] When assisting a consumer with initial enrollment in a QHP through the FFMs, the agent or broker must have a current FFM registration. In any future plan year, the requirement for FFM registration depends

[66] 45 CFR 156.200(f).

[67] In making this determination, CMS would use the same criteria outlined in the market-wide definition of "plan" at 45 CFR 144.103, and the discussion of whether a health plan offered outside the Marketplace is "substantially similar" to a QHP in paragraph (3) of the definition of "QHP" set out at 45 CFR 153.500.

[68] See 45 CFR 155.220(d), (e) and (j).

on whether the agent or broker is providing assistance with updates to the FFM application or enrollment (active re-enrollment), or if the consumer is automatically re-enrolled in the same plan without assistance from the agent or broker in making any changes to the FFM application or the enrollment (passive re-enrollment).[69]

- If the agent or broker is actively assisting the consumer to make changes to the FFM application or to the enrollment, the agent or broker must have a current FFM registration.

- If the consumer is automatically re-enrolled in the same plan without assistance from the agent or broker in making any changes to the FFM application or the enrollment, CMS does not require the agent or broker to have a current FFM registration status at the time of the re-enrollment. Assuming the agent or broker was registered and met all applicable State and Federal requirements at that time of assisting the consumer with the initial enrollment through the FFM, the QHP issuer has the discretion to pay commissions, in accordance with State law and applicable contractual requirements, for the coverage renewal.

The issuer should use the Agent and Broker FFM Registration Completion Lists published by CMS to verify that the NPN of the agent or broker who is credited for the FFM enrollment was registered at the time of the original enrollment or the active re-enrollment.

vii. HHS-Approved Vendors of FFM Training and Information Verification

HHS established standards at 45 CFR § 155.222 for approved vendors to provide training and information verification services by which State licensed agents and brokers could complete the training requirements necessary to assist consumers seeking coverage through the FFMs. This provides an additional avenue by which agents and brokers may satisfy the requirement to receive training in the range of QHP options and the insurance affordability programs; HHS continues to offer training at no cost. An entity that is interested in becoming a vendor must submit an application and, upon approval of the application, execute an agreement with HHS. Vendors are approved for one-year terms and those seeking to continue their recognition the following year must be re-approved by HHS. Approved vendors are also required to adhere to HHS specifications for content, format, and delivery of training; and to collect, store, and share

[69] See "Operational Tips for Agents/Brokers in the Federally-facilitated Marketplaces (FFMs)" (January 22, 2016) available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/AB_Operational_Tips_01_22_2016.pdf. For information about the required steps for agent and broker FFM registration, see "Role of Agents, Brokers, and Web-brokers in Health Insurance Marketplaces" (January 8, 2016) available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Role-of-ABs-in-Marketplace-1_6_16.pdf.

with HHS all data from agent and broker users of the vendor's training in a manner, format, and frequency specified by HHS. Entities whose applications are not approved or who have their approval revoked may request an appeal. The list of approved vendors for Plan Year 2016 is posted on the CCIIO website and we intend to also post the list of approved vendors for Plan Year 2017 on the CCIIO website. HHS continues to monitor vendors' compliance after their respective training programs launch, and HHS may revoke approval if a vendor does not comply with HHS standards.

In the 2017 Payment Notice Final Rule, CMS eliminated the requirement from 45 CFR155.222 that approved vendors to perform information verification services, as CMS intends to continue performing the identity proofing function and expects that QHP issuers are overseeing affiliated agents and brokers to ensure that they have the appropriate licenses required under the applicable State law.

Section 5. Oversight of Marketing Activities

This section describes how CMS will monitor QHP marketing during plan years beginning in 2017 in the FFMs and provides information that supplements what was discussed in the 2015 and 2016 Letters to Issuers. States performing plan management functions in the FFMs are encouraged to take a similar approach.

Regulations at 45 CFR 156.200(e) provide that QHP issuers must not, with respect to their QHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.[70] 45 CFR 156.225(a) requires that in order to have a plan certified as a QHP, a QHP issuer must comply with all applicable State laws on health plan marketing by health insurance issuers. In addition, 45 CFR 156.225(b) states that a QHP issuer must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[71] CMS also reminds issuers that they are subject to section 1557 of the Affordable Care Act, which proposes to prohibit discriminatory marketing practices in its notice of proposed rulemaking.

As noted in the 2016 Letter to Issuers, States generally regulate health plan marketing practices and materials and related documents under State law, and CMS does not intend to review QHP marketing materials for compliance with State standards as described at 45 CFR 156.225(a). In FFM States, CMS may review QHP marketing materials for compliance with 45 CFR 156.200(e) and 45 CFR 156.225(b). CMS will work with States to determine where additional monitoring and review of marketing activities may be needed. For all QHP issuers in the FFMs, CMS

[70] Also see 45 CFR 147.104(e) for the parallel market-wide prohibition.

[71] Also see 45 CFR 147.104(e) for the parallel market-wide prohibition.

recommends that agreements with agents and brokers, as well as marketing materials distributed to enrollees and to prospective enrollees, contain a clause such as the following: "[Insert plan's legal or marketing name] does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations." If CMS receives a consumer complaint about an issuer's marketing activities or about an agent's, broker's, or web-broker's conduct which is generally overseen by the State, CMS will send the complaint to the State regulators, as appropriate, for investigation. Following the State's investigation, CMS may take the necessary enforcement action against the issuer or agent, broker, or web-broker.

All marketing, whether paper, electronic, or other media, must reflect accurate information that complies with both Marketplace and market-wide standards. In addition, marketing materials that solicit PII must comply with the privacy and security standards described at 45 CFR 155.260. CMS will refer cases of false advertising/false information, as well as privacy and/or security violations, to the appropriate State and Federal entities. Following the State's or other entities' investigation, CMS may take the necessary enforcement action against the QHP issuer or agent, broker, or web-broker.

In the 2017 Payment Notice Final Rule, we finalized a new paragraph (j)(2)(i) at 45 CFR 155.220 that requires agents and brokers assisting consumers with FFM transactions to provide consumers with correct information, without omission of material fact, regarding the FFMs, QHPs (including SADPs[72]) offered through the FFMs, and insurance affordability programs, and to refrain from marketing or conduct that is misleading or coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation. We interpret this standard for conduct to require that agents, brokers, and web-brokers avoid the use of "Exchange," "Marketplace," or other words in the name of a business or URL if doing so could reasonably cause confusion with a Federal program or website.

We recommend that, as a best practice, a non-FFM website should indicate if it does not offer all available Marketplace plans, and note that web-broker websites must provide consumers the ability to view all QHPs offered through the Marketplace.[73] If an agent or broker assists a consumer with individual market FFM or FF-SHOP QHP selection through the agent's, broker's, or web-broker's non-FFM website, a standardized disclaimer must be prominently displayed to indicate that the site is not a Health Insurance Marketplace website, and an active link to

[72] As detailed in the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18310 (March 27, 2012), with some limited exceptions, SADPs are considered a type of QHP. We expect agents, brokers, and web-brokers registered with the FFMs to comply with applicable rules and requirements in connection with SADPs, just as they must comply with those rules in connection with medical QHPs.

[73] 45 CFR 155.220(c)(3)(ii).

HealthCare.gov must also be provided.[74] Although CMS does not require disclosure of affiliations with QHP issuers, consistent with 45 CFR 155.220(e), CMS expects agents, brokers, and web-brokers to comply with applicable State standards for disclosing financial information, including financial relationships with QHP issuers.

CHAPTER 6: FF-SHOPs

Section 1. Termination Transactions/Switch Files for Non-renewals

This section describes how the FF-SHOPs communicate group terminations to issuers when a group does not renew its enrollment or coverage through an FF-SHOP or when enrollees in coverage through an FF-SHOP switch to a new issuer for a new plan year.

FF-SHOP issuers are currently not receiving Health Insurance Exchange (HIX) termination transactions when groups do not renew their enrollment or coverage through an FF-SHOP or when enrollees in coverage through an FF-SHOP switch to a new issuer for a new plan year. Instead, FF-SHOP issuers receive a Switch File when these two scenarios occur.

CMS sends two Switch Files via the managed file transfer (MFT) process where files are pushed and pulled from each trading partner's Outbound 30 and Inbound 30 folders at the exchange data center. The files are sent in a pipe delimited format and are created and sent between the 20th and 25th of every month. The Group Switch File identifies employer groups that are not renewing their enrollment or coverage with any issuer through an FF-SHOP. The Member Switch File identifies enrollees that are not renewing their enrollment or coverage through an FF-SHOP, and enrollees who select a different issuer from the one that issued their coverage for the previous plan year. Further, if an issuer remains active, but changes its HIOS ID, CMS sends a Member Switch File for all active enrollments with the issuer. Additional information about the FF-SHOP Switch File is available in the Switch File Interface Control Document located on REGTAP.[75]

Issues and questions concerning Switch Files can be resolved through the FF-SHOP Call Center or through the Enrollment Reconciliation Dispute Resolution process.

[74] See 45 CFR 155.220(c)(3)(vii). Also see 45 CFR 155.220(i), as amended by the 2016 Payment Notice Final Rule, which allows SHOPs to permit agents and brokers, in States that permit such activity under State law, to use an Internet website to provide assistance to qualified employers and facilitate enrollment of enrollees in SHOP QHPs, subject to the requirements of 45 CFR 155.220(c)(3).

[75] Available at: http://www.regtap.info/uploads/library/FFSHOPPASEnrollmentReconciliationICDv19_101615_5CR_101615.docx.

Section 2. Premiums Based on Average Enrollee Premium Amounts

This section provides clarification that for plan years beginning in 2017, CMS will not support calculating premiums based on average enrollee premium amounts.

45 CFR 147.102(c)(3)(iii) and 45 CFR 156.285(a)(4)(ii) establish parameters for premiums based on average enrollee premium amounts in the FF-SHOPs. CMS does not anticipate that the operational capacity to calculate and display premiums based on average enrollee premium amounts will be available to consumers for plan years beginning in 2017 and will provide guidance when this functionality becomes available in the FF-SHOPs for future plan years.

Section 3. Renewals

This section describes the renewal process for employers and employees, as the FF-SHOP system currently does not support automated processes for renewals.

Currently, renewal of FF-SHOP participation and/or coverage is not an automated process and requires both qualified employers and qualified employees to access their accounts on HealthCare.gov. The FF-SHOP renewal process applies to employer groups that were determined eligible to buy coverage through the FF-SHOPs and had qualified employees enroll in a plan through the FF-SHOPs in the previous plan year. While the FF-SHOPs will be sending notices describing the renewal process to employers and employees, this does not relieve issuers of their renewal notice requirements. For information on issuer requirements involving renewal notices, see guidance published by CMS on September 2, 2014.[76] The FF-SHOPs will send notices to employers approximately two months in advance of the date when the group's current coverage through an FF-SHOP will end, so long as rates are available for the quarter in which renewed coverage would take effect. This means, employers will generally receive notices 45-60 days prior to the date when the group's current coverage through an FF-SHOP will end. Qualified employees will receive information about the renewal process when their qualified employer makes a renewed offer of coverage for the new plan year.

Medical and dental coverage renewals will continue to be considered separately so that a qualified employee (and dependents, if applicable) may renew in medical coverage alone, dental coverage alone, or both, provided that the qualified employer continues to offer both medical and dental coverage through the FF-SHOPs.

[76] Available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-final.pdf.

i. Renewals for Employers

An employer may decide to renew its FF-SHOP participation as well as the coverage it offered in the previous year through the FF-SHOPs. The employer may also decide that it will renew its FF-SHOP participation, but not renew the coverage it offered in the previous year through the FF-SHOPs. Both of these circumstances are considered renewals of FF-SHOP participation and must follow the FF-SHOP renewal process, even when they do not result in an issuer's renewing coverage, as defined for purposes of guaranteed renewability.

CMS regulations at 45 CFR 155.725 require the FF-SHOPs to set a standard annual employer election period for renewing FF-SHOP employers and to set a standardized annual open enrollment period for renewing qualified employees. Qualified employers will be able to renew their offer of coverage through the FF-SHOPs electronically through HealthCare.gov as soon as plan and rate information becomes available for the quarter in which their coverage would end, but generally not more than two months before the date an enrollment must be submitted to avoid a gap in coverage: this is when the annual election period begins for that employer. The FF-SHOPs will send notices to employers approximately two months in advance of the date when the group's current coverage through an FF-SHOP will end, so long as rates are available for the quarter in which renewed coverage would take effect; this will generally be 45-60 days prior to the date when the group's current coverage through an FF-SHOP will end. Most of the information included in the qualified employer's account from the previous plan year will be pre-populated upon renewing participation, including contact information, employer contribution preferences, and employee roster information. Qualified employers renewing an offer of coverage in the FF-SHOPs must provide their qualified employees with an annual open enrollment period of at least one week to decide whether to accept the coverage offer. This one-week minimum period is the qualified employees' annual open enrollment period. A qualified employer could offer qualified employees an annual enrollment period of more than one week, but CMS provides for a one-week minimum to enable qualified employers and qualified employees, especially at very small companies, to finalize their annual renewal process more quickly. Consistent with §155.725(h)(2), both the qualified employer and qualified employee renewal process must be completed by 11:59 p.m. ET on the 15th day of the month preceding the desired renewal date for it to take effect by that date. The employer's election period should therefore end at least one week prior to the deadline for completing enrollment renewal that would take effect at the end of the employer's prior plan year.

CMS regulations, at 45 CFR 155.710(d), require that an FF-SHOP treat a qualified employer purchasing FF-SHOP coverage that ceases to be a small employer solely by reason of an increase in the number of employees, as eligible to participate in the FF-SHOP until the employer otherwise fails to meet FF-SHOP eligibility criteria or no longer purchases coverage for qualified employees through the FF-SHOP. Therefore, a qualified employer with qualified employees enrolled in FF-SHOP coverage that increases in size above a State's small group market upper threshold (either 50 or 100 employees), will be able to renew and maintain group coverage

through the FF-SHOP, until the employer otherwise fails to meet FF-SHOP eligibility criteria or no longer purchases coverage for qualified employees through the FF-SHOP. Generally, once employers have been determined eligible for coverage through an FF-SHOP, they remain eligible unless there are any changes to the FF-SHOP through which they offer coverage, unless they no longer offer coverage to all full-time employees, or unless they otherwise fail to meet FF-SHOP eligibility criteria. Pursuant to CMS regulations, at 45 CFR 157.205(f), a qualified employer participating in an FF-SHOP must provide the FF-SHOP with information about dependents or employees whose eligibility status for coverage purchased through the employer in the FF-SHOP has changed.

Personalized notices regarding the annual employer election period and the opportunity to renew or change employer participation in the FF-SHOP will be sent automatically to the user's My Account at HealthCare.gov approximately two months in advance of the date when the group's current coverage through an FF-SHOP will end, so long as rates are available for the quarter in which renewed coverage would take effect. Depending on the preferred method of contact, a paper notice or electronic notice will be sent to the employer. The FF-SHOP Annual Employer Election Period notice will include information about potential actions employers may want to take to renew previous coverage choices, modify previous coverage choices or contributions to employee premiums, or terminate FF-SHOP participation. The notice includes information about the date the current plan year is ending, the first date the employer can opt to renew its coverage offer, and the last day that employers must submit a group renewal to avoid a gap in coverage for the group. Issuers are not responsible for distributing these notices, but are still subject to market-wide requirements regarding notices under 45 CFR 147.106.

Groups whose enrollment and/or coverage through the FF-SHOP has been terminated for non-payment of premium but that are still within their 30 day reinstatement window will not be able to renew FF-SHOP participation through the online system until their prior coverage has been reinstated. If the group's prior coverage is reinstated, CMS does not consider this a gap in FF-SHOP coverage. Groups that are in a grace period for non-payment of premium will be able to renew their coverage through the online system, but will need to pay all premiums owed prior to the start of the new plan year. Groups will also need to pay the first month's premium for their new plan year by the 20th of the month prior to renewal. Payments sent by existing groups during a renewal period will be applied to current year invoices before they are applied to the new plan year. Issuers are expected to effectuate new plan year coverage if they do not receive a cancellation transaction by the 26th of the month prior to the renewal coverage effective date. We note that under §156.285(c)(8)(iii), FF-SHOP issuers are required to effectuate coverage unless an FF-SHOP sends a cancellation notice prior to the coverage effective date. If an employer's full payment is not received in time by an FF-SHOP, the FF-SHOP will issue a cancellation notice. Thus, issuers should not cancel an enrollment transaction unless the FF-SHOP sends a cancellation transaction. Note that after groups initially enroll or renew their coverage, the FF-SHOP will invoice employers for new hires and SEPs on the employer's next monthly invoice

and remit cleared payments received to issuers as part of the FF-SHOP's weekly issuer payment cycle.

ii. Renewals for Qualified Employees

Qualified employees wishing to renew FF-SHOP participation must use HealthCare.gov to respond to a qualified employer's renewed offer of coverage. Some information entered into the system for the previous plan year will be pre-populated in the employee's electronic application. Generally, as long as a qualified employer extends an offer of coverage to an employee or former employee, the employee or former employee is eligible.

Qualified employees should wait until they receive notice of the employer's renewed offer of coverage through the FF-SHOPs to begin the renewal process. Personalized notices regarding the annual employee open enrollment period will be sent automatically to the user's MyAccount at HealthCare.gov within the Employee portal, upon receipt of an employer's renewal offer of coverage. Depending on the preferred method of contact, a paper notice or electronic notice will be sent to the employee. The notice will contain information about the last day of the current plan year, the qualified employee's enrollment period start and end dates, the date by which the employee needs to make coverage decisions to prevent a gap in coverage, how employees can learn more about the offer of coverage for the next plan year, and how to waive or accept coverage, as well as potential actions qualified employees may want to take to renew previous coverage choices, modify previous coverage choices, or terminate FF-SHOP participation. When renewing coverage, qualified employers must provide their qualified employees with an annual open enrollment period of at least one week to decide whether to accept the coverage offer. The employer may provide additional time; however, all qualified employee enrollments must be finalized consistent with the time frames under 45 CFR 155.725(h)(2), and the renewal process for the entire group must be completed by the 15th of a month for coverage to start the first day of the next month. For example, for coverage that ends December 31, 2016, the renewal process must be completed by December 15, 2016 to avoid a coverage gap.

Qualified employees will not be able to make changes to the Social Security Number (SSN), date of birth (DOB), gender, and name for themselves or their dependents as part of the renewal process. These changes can be made by qualified employers contacting the FF-SHOP Call Center. Issuers will receive maintenance transactions for these changes. Changes to enrollee contact information can be made as part of the qualified employee's renewal process. These changes will be sent on renewal transactions. These updates will also display to employers when they log-in to the FF-SHOP.

Section 4. Enrollment Reconciliation

This section describes the monthly enrollment reconciliation process for the FF-SHOPs, including the form and frequency of file submissions.

Pursuant to 45 CFR 155.720(g), SHOPs must reconcile enrollment information and employer participation information with QHPs on no less than a monthly basis. Pursuant to 45 CFR 156.285(c)(5), SHOP issuers must reconcile enrollment files with the SHOPs at least monthly. CMS will continue to leverage the Enrollment Reconciliation fields, file formats, and dispositions used in the individual market FFMs for FF-SHOPs. The FF-SHOP process focuses on only a subset of applicable elements. Some elements from the individual market FFMs, such as APTC and CSRs, are not applicable. The FF-SHOP reconciliation process will focus on a monthly snapshot of active enrollments for the previous month. Group-level enrollment reconciliation is currently out of scope.

The FF-SHOPs and issuers will send monthly reconciliation files through the MFT process. Files are validated and data is compared between the FF-SHOP and issuer files. The FF-SHOPs will send issuer's rejection notices if files fail validation. Discrepancy files are generally sent to issuers within 5 business days from the monthly submission deadline. With the exception of issuer-assigned identifiers, the FF-SHOP enrollment system is generally considered the system of truth. Issuers disagreeing with changes sent on monthly discrepancy files may submit a dispute resolution form as outlined in the Enrollment Reconciliation Interface Control Document located on REGTAP.

Additional details and technical specifications can be found on REGTAP.

Section 5. Reporting Cases of Suspected Fraud or Ineligibility

This section discusses how cases of suspected fraud and ineligibility related to FF-SHOPs can be reported to CMS and the process that CMS has in place to investigate and resolve the cases.

When applying to participate in the FF-SHOPs, employers or employees may provide incorrect or incomplete information. If CMS receives a report that this has happened, it may investigate and implement corrective action as needed. In addition, CMS will work with DOIs, issuers, employers, employees, and other entities to identify and address potential ineligibility and suspected fraud occurring when applying and enrolling in coverage through the FF-SHOPs. To report an incident of potential ineligibility or suspected fraud in the FF-SHOPs, issuers should send an encrypted email to shop@cms.hhs.gov documenting the concern and providing evidence to support the claim. Issuers may also call the FF-SHOP Call Center for more information. At no time should issuers send PII as part of an e-mail communication to CMS. For the individual market in the FFMs, issuers should report any incidents of suspected fraudulent enrollment to their respective Account Manager.

Pursuant to §155.740, employers and employees may appeal a notice of denial of eligibility or a failure of an FF-SHOP to make an eligibility determination in a timely manner.

Section 6. User Interface Changes

This section discusses CMS's plans to make future FF-SHOP system enhancements.

Based on available resources, CMS plans to make several enhancements to the online system functionality available at HealthCare.gov in order to increase FF-SHOP enrollment and reduce its operational costs. Some of these enhancements may include providing more detailed descriptions of plan benefits, enhancing the FF-SHOP Call Center's ability to respond to consumer enrollment concerns without requiring a data correction, and adding agent/broker enhancements to encourage their broader participation.

Final information about FF-SHOP IT system enhancements is forthcoming.

CHAPTER 7: CONSUMER SUPPORT AND RELATED ISSUES

Section 1. Consumer Case Tracking and Resolution

The content of this section applies to QHP and SADP issuers in the FFMs, including in States performing plan management functions.

CMS expects QHP and SADP issuers to thoroughly investigate and resolve consumer issues received directly from members or forwarded to the QHP or SADP issuer by the State through the issuer's internal customer service process and as required by State law. Additionally, QHP and SADP issuers operating in the FFMs and SBM-FPs must investigate and resolve consumer cases, including complaints, forwarded by CMS in accordance with the requirements at 45 CFR 156.1010. Cases are forwarded through the Health Insurance Casework System (HICS). With the exception of anonymized matters recorded in the "Machine Readable Discrepancy" category of the HICS, CMS expects issuers to resolve all cases in a timely and accurate manner to ensure consumers receive the highest level of service and to meet QHP and SADP issuer participation standards as outlined at 45 CFR 156.200. Timeframes for resolving cases forwarded by CMS are specified in 45 CFR 156.1010(d). Issuers are expected to acquire and maintain sufficient access to the HICS, complying with all applicable CMS security and certification requirements. Additional information on acquiring access can be found in the Health Insurance Casework System Access Guide distributed on May 21, 2015.

HICS will also be used to record anonymized matters brought to CMS' attention through consumer feedback about machine readable data provided by issuers, including plan provider network and formulary information. The definition of a "case" under 45 CFR 156.1010(a) refers to "a communication brought by a complainant." However, in the event of a machine readable data discrepancy, the identity of the complainant is not relevant to identifying and correcting the issue, which potentially could affect all enrollees and potential enrollees in the plan. Accordingly, CMS does not consider these matters to be "cases," and certain requirements under 45 CFR 156.1010 applicable to cases (including timeframes for resolution under 45 CFR

156.1010(d) and complainant notification requirements under 45 CFR 156.1010(f)) will not apply to anonymized machine readable data discrepancies reported in this section of HICS.

CMS expects issuers to monitor these anonymized matters and use the data to identify trends that could indicate that their machine-readable files need to be corrected or updated. CMS may also monitor this data to identify areas for improvement for machine-readable content, and may provide future guidance about handling these matters.

Cases that CMS may forward include issues related to cancellations or terminations for any reason (including for non-payment of premiums), reinstatement review, premium or premium payment disputes, proper application of the APTC and CSRs, and adjustments of effective dates based on special enrollment periods (SEPs), final appeals decisions, delayed enrollment processing, or other enrollment errors. In all cases, CMS expects QHP and SADP issuers operating in the FFMs and SBM-FPs to conduct appropriate research using all of the tools and systems available to them, including but not limited to 834 transactions and pre-audit files. Additionally, CMS expects QHP and SADP issuers operating in the FFMs and SBM-FPs to contact consumers as appropriate to conduct their investigations and research in order to ensure that issuers are using the most recent information available from the consumer. Issuers may often need to contact a consumer prior to the resolution of a case as a critical part of the investigation and research process. CMS expects that issuers will carry out the needed research for their cases in a comprehensive manner that assures consumers that issuers' case resolutions are based on all of the available and most current information. CMS staff is available to assist QHP and SADP issuers by providing technical assistance on casework matters, and cases beyond issuers' control to resolve may result in reassignment of the case to CMS.

QHP and SADP issuers operating in the FFMs, including in States performing plan management functions, and in SBM-FPs are expected to comply with all applicable State and Federal laws related to consumer complaints, including any applicable requirement to advise consumers of their appeal rights. CMS tracks cases and uses this information as a tool for directing oversight activities in the FFMs and SBM-FPs. To the greatest degree possible, CMS collaborates with States, sharing information suggestive of issuer performance problems and provides HICS access to State regulators.

CMS will continue to work with QHP and SADP issuers to identify ways to improve the customer service experience for consumers in FFM and SBM-FP States, including promoting best practices, enhancing the HICS, refining casework guidance, and seeking to minimize cases assigned to issuers in HICS for review and handling.

Section 2. Coverage Appeals

The content of this section applies to all QHP issuers in the FFM, including in States performing plan management functions. This does not apply to SADPs.

As in plan years beginning in 2015 and 2016, in 2017 QHPs will be required to meet the same standards for internal claims and appeals and external review established at 45 CFR 147.136, which implements section 2719 of the PHS Act, as added by the Affordable Care Act. Section 2719 of the PHS Act requires that all non-grandfathered group health plans and non-grandfathered health insurance issuers offering group or individual health insurance coverage implement an effective process for internal claims and appeals and external review. QHPs must fully comply with the requirements of 45 CFR 147.136.

Section 3. Meaningful Access

This section summarizes the requirements and guidance that apply to QHP issuers (including SADP issuers) to ensure meaningful access by LEP speakers and by individuals with disabilities.

In the 2016 Payment Notice Final Rule, CMS finalized amendments to 45 CFR 155.205(c) pertaining to oral interpretation, the use of taglines indicating the availability of language services, and website translation. CMS also amended 45 CFR 156.250, which extends the requirements in 45 CFR 155.205(c) to QHP issuers, to require QHP issuers to provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in a manner consistent with 45 CFR 155.205(c). A document is deemed to meet this standard if the issuer is required by State or Federal law or regulation to provide it to a qualified individual, applicant, qualified employer, qualified employee, or enrollee.

Under these amendments to 45 CFR 156.250, QHP issuers must ensure meaningful access to at least the following essential documents:

- Applications;
- Consent, grievance, and complaint forms, and any documents requiring a signature;
- Correspondence containing information about eligibility and participation criteria;
- Notices pertaining to the denial, reduction, modification, or termination of services, benefits, non-payment, and/or coverage;
- A plan’s explanation of benefits or similar claim processing information;
- Rebate notices;
- Summary of benefits and coverage disclosures;
- Formulary drug lists;
- Provider directories; and

- The policy, insurance contract, evidence of coverage, or similar legally-required document.

In the 2016 Payment Notice Final Rule, under 45 CFR 155.205(c)(2)(i)(A), CMS specified that a QHP issuer's existing obligation to provide oral interpretation services includes making available telephonic interpretation services in at least 150 languages.

CMS also specified other language access requirements pertaining to taglines and translation of website content that apply to QHP issuers. These requirements will become applicable for issuers beginning with the first day of the open enrollment period for the individual market for the 2017 benefit year. First, under 45 CFR 155.205(c)(2)(iii)(A), we specified that a QHP issuer's existing requirement to include taglines in non-English languages includes providing taglines on website content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by individuals with limited English proficiency in the relevant State, as determined in HHS guidance. For this purpose, a document is deemed to be critical for obtaining health insurance coverage or access to health care services through the QHP if it is required to be provided by State or Federal law or regulation to the qualified individual, applicant, qualified employer, qualified employee, or enrollee.

Under 45 CFR 155.205(c)(2)(iv)(B), we specified that a QHP issuer must translate certain website content that is "critical" within the meaning of 45 CFR 156.250, into any non-English language that is spoken by an LEP population that reaches 10 percent or more of the population of the relevant State, as determined in HHS guidance. HHS expects to issue guidance beginning in March 2016 identifying the non-English languages that are triggered by these standards for each State as well as sample taglines.

In order to achieve greater consistency among certain programs within HHS, CMS continues to work with other HHS components to further specify standards for ensuring meaningful access by LEP speakers and by people with disabilities.[77]

Finally, QHP issuers operating in the FFMs are reminded that the meaningful access requirements at 45 CFR 155.205(c), 155.230(b), and 156.250, as well as non-discrimination prohibitions at 45 CFR 156.200(e), are independent of other obligations QHP issuers might have. For example, QHP issuers that receive Federal financial assistance are subject to Title VI of the

[77] For instance, CMS intends to continue coordinating with OCR in OCR's implementation of section 1557 of the Affordable Care Act.

Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973,[78] and section 1557 of the Affordable Care Act,[79] and as a result, have separate responsibilities under the law not to discriminate on the basis of race, color, national origin, sex (including gender identity), age, and disability, in providing access to their services.

Section 4. Summary of Benefits and Coverage

The content of this section applies to all QHP issuers in the FFM, including States performing plan management functions.

QHP issuers are required to provide the Summary of Benefits and Coverage (SBC) in a manner compliant with the standards set forth in 45 CFR 147.200, which implements section 2715 of the PHS Act, as added by the Affordable Care Act. Specifically, issuers must fully comply with the requirements of 45 CFR 147.200(a)(3), which requires issuers to "provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance."

On June 16, 2015, the Departments, published final rules regarding the SBC, which amend the final regulations published on February 14, 2012.[80] The June 2015 final regulations include amendments clarifying that, under Section 2715(b)(3)(I) of the Public Health Service Act, as added by the Affordable Care Act, issuers must include a web address where a copy of the individual coverage policy or group certificate of coverage can be reviewed and obtained. The final regulations require these documents to be easily available to individuals, plan sponsors, participants and beneficiaries shopping for coverage and prior to submitting an application for coverage. In addition, the final regulations require a QHP issuer to disclose on the SBC whether non-excepted abortion services as well as excepted abortion services (that is, those abortion services for which public funding is permitted) are covered or excluded, consistent with the

[78] Consistent with Section 504 of the Rehabilitation Act and HHS implementing regulations at 45 CFR 84, covered entities, which include all recipients of Federal financial assistance from HHS, are required to "provide auxiliary aids to persons with disabilities, at no additional cost, where necessary to afford an equal opportunity to participate in or benefit from a program or activity" (http://www.hhs.gov/ocr/civilrights/understanding/disability/). CMS encourages QHP issuers seeking to understand their legal obligations to provide auxiliary aids and services to people with disabilities to reference the U.S. Department of Justice's Effective Communications guidance at: http://www.ada.gov/effective-comm.htm.

[79] Nondiscrimination in Health Programs and Activities, Notice of Proposed Rulemaking, 80 Federal Register 54172 (Sept. 8, 2015) (proposing 45 CFR 92.8 that would establish, among other things, notice requirements on covered entities regarding provision of language assistance services and auxiliary aids and services; and proposing 45 CFR 92.201 that would require, among other things, a covered entity to take reasonable steps to provide meaningful access to each individual with LEP that it serves or encounters in its health programs or activities).

[80] Summary of Benefits and Coverage and Uniform Glossary, 80 Federal Register 34292 (June 16, 2015).

manner specified in guidance by the Secretary.[81] These final regulations were generally applicable for SBCs issued in connection with individual market coverage that began on or after January 1, 2016.[82] In the preamble to the June 2015 final rules, the Departments stated that revisions to the SBC template and supporting materials which were proposed on December 30, 2014 would be finalized separately from the final regulations. We note that the guidance for QHP issuers regarding the wording and placement of this disclosure on the SBC will be included in the final SBC template and instruction guides, and are not included in the final regulations. Issuers should continue to use the current SBC template and supporting materials until the proposed revisions to the SBC template and related supporting materials are finalized. The Departments are going through a separate process to finalize the SBC template and associated documents.[83]

In the 2016 Payment Notice Final Rule, CMS amended 45 CFR 156.420 and §156.425 to require QHP issuers to provide SBCs that accurately represent plan variations in a manner consistent with the requirements set forth at 45 CFR 147.200, and, after receiving notice from the Marketplace of an enrollee's assignment into a new plan variation (or standard QHP without cost-sharing reductions), provide the individual an SBC that accurately reflects the new plan variation (or standard QHP without cost-sharing reductions) as soon as practicable following receipt of notice from the Marketplace, but not later than 7 business days following receipt of notice. In accordance with these new regulations, beginning no later than November 1, 2015, QHP issuers must provide separate SBCs for each plan variation and therefore may not combine information about multiple plan variations in one SBC. Issuers offering plan variations must include a separate URL linking to the SBC created for each plan variation as part of the QHP data submission to CMS.

As noted above, QHP issuers are responsible for complying with the culturally and linguistically appropriate standards set forth in the 2016 Payment Notice Final Rule. Among other things, this final rule sets out amended language access requirements at 45 CFR 155.205(c) with respect to oral interpretation, written translations, taglines, and website translations. QHP issuers must provide an addendum with language taglines in the top 15 languages spoken by the LEP populations of the relevant State within their SBCs for QHPs offered through a Marketplace. Any additional taglines required under Public Health Service Act sections 2715 and 2719 or their implementing regulations may also be included in this addendum. The addendum, which must

[81] 45 CFR 147.200(a)(2)(i)(N).

[82] 45 CFR 147.200(g).

[83] See Federal Register notice at 81 FR 9860. Proposed templates are available at: https://www.cms.gov/cciio/resources/Regulations-and-Guidance/index.html#Summary of Benefits and Coverage and Uniform Glossary under "February 2016 Proposed Supporting Materials for Public Comment."

only include tagline information is authorized to be provided along with the SBC by 45 CFR 155.205(c) and is not considered a part of the SBC document. Therefore, the addendum will not count towards the four double-sided page limit for the SBC under PHS Act section 2715(b)(1).

On September 8, 2015, CMS issued an FAQ that provided a limited enforcement safe harbor with respect to the date by which the individual coverage policy or group certificate of coverage documents were required to be made accessible via a web address. This FAQ stated that HHS would not take enforcement action against an issuer that made the individual coverage policy or group certificate of coverage documents accessible online no later than November 1, 2015.[84] We remind issuers that this enforcement safe harbor is no longer effective, and issuers must include on the SBC a web address where the actual individual coverage policy or group certificate of coverage documents can be reviewed and obtained, including by individuals and plan sponsors shopping for coverage.

Lastly, we remind issuers that all URL links included on the SBC must be readily obtainable (that is, without requiring logging on to a website, entering a policy number, clicking through several web pages, or creating user accounts, memberships, or registrations) to consumers, including shoppers, and link directly to the information referenced on the SBC. For example, in accordance with 45 CFR 147.200(a)(2)(i)(L), the link for obtaining information on prescription drug coverage in the SBC must directly link to the formulary for the benefit package reflected on the SBC, as noted previously. Similarly, pursuant to 45 CFR 147.200(a)(2)(i)(J), the web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained must also link directly from the appropriate space on the SBC and be readily obtainable to shoppers.

CHAPTER 8: TRIBAL RELATIONS AND SUPPORT

The Federal Government, and therefore CMS, has a historic and unique relationship with Federally-recognized tribes, and the health programs operated by the Indian Health Service (IHS), Tribes and Tribal organizations and Urban Indian organizations. These are collectively known as Indian health care providers. In adhering to QHP certification standards, CMS reminds QHPs to contract with Indian health care providers, through which a significant number of American Indians and Alaska Natives (AI/AN) access health care. To promote contracting

[84] This relief was limited to the requirement to post the individual coverage policy or group certificate of coverage. Issuers were still required to provide the SBC in accordance with the timeframes set forth in the final rules. Issuers were required to provide on the SBC the web address where the documents would be available by November 1, 2015, and to include language on the web page indicating that the documents would be accessible on November 1, 2015. This relief was only applicable with respect to the requirement to make individual coverage policy and group certificate of coverage documents accessible online, and did not apply to any other requirements of the June 12, 2015 final rules.

between issuers and Indian health care providers, CMS is continuing to require QHPs to offer contracts in good faith to all available Indian health care providers in the QHP's service area, applying the special terms and conditions necessitated by Federal law and regulations as referenced in the Model QHP Addendum (Addendum). [85]

CMS developed the Addendum to facilitate the inclusion of Indian health care providers in QHP provider networks. The Addendum is a model standardized document for QHP issuers to use in contracting with Indian health care providers. To make it easier for QHPs to find Indian health care providers, a list of eligible providers and their address and contact information may be found on the HHS ECP list available on our CCIIO website. We strongly encourage issuers to ensure each offer is sent to the correct address and contacts. Similarly, we encourage all Indian health care providers to ensure their contact information correctly appears on the HHS ECP list and review all offers and respond timely to issuers.

Section 206 of the Indian Health Care Improvement Act (IHCIA) (25 USC 1621e) provides for a right of recovery from an insurance company and other third party entities, including QHP issuers, for reasonable charges billed by an Indian health care provider when providing services, or, if higher, the highest amount the third party would pay for services furnished by other providers. This right of recovery applies whether the Indian health care provider is in a plan network or not. Further details can be found at https://www.ihs.gov/ihcia/.

Even though Indian health care providers have a right of recovery under section 206 of the IHCIA, CMS encourages issuers and Indian health care providers to develop mutually beneficial business relationships that promote effective care for medically underserved and vulnerable populations.

CHAPTER 9: STATE-BASED MARKETPLACES ON THE FEDERAL PLATFORM

In the 2017 Payment Notice Final Rule, we finalized rules related to State-based Marketplaces on the Federal Platform, or SBM-FPs, that leverage existing Federal assets and operations to support their Marketplace functions and rules governing their QHP issuers. Pursuant to approval from HHS through the Blueprint process described under 45 CFR 155.106 and the execution of a Federal platform agreement with HHS, States may agree to rely on HHS for eligibility and enrollment and related functions. These functions include, but are not limited to, the consumer Call Center, casework processes, and the related information technology infrastructure. Under the Federal platform agreement, the SBM-FP will also agree to require its QHP issuers to comply with certain FFM standards for QHPs, as well as user fee collection requirements. SBM-FPs will retain primary responsibility for plan management functions, including QHP certification. In the

[85] The model QHP Addendum for Indian health providers is available at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

Federal platform agreement, an SBM-FP will agree to use the Federal infrastructure to perform these functions for its individual market Marketplace, its SHOP Marketplace, or both its individual and SHOP Marketplaces. We intend to release the Federal platform agreement at a later date.

Although an SBM-FP will retain primary responsibility for overseeing QHPs and issuers, under 45 CFR 155.200(f), an SBM-FP must agree to enforce certain QHP and QHP issuer requirements that are no less strict than the requirements that HHS applies to QHPs and QHP issuers in the FFMs as follows:

- 45 CFR 156.122(d)(2): the standards for QHPs to make available published up-to-date, accurate, and complete formulary drug lists on its website in a format and at times determined by HHS;
- 45 CFR 156.230: network adequacy standards;
- 45 CFR 156.235: ECP standards;
- 45 CFR 156.298: meaningful difference standards;
- 45 CFR 156.330: issuer change of ownership standards;
- 45 CFR 156.340(a)(4): issuer compliance and compliance of delegated and downstream entity standards; and
- 45 CFR 156.1010: casework standards.

Note that issuers and plans offered through an SBM-FP must comply with rules, as interpreted and implemented in policy and guidance related to the Federal eligibility and enrollment infrastructure. These will be the same requirements related to eligibility and enrollment that are applicable to QHP issuers and plans on FFMs, as the Federal platform will not have the capacity to modify enrollment periods or otherwise provide customization for other eligibility and enrollment processes in SBM-FPs in 2017. SBM-FP issuers must also comply with certain FFM enrollment policies and operations (e.g., premium payment and grace period rules, effective date logic, acceptable transaction codes, and reconciliation rules) for the FFM to successfully process 834 transactions with issuers and minimize any data discrepancies for reconciliation.

Finally, under 45 CFR 155.200(f)(3), HHS will work with SBM-FPs to enforce the above-listed FFM standards directly against SBM-FP issuers and/or QHPs, when the SBM-FP is not substantially enforcing one or more of the requirements. Under such a circumstance, HHS will have the authority to suppress a plan under 45 CFR 156.815. This will ensure that consumers shopping for coverage on HealthCare.gov have access to QHPs that are in compliance with the FFM standards with which SBM-FP issuers must comply as a condition of offering QHPs in an SBM-FP (Pursuant to 45 CFR 156.815(c), OPM will notify the Marketplace if an MSP option

needs to be suppressed). CMS intends to work closely and collaboratively with SBM-FPs, and we believe that our collaboration with SBMs that have used the Federal platform for eligibility and enrollment functions to date has been close and effective with respect to enforcement matters.

Additional Resources

Helpful Links and Websites

Nevada Division of Insurance Website

Home Page: http://doi.nv.gov/

Network Adequacy Page: http://doi.nv.gov/Insurers/Life-Health/Network-Adequacy/

Centers for Medicare **&** Medicaid Services

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html

2017 Letter to Issuers in the Federally-facilitated Marketplaces

http://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Insurers/Life_and_Health/PY2017Issuerletter.pdf

NAIC Glossaries

Glossary of Insurance Terms: http://www.naic.org/consumer_glossary.htm

Glossary of Health Insurance and Medical Terms

http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf

Common Acronyms and Abbreviations

http://www.naic.org/documents/library_Acronyms_Proc.pdf

Healthcare.gov Glossary: https://www.healthcare.gov/glossary/

Nevada State Office of Rural Health – NV Rural & Frontier Health Data Book January 2015

http://medicine.nevada.edu/Documents/unsom/statewide/rural/data-book-2015/Nevada_Rural_and_Frontier_Health_Data_Book_2015DraftEmbedOpt.pdf

Glossary of Health Insurance and Medical Terms

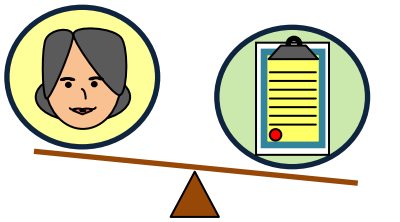
- This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate. You can get a copy of the policy at [www.insurancecompany.com] or you may call [1-800-xxx-xxxx.]
- Bold text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



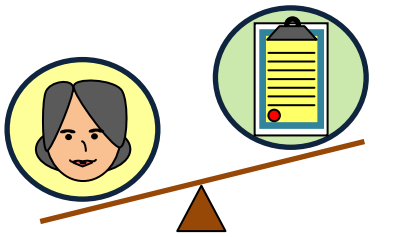
Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services received in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

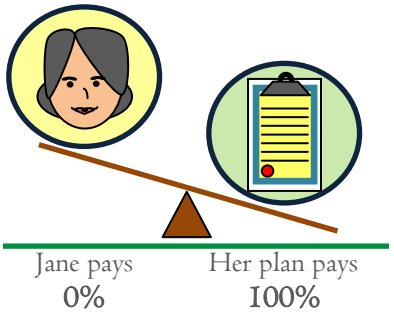
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit


The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

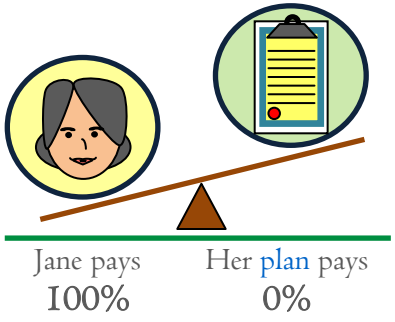
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Policy Period

December 31st
End of Policy Period

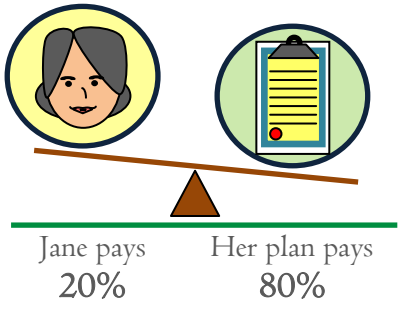


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

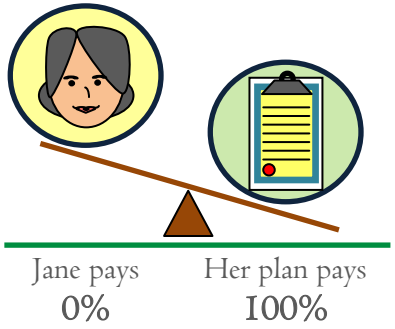


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Glossary of Insurance Terms

This page provides a glossary of insurance terms and definitions that are commonly used in the insurance business. New terms will be added to the glossary over time.

The definitions in this glossary are developed by the **NAIC Research and Actuarial Department** staff based on various insurance references. These definitions represent a common or general use of the term. Some words and/or phrases may be defined differently by other entities, or used in a context such that the definition shown may not be applicable.

(Click on the letter to view terms beginning with that alphabet.)

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

Accident - an unexpected event or circumstance without deliberate intent.

Accident Insurance - insurance for unforeseen bodily injury.

Accident Only - an insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident.

Accident Only or AD&D - policies providing coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Accidental Bodily Injury - unexpected injury to a person.

Accidental Death & Dismemberment - an insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

Accumulation Period - period of time insured must incur eligible medical expenses at least equal to the deductible amount in order to establish a benefit period under a major medical expense or comprehensive medical expense policy.

Actual Cash Value - repayment value for indemnification due to loss or damage of property; in most cases it is replacement cost minus depreciation

Actuarial Report - (PC Insurance)a document or other presentation, prepared as a formal means of conveying to the state regulatory authority and the Board of Directors, or its equivalent, the actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the actuary's opinion or findings and that documents the analysis underlying the opinion. (In Life and Health) this document would be called an "Actuarial Memorandum."

Actuary - business professional who analyzes probabilities of risk and risk management including calculation of premiums, dividends and other applicable insurance industry standards.

Adjuster - a person who investigates claims and recommends settlement options based on estimates of damage and insurance policies held.

Admission - hospital inpatient care for any medical condition.

Admitted Assets - insurer assets which can be valued and included on the balance sheet to determine financial viability of the company.

Admitted Company - an insurance company licensed to do business in a state(s), domiciled in an alternative state or country.

Advance Premiums - occur when a policy has been processed, and the premium has been paid prior to the effective date. These are a liability to the company and not included in written premium or the unearned premium reserve.

Adverse Selection - the social phenomenon whereby persons with a higher than average probability of loss seek greater insurance coverage than those with less risk.

Advisory Organization - a group supported by member companies whose function is to gather loss statistics and publish trended loss costs.

Affiliate - a person or entity that directly, or indirectly, through one or more other persons or entities, controls, is controlled by or is under common control with the insurer.

Agent - an individual who sells, services, or negotiates insurance policies either on behalf of a company or independently.

Aggregate - the maximum dollar amount or total amount of coverage payable for a single loss, or multiple losses, during a policy period, or on a single project.

Aggregate Cost Payments - method of reimbursement of a health plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services, and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan that put their respective capital and surplus at risk in guaranteeing each other.

Aircraft - coverage for aircraft (hull) and their contents; aircraft owners' and aircraft manufacturers liability to passengers, airports and other third parties.

ALAE - an estimate of the claims settlement associated with a particular claim or claims.

Alien Company - an insurance company formed according to the laws of a foreign country. The company must conform to state regulatory standards to legally sell insurance products in that state.

Allied Lines - coverages which are generally written with property insurance, e.g., glass, tornado, windstorm and hail; sprinkler and water damage; explosion, riot, and civil commotion; growing crops; flood; rain; and damage from aircraft and vehicle, etc.

All-Risk - also known as open peril, this type of policy covers a broad range of losses. The policy covers risks not explicitly excluded in the policy contract.

Alternative Workers' Compensation - other than standard workers' compensation coverage, employer's liability and excess workers' compensation (e.g., large deductible, managed care).

Ambulatory Services - health services provided to members who are not confined to a health care institution. Ambulatory services are often referred to as "outpatient" services.

Annual Statement - an annual report required to be filed with each state in which an insurer does business. This report provides a snapshot of the financial condition of a company and significant events which occurred throughout the reporting year.

Annuitant - the beneficiary of an annuity payment, or person during whose life and annuity is payable.

Annuities – Immediate Non-variable - an annuity contract that provides for the fixed payment of the annuity at the end of the first interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months.

Annuity - a contract providing income for a specified period of time, or duration of life for a person or persons.

Appraisal - an estimate of value.

Arbitration - a binding dispute resolution tactic whereby a conciliator with no interest in the outcome intercedes.

Assessed Value - estimated value for real or personal property established by a taxing entity

Asset - probable future economic benefits obtained or controlled by a particular entity as a result of past transactions or events. An asset has three essential characteristics: It embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows; A particular entity can obtain the benefit and control others' access to it; and The transaction or other event-giving rise to the entity's right to or control of the benefit has already occurred.

Asset Risk - in the risk-based capital formula, risk assigned to the company's assets.

Assigned Risk - A governmental pool established to write business declined by carriers in the standard insurance market.

Assisted Living Care - a policy or rider that provides coverage only while a policyholder is confined to an assisted living facility and meets the policy requirements for coverage.

Assumed Reinsurance - the assumption of risk from another insurance entity within a reinsurance agreement or treaty.

Authorized Company - an insurer licensed or admitted to do business in a particular state.

Authorized Control Level Risk Based Capital - theoretical amount of capital plus surplus an insurance company should maintain.

Authorized Reinsurance - reinsurance placed with a reinsurer who is licensed or otherwise allowed to conduct reinsurance within a state.

Auto Liability - coverage that protects against financial loss because of legal liability for motor vehicle related injuries (bodily injury and medical payments) or damage to the property of others caused by accidents arising out of ownership, maintenance or use of a motor vehicle (including recreational vehicles such as motor homes). Commercial is defined as all motor vehicle policies that include vehicles that are used primarily in connection with business, commercial establishments, activity, employment, or activities carried on for gain or profit. No Fault is defined by the state concerned.

Auto Physical Damage - motor vehicle insurance coverage (including collision, vandalism, fire and theft) that insures against material damage to the insured's vehicle. Commercial is defined as all motor vehicle policies that include vehicles that are used in connection with business, commercial establishments, activity, employment, or activities carried on for gain or profit.

Automobile Liability Insurance - coverage for bodily injury and property damage incurred through ownership or operation of a vehicle.

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Balance Sheet - accounting statement showing the financial condition of a company at a particular date.

BCEGS - Building Code Effectiveness Grading Schedule - classification system for assessment of building codes per geographic region with special emphasis on mitigation of losses from natural disasters.

Beneficiary - an individual who may become eligible to receive payment due to will, life insurance policy, retirement plan, annuity, trust, or other contract.

Benefits (Medical & Hospital Expenses) - total expenditures for health care services paid to or on behalf of a member.

Blanket coverage - coverage for property and liability that extends to more than one location, class of property or employee.

Boatowners/Personal Watercraft - covers damage to pleasure boats, motors, trailers, boating equipment and personal watercraft as well as bodily injury and property damage liability to others.

Bodily Injury - physical injury including sickness or disease to a person.

Boiler & Machinery or Equipment Breakdown & Machinery - coverage for the failure of boilers, machinery and other electrical equipment. Benefits include (i) property of the insured, which has been directly damaged by the accident; (ii) costs of temporary repairs and expediting expenses; and (iii) liability for damage to the property of others. Coverage also includes inspection of the equipment.

Bonds - a form of debt security whereby the debt holder has a creditor stake in the company. Obligations issued by business units, governmental units and certain nonprofit units having a fixed schedule for one or more future payments of money; includes commercial paper, negotiable certificates of deposit, repurchase agreements and equipment trust certificates.

Book Value - original cost, including capitalized acquisition costs and accumulated depreciation, unamortized premium and discount, deferred origination and commitment fees, direct write-downs, and increase/decrease by adjustment.

Broker - an individual who receives commissions from the sale and service of insurance policies. These individuals work on behalf of the customer and are not restricted to selling policies for a specific company but commissions are paid by the company with which the sale was made.

Builders' Risk Policies - typically written on a reporting or completed value form, this coverage insures against loss to buildings in the course of construction. The coverage also includes machinery and equipment used in the course of construction and to materials incidental to construction.

Burglary and Theft - coverage for property taken or destroyed by breaking and entering the insured's premises, burglary or theft, forgery or counterfeiting, fraud, kidnap and ransom, and off-premises exposure.

Business Auto - coverage for motor vehicles, other than those in the garage business, engaged in commerce. Business auto filings include singularly or in any combination coverage such as the following: Auto Liability, PIP, MP, Uninsured Motorist and/or Underinsured Motorists (UM/UIM); Specified Causes of Loss, Comprehensive, and Collision.

Business Interruption - loss of income as a result of property damage to a business facility.

Business owners Policy - business insurance typically for property, liability and business interruption coverage.

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Calendar Year Deductible - in health insurance, the amount that must be paid by the insured during a calendar year before the insurer becomes responsible for further loss costs.

Capital and Surplus - a company's assets minus its liabilities.

Capital and Surplus Requirement - statutory requirement ordering companies to maintain their capital and surplus at an amount equal to or in excess of a specified amount to help assure the solvency of the company by providing a financial cushion against expected loss or misjudgments and generally measured as a company's admitted assets minus its liabilities, determined on a statutory accounting basis.

Capital Gains (Loss) - excess (deficiency) of the sales price of an asset over its book value. Calculated on the basis of original cost adjusted, as appropriate, for accrual of discount or amortization of premium and for depreciation.

Capitation Arrangement - a compensation plan used in connection with some managed care contracts where a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. Capitated payments are sometimes expressed in terms of a "per member/per month" payment. The capitated provider is generally responsible, under the conditions of the contract, for delivering or arranging for the delivery of all contracted health services required by the covered person.

Captive Agent - an individual who sells or services insurance contracts for a specific insurer or fleet of insurers.

Captive Insurer - an insurance company established by a parent firm for the purpose of insuring the parent's exposures.

Carrying Value (Amount) - the SAP book value plus accrued interest and reduced by any valuation allowance and any nonadmitted adjustment applied to the individual investment.

Cash - a medium of exchange.

Cash Equivalent - short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Investments with original maturities of three months or less qualify under this definition.

Casualty Insurance - a form of liability insurance providing coverage for negligent acts and omissions such as workers compensation, errors and omissions, fidelity, crime, glass, boiler, and various malpractice coverages.

Catastrophe Bonds - Bonds issued by an insurance company with funding tied to the company's losses from disasters, or acts of God. A loss exceeding a certain size triggers a reduction in the bond value or a change in the bond structure as loss payments are paid out of bond funds.

Catastrophe Loss - a large magnitude loss with little ability to forecast.

Ceded Premium - amount of premium (fees) used to purchase reinsurance.

Ceding Company - an insurance company that transfers risk by purchasing reinsurance.

Centers for Medicare & Medicaid Services (CMS) - U.S. governmental agency responsible for the licensing of federally qualified HMOs. This was formerly the Health Care Financing Administration.

Change in Valuation Basis - a change in the interest rate, mortality assumption or reserving method or other factors affecting the reserve computation of policies in force.

Chartered Life Underwriter (CLU) - a professional designation awarded by the American College to persons in the life insurance field who pass a series of exams in insurance, investment, taxation, employee benefit plans, estate planning, accounting, management, and economics.

Chartered Property Casualty Underwriter (CPCU) - a professional designation awarded by the American Institute of Property and Casualty Underwriters to persons in the property and liability insurance field who pass a series of exams in insurance, risk management, economics, finance, management, accounting, and law. Designates must also have at least three years experience in the insurance business or related field.

Claim - a request made by the insured for insurer remittance of payment due to loss incurred and covered under the policy agreement.

Claims Adjustment Expenses - costs expected to be incurred in connection with the adjustment and recording of accident and health, auto medical and workers' compensation claims.

Claims-made Form - A type of liability insurance form that only pays if the both event that causes (triggers)the claim and the actual claim are submitted to the insurance company during the policy term

Class Rating - a method of determining rates for all applicants within a given set of characteristics such as personal demographic and geographic location.

Coinsurance - A clause contained in most property insurance policies to encourage policy holders to carry a reasonable amount of insurance. If the insured fails to maintain the amount specified in the clause (Usually at least 80%), the insured shares a higher proportion of the loss. In medical insurance a percentage of each claim that the insured will bear.

Collar - an agreement to receive payments as the buyer of an Option, Cap or Floor and to make payments as the seller of a different Option, Cap or Floor.

Collateral Loans - unconditional obligations for the payment of money secured by the pledge of an investment.

Collateralized Bond Obligations (CBOs) - an investment-grade bond backed by a pool of low-grade debt securities, such as junk bonds, separated into tranches based on various levels of credit risk.

Collateralized Mortgage Obligations (CMOs) - a type of mortgage-backed security (MBS) with separate pools of pass-through security mortgages that contain varying classes of holders and maturities (tranches) with the advantage of predictable cash flow patterns.

Combinations - a special form of package policy composed of personal automobile and homeowners insurance.

Combined Ratio - an indication of the profitability of an insurance company, calculated by adding the loss and expense ratios.

Commencement Date - date when the organization first became obligated for any insurance risk via the issuance of policies and/or entering into a reinsurance agreement. Same as "effective date" of coverage.

Commercial Auto - coverage for motor vehicles owned by a business engaged in commerce that protects the insured against financial loss because of legal liability for motor vehicle related injuries, or damage to the property of others caused by accidents arising out of the ownership, maintenance, use, or care-custody & control of a motor vehicle. This includes Commercial Auto Combinations of Business Auto, Garage, Truckers and/or Other Commercial Auto.

Commercial Earthquake - earthquake property coverage for commercial ventures.

Commercial Farm and Ranch - a commercial package policy for farming and ranching risks that includes both property and liability coverage. Coverage includes barns, stables, other farm structures and farm inland marine, such as mobile equipment and livestock.

Commercial Flood - separate flood insurance policy sold to commercial ventures.

Commercial General Liability - flexible & broad commercial liability coverage with two major sub-lines: premises/operations sub-line and products/completed operations sub-line.

Commercial Mortgage-Backed Securities - a type of mortgage-backed security that is secured by the loan on a commercial property.

Commercial Multiple Peril - policy that packages two or more insurance coverages protecting an enterprise from various property and liability risk exposures. Frequently includes fire, allied lines, various other coverages (e.g., difference in conditions) and liability coverage. Such coverages would be included in other annual statement lines, if written individually. Include under this type of insurance multi-peril policies (other than farmowners, homeowners and automobile policies) that include coverage for liability other than auto.

Commercial Package Policy - provides a broad package of property and liability coverages for commercial ventures other than those provided insurance through a business owners policy.

Commercial Property - property insurance coverage sold to commercial ventures.

Commission - a percentage of premium paid to agents by insurance companies for the sale of policies.

Community Rating - a rating system where standard rating is established and usually adjusted within specific guidelines for each group on the basis of anticipated utilization by the group's employees.

Company Code - a five-digit identifying number assigned by NAIC, assigned to all insurance companies filing financial data with NAIC.

Completed Operations Liability - policies covering the liability of contractors, plumbers, electricians, repair shops, and similar firms to persons who have incurred bodily injury or property damage from defective work or operations completed or abandoned by or for the insured, away from the insured's premises.

Comprehensive (Hospital and Medical) - line of business providing for medical coverages; includes hospital, surgical, major medical coverages; does not include Medicare Supplement, administrative services (ASC) contracts, administrative services only (ASO) contracts, federal employees health benefit plans (FEHBP), medical only programs, Medicare and Medicaid programs, vision only and dental only business.

Comprehensive General Liability (CGL) - coverage of all business liabilities unless specifically excluded in the policy contract.

Comprehensive Personal Liability - comprehensive liability coverage for exposures arising out of the residence premises and activities of individuals and family members. (Non-business liability exposure protection for individuals.)

Comprehensive/Major Medical - policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses. Coverage excludes Short-Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage.

Concurrent Causation - property loss incurred from two or more perils in which only one loss is covered but both are paid by the insurer due to simultaneous incident.

Conditions - requirements specified in the insurance contract that must be upheld by the insured to qualify for indemnification.

Condos - homeowners insurance sold to condominium owners occupying the described property.

Construction and Alteration Liability - covering the liability of an insured to persons who have incurred bodily injury or property damage from alterations involving demolition, new construction or change in size of a structure on the insured's premises.

Contingency Reserves - required by some jurisdictions as a hedge against adverse experience from operations, particularly adverse claim experience.

Contingent Liability - the liability of an insured to persons who have incurred bodily injury or property damage from work done by an independent contractor hired by the insured to perform work that was illegal, inherently dangerous, or directly supervised by the insured

Continuation of Care Requirement - statutory or contractual provision requiring providers to deliver care to an enrollee for some period following the date of a Health Plan Company's insolvency.

Continuing Care Retirement Communities - senior housing arrangements that in addition to housing include some provision for skilled nursing care.

Contract Reserves - reserves set up when, due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim and premium reserves.

Contractual Liability - liability coverage of an insured who has assumed the legal liability of another party by written or oral contract. Includes a contractual liability policy providing coverage for all obligations and liabilities incurred by a service contract provider under the terms of service contracts issued by the provider.

Convertible Term Insurance Policy - an insurance policy that can be converted into permanent insurance without a medical assessment. The insurer is required to renew the policy regardless of the health of the insured subject to policy conditions.

Coordination of Benefits (COB) - provision to eliminate over insurance and establish a prompt and orderly claims payment system when a person is covered by more than one group insurance and/or group service plan.

Copay - a cost sharing mechanism in group insurance plans where the insured pays a specified dollar amount of incurred medical expenses and the insurer pays the remainder.

Corrective Order - commissioner's directive of action to be completed by an insurer.

Covered Lives - The total number of lives insured, including dependents, under individual policies and group certificates.

Credit - individual or group policies that provide benefits to a debtor for full or partial repayment of debt associated with a specific loan or other credit transaction upon disability or involuntary unemployment of debtor, except in connection with first mortgage loans.

Credit – Assumption Agreement - an insurance certificate issued on an existing insurance contract indicating that another insurer has assumed all of the risk under the contract from the ceding insurance company.

Credit - Credit Default - coverage purchased by manufacturers, merchants, educational institutions, or other providers of goods and services extending credit, for indemnification of losses or damages resulting from the nonpayment of debts owed to them for goods or services provided in the normal course of their business.

Credit – Involuntary Unemployment - makes loan/credit transaction payments to the creditor when the debtor becomes involuntarily unemployed.

Credit Accident and Health (group and individual) - coverage provided to or offered to borrowers in connection with a consumer credit transaction where the proceeds are used to repay a debt or an installment loan in the event the consumer is disabled as the result of an accident, including business not exceeding 120 months duration.

Credit Disability - makes monthly loan/credit transaction payments to the creditor upon the disablement of an insured debtor.

Credit Health Insurance - policy assigning creditor as beneficiary for insurance on a debtor thereby remitting balance of payment to creditor should the debtor become disabled.

Credit Involuntary Unemployment - credit insurance that provides a monthly or lump sum benefit during an unpaid leave of absence from employment resulting from specified causes, such as layoff, business closure, strike, illness of a close relative and adoption or birth of a child. This insurance is sometimes referred to as Credit Family Leave.

Credit Life Insurance - policy assigning creditor as beneficiary for insurance on a debtor thereby remitting balance of payment to creditor upon death of debtor.

Credit Personal Property Insurance - insurance written in connection with a credit transaction where the collateral is not a motor vehicle, mobile home or real estate and that covers perils to the goods purchased through a credit transaction or used as collateral for a credit transaction and that concerns a creditor's interest in the purchased goods or pledged collateral, either in whole or in part; or covers perils to goods purchased in connection with an open-end transaction.

Credit Placed Insurance - insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to property as a result of fire, theft, collision or other risks of loss that would either impair a creditor's interest or adversely affect the value of collateral. "Creditor Placed Home" means "Creditor Placed Insurance" on homes, mobile homes and other real estate. "Creditor Placed Auto" means insurance on automobiles, boats or other vehicles.

Credit Risk - part of the risk-based capital formula that addresses the collectability of a company's receivables and the risk of losing a provider or intermediary that has received advance capitation payments.

Creditor-Placed Auto - single interest or dual interest credit insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss to property that would either impair a creditor's interest or adversely affect the value of collateral on automobiles, boats, or other vehicles.

Creditor-Placed Home - single interest or dual interest credit insurance purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss to property that would either impair a creditor's interest or adversely affect the value of collateral on homes, mobile homes, and other real estate.

Crop - coverage protecting the insured against loss or damage to crops from a variety of perils, including but not limited to fire, lightening, loss of revenue, tornado, windstorm, hail, flood, rain, or damage by insects.

Crop-Hail Insurance - coverage for crop damage due to hail, fire or lightning.

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D

Date of Issue - date when an insurance company issues a policy.

Declarations - policy statements regarding the applicant and property covered such as demographic and occupational information, property specifications and expected mileage per year .

Deductible - Portion of the insured loss (in dollars) paid by the policy holder

Deferred Annuity - annuity payment to be made as a single payment or a series of installments to begin at some future date, such as in a specified number of years or at a specified age.

Demutualization - conversion of a mutual insurance company to a capital stock company.

Dental Insurance - policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.

Dental Only - line of business providing dental only coverage; coverage can be on a stand-alone basis or as a rider to a medical policy. If the coverage is as a rider, deductibles or out-of-pocket limits must be set separately from the medical coverage. Does not include self-insured business as well as FEHBP or Medicare and Medicaid programs.

Derivative - securities priced according to the value of other financial instruments such as commodity prices, interest rates, stock market prices, foreign or exchange rates.

Difference In Conditions (DIC) Insurance - special form of open-peril coverage written in conjunction with basic fire coverage and designed to provide protection against losses not reimbursed under the standard fire forms. Examples are flood and earthquake coverage.

Direct Incurred Loss - loss whereby the proximate cause is equivalent to the insured peril.

Direct Loss - Damage to covered real or personal property caused by a covered peril.

Direct Writer - an insurance company that sells policies to the insured through salaried representatives or exclusive agents only; reinsurance companies that deal directly with ceding companies instead of using brokers.

Direct Written Premium - total premiums received by an insurance company without any adjustments for the ceding of any portion of these premiums to the Reinsurer.

Directors & Officers Liability - liability coverage protecting directors or officers of a corporation from liability arising out of the performance of their professional duties on behalf of the corporation.

Disability Income - a policy designed to compensate insured individuals for a portion of the income they lose because of a disabling injury or illness.

Disability Income - Long-Term - policies that provide a weekly or monthly income benefit for more than five years for individual coverage and more than one year for group coverage for full or partial disability arising from accident and/or sickness.

Disability Income - Short-Term - policies that provide a weekly or monthly income benefit for up to five years for individual coverage and up to one year for group coverage for full or partial disability arising from accident and/or sickness.

Dividend - a refund of a portion of the premium paid by the insured from insurer surplus.

Domestic Insurer - an insurance company that is domiciled and licensed in the state in which it sells insurance.

Dual Interest - insurance that protects the creditor's and the debtor's interest in the collateral securing the debtor's credit transaction. "Dual Interest" includes insurance commonly referred to as "Limited Dual Interest."

Dwelling Property/Personal Liability - a special form of package policy composed of dwelling fire and/or allied lines, and personal liability insurance.

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Early warning system - a system designed by insurance industry regulators of identifying practices and risk-related trends that contribute to systemic risk by measuring insurer' financial stability.

Earned Premium - portion of insured's prepaid premium allocated to the insurance company's loss experience, expenses, and profit year- to -date.

Earthquake - property coverages for losses resulting from a sudden trembling or shaking of the earth, including that caused by volcanic eruption. Excluded are losses resulting from fire, explosion, flood or tidal wave following the covered event.

EBNR - Earned but not reported - premium amount insurer reasonably expects to receive for which contracts are not yet final and exact amounts are not definite.

EDP Policies - coverage to protect against losses arising out of damage to or destruction of electronic data processing equipment and its software.

Effective Date - date at which an insurance policy goes into force.

Elevators and Escalators Liability - liability coverage for bodily injury or property damage arising from the use of elevators or escalators operated, maintained or controlled by the insured.

Employee Benefit Liability - liability protection for an employer for claims arising from provisions in an employee benefit insurance plan provided for the economic and social welfare of employees. Examples of items covered are pension plans, group life insurance, group health insurance, group disability income insurance, and accidental death and dismemberment.

Employee Retirement Income Security Act of 1974 (ERISA) - a federal statute governing standards for private pension plans, including vesting requirements, funding mechanisms, and plan design.

Employers Liability - employers' liability coverage for the legal liability of employers arising out of injuries to employees. This code should be used when coverage is issued as an endorsement, or as part of a statutory workers' compensation policy.

Employment Practices Liability Coverage - liability insurance for employers providing coverage for wrongful termination, discrimination, or sexual harassment of the insured's current or former employees.

Encumbrance - outstanding mortgages or other debt related to real estate and any unpaid accrued acquisition or construction costs.

Endorsement - an amendment or rider to a policy adjusting the coverages and taking precedence over the general contract.

Enrollment – The total number of plans, not the total number of covered lives, providing coverage to the enrollee and their dependents.

Environmental Impairment Liability (EIL) - coverage for negligence or omission resulting in pollution or environmental contamination.

Environmental Pollution Liability - liability coverage of an insured to persons who have incurred bodily injury or property damage from acids, fumes, smoke, toxic chemicals, waste materials or other pollutants.

Equity Indexed Annuity - a fixed annuity that earns interest or provides benefits that are linked to an external reference or equity index, subject to a minimum guarantee.

Errors and Omissions Liability | Professional Liability other than Medical - liability coverage of a professional or quasi professional insured to persons who have incurred bodily injury or property damage, or who have sustained any loss from omissions arising from the performance of services for others, errors in judgment, breaches of duty, or negligent or wrongful acts in business conduct.

Event Cancellation - coverage for financial loss because of the cancellation or postponement of a specific event due to weather or other unexpected cause beyond the control of the insured.

Excess and Umbrella Liability - liability coverage of an insured above a specific amount set forth in a basic policy issued by the primary insurer; or a self insurer for losses over a stated amount; or an insured or self insurer for known or unknown gaps in basic coverages or self insured retentions.

Excess of Loss Reinsurance - loss sharing mechanism where an insurer pays all claims up to a specified amount and a reinsurance company pays any claims in excess of stated amount.

Excess Workers' Compensation - either specific and/or aggregate excess workers' compensation insurance written above an attachment point or self-insured retention.

Expense Ratio - percentage of premium income used to attain and service policies. Derived by subtracting related expenses from incurred losses and dividing by written premiums.

Experience Rating - rating system where each group is rated entirely on the basis of its own expected claims in the coming period, with retrospective adjustments for prior periods. This method is prohibited under the conditions for federal qualification.

Exposure - risk of possible loss.

Extra Expense Insurance - a type of property insurance for extraordinary expenses related to business interruption such as a back-up generator in case of power failure.

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Face Amount - the value of a policy to be provided upon maturity date or death.

Facultative Reinsurance - reinsurance for a specific policy for which terms can be negotiated by the original insurer and reinsurer.

FAIR Plan - Fair Access to Insurance Requirements - state pools designed to provide insurance to property owners who are unable to obtain property insurance through conventional means.

Fair Value - the amount at which an asset (or liability) could be bought (or incurred) or sold (or settled) in a current transaction between willing parties, that is, other than in a forced or liquidation sale. Quoted market prices in active markets are the best evidence of fair value and shall be used as the basis for the measurement, if available. If a quoted market price is available, the fair value is the product of the number of trading units times market price.

Farmowners Insurance - farmowners insurance sold for personal, family or household purposes. This package policy is similar to a homeowners policy, in that it has been developed for farms and ranches and includes both property and liability coverage for personal and business losses. Coverage includes farm dwellings and their contents, barns, stables, other farm structures and farm inland marine, such as mobile equipment and livestock.

Federal Flood Insurance - coverage for qualifying residents and businesses in flood prone regions through the National Flood Insurance Act, a federally subsidized flood insurance program enacted in 1968.

Federally Reinsured Crop - crop insurance coverage that is either wholly or in part reinsured by the Federal Crop Insurance Corporation (FCIC) under the Standard Reinsurance Agreement (SRA). This includes the following products: Multiple Peril Crop Insurance (MPCI); Catastrophic Insurance, Crop Revenue Coverage (CRC); Income Protection and Revenue Assurance.

Fees Payable - fees incurred but not yet paid.

FEMA - Federal Emergency Management Agency - an independent agency, tasked with responding to, planning for, mitigating and recovery efforts of natural disasters.

Fidelity - a bond or policy covering an employer's loss resulting from an employee's dishonest act (e.g., loss of cash, securities, valuables, etc.).

Financial Guaranty - a surety bond, insurance policy, or an indemnity contract (when issued by an insurer), or similar guaranty types under which loss is payable upon proof of occurrence of financial loss to an insured claimant, obligee or indemnitee as a result of failure to perform a financial obligation or any other permissible product that is defined as or determined to be financial guaranty insurance.

Financial Reporting - insurance companies are required to maintain records and file annual and quarterly financial statements with regulators in accordance with statutory accounting principles (SAP). Statutory rules also govern how insurers should establish reserves for invested assets and claims and the conditions under which they can claim credit for reinsurance ceded.

Financial Responsibility Law - a statute requiring motorists to show capacity to pay for automobile-related losses.

Financial Statement - balance sheet and profit and loss statement of an insurance company. This statement is used by the NAIC, and by State Insurance Commissioners to regulate an insurance company according to reserve requirements, assets, and other liabilities.

Fire - coverage protecting the insured against the loss to real or personal property from damage caused by the peril of fire or lightning, including business interruption, loss of rents, etc.

Fire Legal Liability - coverage for property loss liability as the result of separate negligent acts and/or omissions of the insured that allows a spreading fire to cause bodily injury or property damage of others. An example is a tenant who, while occupying another party's property, through negligence causes fire damage to the property.

Flood - coverage protecting the insured against loss or damage to real or personal property from flood. (Note: If coverage for flood is offered as an additional peril on a property insurance policy, file it under the applicable property insurance filing code.)

Foreign Insurer - an insurance company selling policies in a state other than the state in which they are incorporated or domiciled.

Foreign Investment - an investment in a foreign jurisdiction, or an investment in a person, real estate or asset domiciled in a foreign jurisdiction. An investment shall not be deemed to be foreign if the issuing person, qualified primary credits source or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless: a) The issuing person is a shell business entity; and b) The investment is not assumed, accepted, guaranteed or insured or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

Foreign jurisdiction - a jurisdiction outside of the United States, Canada or any province or political subdivision of the foregoing.

Fraternal Insurance - a form of group coverage or disability insurance available to members of a fraternal organization.

Fronting - an arrangement in which a primary insurer acts as the insurer of record by issuing a policy, but then passes the entire risk to a reinsurer in exchange for a commission. Often, the fronting insurer is licensed to do business in a state or country where the risk is located, but the reinsurer is not.

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Generally Accepted Accounting Principles (GAAP) - an aggregate of the accounting standards, principles and best practices for the preparation of financial statements allowing for consistency in reporting.

Gramm-Leach Bliley Act (GLBA) - act, repealing Glass-Steagal Act of 1933, allows consolidation of commercial banks, investment institutions and insurance companies. Established a framework of responsibilities of federal and state regulators for these financial industries. It permits financial services companies to merge and engage in a variety of new business activities, including insurance, while attempting to address the regulatory issues raised by such combinations.

Goodwill - the difference between the cost of acquiring the entity and the reporting entity's share of the book value of the acquired entity.

Gross Paid-in and Contributed Surplus - amount of capital received in excess of the par value of the stock issued.

Gross Premium - the net premium for insurance plus commissions, operating and miscellaneous commissions. For life insurance, this is the premium including dividends.

Group Accident and Health - coverage written on a group basis (e.g., employees of a single employer and their dependents) that pays scheduled benefits or medical expenses caused by disease, accidental injury or accidental death. Excludes amounts attributable to uninsured accidents and health plans and the uninsured portion of partially insured accident and health plans.

Group Annuities – Deferred Non- Variable and Variable - an annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some designated future date.

Group Annuities – Deferred Variable - an annuity contract that provides an accumulation based fund where the accumulation varies in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. Must include at least one option to have the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder and may include at least one option to have the series of payments vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. This annuity contract provides for the initiation of payments at some designated future date.

Group Annuities – Immediate Non-Variable and Variable - an annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some interval that may vary, however the annuity payouts must begin within 13 months.

Group Annuities – Immediate Variable - an annuity contract that provides for the first payment of the annuity at the end of the fixed interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months. The amount varies with the value of equities (separate account) purchased as investments by the insurance companies.

Group Annuities – Unallocated - annuity contracts or portions thereof where the Insurer purchases an annuity for the retirees.

Group Annuity - a contract providing income for a specified period of time, or duration of life for a person or persons established to benefit a group of employees.

Group Health - health insurance issued to employers, associations, trusts, or other groups covering employees or members and/or their dependents, to whom a certificate of coverage may be provided.

Group Code - a unique three to five digit number assigned by the NAIC to identify those companies that are part of a larger group of insurance companies.

Group Credit – Life - contracts sold in connection with loan/credit transactions or other credit transactions, which do not exceed a stated duration and/or amount and provide insurance protection against death.

Group Health Organizations – Health Maintenance (HMO) - a plan under which an enrollee pays a membership fixed fee in advance in return for a wide range of comprehensive health care services with the HMO's approved providers in a designated service area.

Guaranty Fund - funding mechanism employed by states to provide funds to cover policyholder obligations of insolvent reporting entities.

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Hard Market - a market characterized by high demand and low supply.

Hazard - circumstance which tends to increase the probability or severity of a loss.

Health – Excess/Stop Loss - this type of insurance may be extended to either a health plan or a self-insured employer plan. Its purpose is to insure against the risk that any one claim will exceed a specific dollar amount or that an entire plan's losses will exceed a specific amount.

Health Insurance - a generic term applying to all types of insurance indemnifying or reimbursing for losses caused by bodily injury or illness including related medical expenses.

Health Maintenance Organization (HMO) - a medical group plan that provides physician, hospital, and clinical services to participating members in exchange for a periodic flat fee.

Health Plan - written promise of coverage given to an individual, family, or group of covered individuals, where a beneficiary is entitled to receive a defined set of health care benefits in exchange for a defined consideration, such as a premium.

Hold-Harmless Agreement - A risk transfer mechanism whereby one party assumes the liability of another party by contract

Homeowners Insurance - a package policy combining real and personal property coverage with personal liability coverage. Coverage applicable to the dwelling, appurtenant structures, unscheduled personal property and additional living expense are typical. Includes mobile homes at a fixed location.

Hospital Indemnity Coverage - coverage that provides a pre-determined, fixed benefit or daily indemnity for contingencies based on a stay at a hospital or intensive care facility.

Hull Insurance - coverage for damage to a vessel or aircraft and affixed items.

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Incontestability Provision - a life insurance and annuity provision limiting the time within which the insurer has the legal right to void the contract on grounds of material misrepresentation in the policy application.

Incurred But Not Reported (IBNR) - (Pure IBNR) claims that have occurred but the insurer has not been notified of them at the reporting date. Estimates are established to book these claims. May include losses that have been reported to the reporting entity but have not yet been entered into the claims system or bulk provisions. Bulk provisions are reserves included with other IBNR reserves to reflect deficiencies in known case reserves. IBNR can sometimes include estimates of incurred but Not Enough Reported (IBNER)

Incurred Claims - paid claims plus amounts held in reserve for those that have been incurred but not yet paid.

Incurred Losses - sustained losses, paid or not, during a specified time period. Incurred losses are typically found by combining losses paid during the period plus unpaid losses sustained during the time period minus outstanding losses at the beginning of the period incurred in the previous period.

Indemnity, Principle of - a general legal principle related to insurance that holds that the individual recovering under an insurance policy should be restored to the approximate financial position he or she was in prior to the loss. Legal principle limiting compensation for damages be equivalent to the losses incurred.

Independent Adjuster - freelance contractor paid a fee for adjusting losses on behalf of companies.

Independent Agent - a representative of multiple insurance companies who sells and services policies for records which they own and operate under the American Agency System.

Independent Contractor - an individual who is not employed for a company but instead works for themselves providing goods or services to clients for a fee.

Index Annuity - an interest bearing fixed annuity tied to an equity index, such as the Dow Jones Industrial Average or S & P 500.

Individual Annuities – Deferred Variable - an annuity contract that provides an accumulation based fund where the accumulation varies in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. Must include at least one option to have the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder and may include at least one option to have the series of payments vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. This annuity contract provides for the initiation of payments at some designated future date.

Individual Annuities – Immediate Variable - an annuity contract that provides for the first payment of the annuity at the end of the fixed interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months. The amount varies with the value of equities (separate account) purchased as investments by the insurance companies.

Individual Annuities – Special - contracts with certain noteworthy attributes.

Individual Annuities- Deferred Non-Variable and Variable - an annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some designated future date.

Individual Annuities- Deferred Non-Variable - an annuity contract that provides an accumulation based on funds that accumulate based on a guaranteed crediting interest rate or additional interest rate. This annuity contract provides for the initiation of payments at some designated future date.

Individual Annuities- Immediate Non-Variable - an annuity contract that provides for the fixed payment of the annuity at the end of the first interval of payment after purchase. The interval may vary, however the annuity payouts must begin within 13 months.

Individual Annuities- Immediate Non-Variable and Variable - an annuity contract that provides an accumulation based on both (1) funds that accumulate based on a guaranteed crediting interest rates or additional interest rate applied to designated considerations, and (2) funds where the accumulation vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The contract provides for the initiation of payments at some interval that may vary, however the annuity payouts must begin within 13 months.

Individual Health - health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes conversions from group policies.

Individual Credit – Credit Disability - makes monthly loan/credit transaction payments to the creditor upon the disablement of an insured debtor.

Individual Credit – Life - contracts sold in connection with loan/credit transactions or other credit transactions, which do not exceed a stated duration and/or amount and provide insurance protection against death.

Industrial Life - Industrial life insurance, also called "debit" insurance, is insurance under which premiums are paid monthly or more often, the face amount of the policy does not exceed a stated amount, and the words "industrial policy" are printed in prominent type on the face of the policy.

Inland Marine - coverage for property that may be in transit, held by a bailee, at a fixed location, a movable good that is often at different locations (e.g., off road constructions equipment), or scheduled property (e.g., Homeowners Personal Property Floater) including items such as live animals, property with antique or collector's value, etc. This line also includes instrumentalities of transportation and communication, such as bridges, tunnels, piers, wharves, docks, pipelines, power and phone lines, and radio and television towers.

Insurable Interest - A right or relationship in regard to the subject matter of the insured contract such that the insured can suffer a financial loss from damage, loss or destruction to it. (Bickelhaupt and Magee)

Insurance - an economic device transferring risk from an individual to a company and reducing the uncertainty of risk via pooling.

Insurance Holding Company System - consists of two or more affiliated persons, one or more of which is an insurer.

Insurance Regulatory Information System (IRIS) - a baseline solvency screening system for the National Association of Insurance Commissioners (NAIC) and state insurance regulators established in the mid-1970s.

Insurance to Value - Amount of insurance purchased vs. the actual replacement cost of the insured property expressed as a ratio.

Insured - party(ies) covered by an insurance policy.

Insurer - an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state.

Intermediary - a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a health insurer and its enrollees via a separate contract between the intermediary and the insurer.

International - includes all business transacted outside the U.S. and its territories and possessions where the appropriate line of business is not determinable.

Internet Liability Insurance/Cyber Insurance - coverage for cyber commerce including copyright infringement, libel, and violation of privacy.

Investment grade - the obligation has been determined to be in one of the top four generic lettered rating classifications by a securities rating agency acceptable to the commissioner, that the obligation has been identified in writing by such a rating agency to be of investment grade quality, or, if the obligation has not been submitted to any such rating agency, that the obligation has been determined to be investment grade (Class 1 and Class 2) by the Securities Valuation Office of the National Association of Insurance Commissioners.

Investment Income Accrued - investment income earned as of the reporting date but not legally due to be paid to the reporting entity until subsequent to the reporting date.

Investment Income Due - investment income earned and legally due to be paid to the reporting entity as of the reporting date.

Investment Income Gross - shall be recorded as earned and shall include investment income collected during the period, the change in investment income due and accrued, the change in unearned investment income plus any amortization (e.g., discounts or premiums on bonds, origination fees on mortgage loans, etc.)

Irrevocable Beneficiary - a life insurance policy beneficiary who has a vested interest in the policy proceeds even during the insured's lifetime because the policy owner has the right to change the beneficiary designation only after obtaining the beneficiary's consent.

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Joint and Last Survivor Annuity - retirement plan that continues to payout so long as at least one, of two or more, annuitants is alive.

Joint Underwriting Association (JUA) - a loss-sharing mechanism combining several insurance companies to provide extra capacity due to type or size of exposure.

Joint-Life Annuity - an annuity contract that ceases upon the death of the first of two or more annuitants.

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Key-Persons Insurance - a policy purchased by, for the benefit of, a business insuring the life or lives of personnel integral to the business operations.

Kidnap/Ransom Insurance - coverage for ransom or extortion costs and related expenses.

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Lapse - termination of a policy due to failure to pay the required renewal premium.

Level Premium Insurance - life insurance policy for which the cost is equally distributed over the term of the premium period, remaining constant throughout.

Liability - a certain or probable future sacrifice of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transactions(s) or event(s). three essential characteristics: a) It embodies a present duty or responsibility to one or more other entities that entails settlement by probable future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand; b) The duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice; and c) The transaction or other event obligating the entity has already happened.

Life – Endowment - insurance that pays the same benefit amount should the insured die during the term of the contract, or if the insured survives to the end of the specified coverage term or age.

Life – Flexible Premium Adjustable Life - a group life insurance that provides a face amount that is adjustable to the certificate holder and allows the certificate holder to vary the modal premium that is paid or to skip a payment so long as the certificate value is sufficient to keep the certificate in force, and under which separately identified interest credits (other than in connection with dividend accumulation, premium deposit funds or other supplementary accounts) and mortality and expense charges are made to individual certificates while providing minimum guaranteed values.

Life Settlements - a contract or agreement in which a policyholder agrees to sell or transfer ownership in all or part of a life insurance policy to a third party for compensation that is less than the expected death benefit of a policy.

Lifetime Disability Benefit - a provision in some disability income policies to recoup lost wages for the term of disability or remainder of insured's life in case of permanent disability.

Limited Benefit - policies that provide coverage for vision, prescription drug, and/or any other single service plan or program. Also include short-term care policies that provide coverage for less than one year for medical and other services provided in a setting other than an acute care unit of the hospital.

Limited Payment Life Insurance - a form of whole-life insurance with a pre-defined number of premiums to be paid.

Limited Policies - health insurance coverage for a certain ailment, such as cancer.

Limits - maximum value to be derived from a policy.

Line of Business - classification of business written by insurers.

Liquor Liability - coverage for the liability of an entity involved in the retail or wholesale sales of alcoholic beverages, or the serving of alcoholic beverages, to persons who have incurred bodily injury or property damage arising from an intoxicated person.

Living benefits rider - a rider attached to a life insurance policy providing long term care for the terminally ill.

Lloyd's of London - association offering membership in various syndicates of wealthy individuals organized for the purpose of writing insurance for a particular hazard.

Loan-backed Securities - pass-through certificates, collateralized mortgage obligations (CMOs), and other securitized loans not included in structured securities where payment of interest and/or principal is directly proportional to the interest and/or principal received by the issuer from the mortgage pool or other underlying securities.

Long Duration Contracts - contracts, excluding financial guaranty contracts, mortgage guaranty contracts and surety contracts, that fulfill both of the following conditions: (1) the contract term is greater than or equal to thirteen months and (2) the insurer can neither cancel nor increase the premium during the contract term.

Long-Term Care - policies that provide coverage for not less than one year for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, including policies that provide benefits for cognitive impairment or loss of functional capacity. This includes policies providing only nursing home care, home health care, community based care, or any combination. The policy does not include coverage provided under comprehensive/major medical policies, Medicare Advantage, or for accelerated heath benefit-type products.

Long-Term Disability Income Insurance - policy providing monthly income payments for insureds who become disabled for an extensive length of time, typically two years or longer.

Loss - physical damage to property or bodily injury, Including loss of use or loss of income

Loss Adjustment Expense (LAE) - expected payments for costs to be incurred in connection with the adjustment and recording of losses. Can be classified into two broad categories: Defense and Cost Containment (DCC) and Adjusting and Other (AO). Can also be separated into (Allocated Loss Adjustment Expense) and (Unallocated Loss Adjustment Expense for ratemaking purposes.

Loss Frequency - incidence of claims on a policy during a premium period.

Loss of Use Insurance - policy providing protection against loss of use due to damage or destruction of property.

Loss Payable Clause - coverage for third party mortgagee in case of default on insured property, secured by a loan, that has been lost or damaged.

Loss Ratio - the percentage of incurred losses to earned premiums.

Loss Reserve - the amount that insurers set aside to cover claims incurred but not yet paid.

Loss Reserves - an estimate of liability or provision in an insurer's financial statement, indicating the amount the insurer expects to pay for losses incurred but not yet reported or reported claims that haven't been paid.

Losses Incurred - Includes claims that have been paid and/or have amounts held in reserve for future payment

Losses Incurred But Not Reported (IBNR) - An estimated amount set aside by the insurance company to pay claims that may have occurred, but for some reason have not yet been reported to the insurance company.

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Major Medical - a hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered.

Malpractice - alleged misconduct or negligence in a professional act resulting in loss or injury.

Managed Care - system of health care delivery that attempts to influence the utilization, quality, and cost of services provided.

Mandated benefits - insurance required by state or federal law.

Manufacturers Output Policies - provides broad form coverage of personal property of an insured manufacturer including raw material, goods in process, finished goods and goods shipped to customers.

Margin Premium - a deposit that an organization is required to maintain with a broker with respect to the Futures Contracts purchased or sold.

Market Value - fair value or the price that could be derived from current sale of an asset.

Mechanical Breakdown Insurance - premiums attributable to policies covering repair or replacement service, or indemnification for that service, for the operational or structural failure of property due to defects in materials or workmanship, or normal wear and tear. (May cover motor vehicles, mobile equipment, boats, appliances, electronics, residual structures, etc.)

Medicaid - policies issued in association with the Federal/State entitlement program created by Title XIX of the Social Security Act of 1965 that pays for medical assistance for certain individuals and families with low incomes and resources.

Medical & Hospital Expenses (Benefits or Claims) - total expenditures for health care services paid to or on behalf of members.

Medical Malpractice - insurance coverage protecting a licensed health care provider or health care facility against legal liability resulting from the death or injury of any person due to the insured's misconduct, negligence, or incompetence, in rendering or failure to render professional services.

Medical Only - line of business that provides medical only benefits without hospital coverage. An example would be provider-sponsored organizations where there is no coverage for other than provider (non-hospital) services. Does not include self-insured business, FEHBP, Medicare and Medicaid programs, or dental only business.

Medical Professional Liability - insurance coverage protecting a licensed health care provider or health care facility against legal liability resulting from the death or injury of any person due to the insured's misconduct, negligence, or incompetence in rendering professional services. Medical Professional Liability is also known as Medical Malpractice.

Medicare - a state assistance program, passed under Title XVIII of the Social Security Amendments of 1965, to provide hospital and medical expense insurance to those over 65 years of age.

Medicare + Choice - a major initiative in the Balanced Budget Act of 1997 (also called Medicare Part C), under which Medicare beneficiaries may select from among several managed care options or a Medicare system.

Medicare Advantage Plan - an HMO, PPO, or Private Fee-For Service Plan that contracts with Medicare Advantage Prescription Drug Plan also includes drug benefits. The plan may provide extra coverage such as vision, hearing, dental, and/or health and wellness programs. Medicare pays a fixed amount for insured's care every month to the companies offering Medicare Advantage plans.

Medicare Cost - contract with Center for Medicare and Medicaid Services (CMS) for Medicare coverage. These contracts with CMS provide reimbursement through pre-determined monthly amount per member based on a total estimated budget. The beneficiary may use providers outside the provider network. Does not include stand alone Medicare Part D Plans.

Medicare Part D - Stand-Alone - stand-alone Part D coverage written through individual contracts; stand-alone Part D coverage written through group contracts and certificates; and Part D coverage written on employer groups where the reporting entity is responsible for reporting claims to the Centers for Medicare & Medicaid Services (CMS).

Medicare Supplement - Insurance coverage sold on an individual or group basis to help fill the "gaps" in the protections granted by the federal Medicare program. This is strictly supplemental coverage and cannot duplicate any benefits provided by Medicare. It is structured to pay part or all of Medicare's deductibles and co-payments. It may also cover some services and expenses not covered by Medicare. Also known as Medigap" insurance.

Medigap - supplementary private health insurance products to Medicare insurance benefits.

Minimum Premium Plan - an arrangement under which an insurance carrier will, for a fee, handle the administration of claims and insure against large claims for a self-insured group. The employer self-funds a fixed percentage (e.g. 90%) of the estimated monthly claims, and the insurer covers the remainder.

Mobile Homes - Homeowners - homeowners insurance sold to owners occupying the described mobile home.

Mobile Homes under Transport - coverage for mobile homes while under transport for personal or commercial use.

Modified Guaranteed - an annuity that contains a provision that adjusts the value of withdrawn funds based on a formula in the contract. The formula reflects market value adjustments.

Member - A person who has enrolled as a subscriber or an eligible dependent of a subscriber and for whom the health organization has accepted the responsibility for the provision of health services as may be contracted for.

Moral Hazard - personality characteristics that increase probability of losses. For example not taking proper care to protect insured property because the insured knows the insurance company will replace it if it is damaged or stolen.

Morale Hazard - negligence or disregard on the part of the insured which could lead to probable loss.

Morbidity - the frequency or severity of disease or illness within a subset of the population.

Morbidity Risk - the potential for a person to experience illness, injury, or other physical or psychological impairment, whether temporary or permanent. Morbidity risk excludes the potential for an individual's death, but includes the potential for an illness or injury that results in death.

Morbidity Table - a statistical record of the rate of illness among the defined age groups.

Mortality Table - chart that shows the death rates of a particular population at each age displayed as the number of deaths per thousand.

Mortgage - a note used to secure a loan for real property.

Mortgage Guaranty - insurance that indemnifies a lender for loss upon foreclosure if a borrower fails to meet required mortgage payments.

Mortgage Insurance - a form of life insurance coverage payable to a third party lender/mortgagee upon the death of the insured/mortgagor for loss of loan payments.

Mortgage-Backed Securities - a type of asset-backed security that is secured by a mortgage or collection of mortgages. These securities must also be grouped in one of the top two ratings as determined by an accredited credit rating agency, and usually pay periodic payments that are similar to coupon payments. Furthermore, the mortgage must have originated from a regulated and authorized financial institution.

Multi-Peril Insurance - personal and business property coverage combining several types of property insurance in one policy.

Municipal Bond Guarantee Insurance - coverage sold to municipalities to guarantee the principle payment on bonds issued.

Municipal Liability - liability coverage for the acts of a municipality.

Municipal obligation bond - any security, or other instrument, including a state lease but not a lease of any other governmental entity, under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project servicing a substantial public purpose, and 1) Payable from tax revenues, but not tax allocations, within the jurisdiction of such governmental unit; 2) Payable or guaranteed by the United States of America or any agency, department or instrumentality thereof, or by a state housing agency; 3) Payable from rates or charges (but not tolls) levied or collected in respect of a non-nuclear utility project, public transportation facility (other than an airport facility) or public higher education facility; or 4) With respect to lease obligations, payable from future appropriations.

Mutual Insurance Company - a privately held insurer owned by its policyholders, operated as a non-profit that may or may not be incorporated.

Mutual Insurance Holding Company - a company organized as a mutual and owning a capital stock insurer or insurers for the benefit of pooling risk for many people, typically those in the same industry.

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Named Insured - the individual defined as the insured in the policy contract. .

Named Peril Coverage - insurance for losses explicitly defined in the policy contract.

National Association of Insurance Commissioners (NAIC) - the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

Negligence - failure to exercise reasonable consideration resulting in loss or damage to oneself or others.

Net Admitted Assets - total of assets whose values are permitted by state law to be included in the annual statement of the insurer.

Net Income - total revenues from an insurer's operations less total expenses and income taxes

Net Premiums Earned - premiums on property/casualty or health policies that will not have to be returned to the policyholder if the policy is cancelled.

NFIP - National Flood Insurance Program - flood insurance and floodplain management for personal and business property administered under the National Flood Act of 1968. Encourages participation by private insurers through a flood insurance pool .

Nonadmitted Assets - assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests and should not be recognized on the balance sheet.

Nonadmitted Insurer - insurance company not licensed to do business within a given state.

Non-controlled stock insurers - insurers in which a parent company has: 1) a financial interest represented by the direct or indirect ownership of less than 50% of voting shares, and 2) does not have the ability to exercise control over the insurer, e.g., through voting stock or management contract

Non-proportional Reinsurance - reinsurance that is not secured on individual lives for specific individual amount of reinsurance, but rather reinsurance that protects the ceding company's overall experience on its entire portfolio of business, or at least a broad segment of it. The most common forms of non-proportional reinsurance are stop loss and catastrophe.

Notional Value - the principal value upon which future payments are based in a derivative transaction as at a specific period in time (the "as of" reporting date) in the reporting currency.

Nationally Recognized Statistical Rating Organization (NRSRO) - refers to rating organizations so designated by the SEC whose status has been confirmed by the Securities Valuation Office. Examples are: Moody's Investors Service, Inc., Standard & Poor's (S&P), A.M. Best Company (A.M. Best) and Fitch Ratings and Dominion Bond Rating Service (DBRS).

Nuclear Energy Liability - coverage for bodily injury and property damage liability resulting from the nuclear energy material (whether or not radioactive) on the insured business's premises or in transit.

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O

Occurrence - an accident , including injurious exposure to conditions, which results, during the policy period in bodily injury or property damage neither expected or intended from the standpoint of the insured. (Bickelhaupt and Magee)

Ocean Marine - coverage for ocean and inland water transportation exposures; goods or cargoes; ships or hulls; earnings; and liability.

Officer - a president, vice-president, treasurer, actuary, secretary, controller and any other person who performs for the company functions corresponding to those performed by the foregoing officers.

Option - an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more Underlying Interests.

Other Accident and Health - accident and health coverages not otherwise properly classified as Group Accident and Health or Credit Accident and Health (e.g., collectively renewable and individual non-cancelable, guaranteed renewable, non-renewable for stated reasons only, etc.). Include all Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

Other Considerations - Unallocated annuity considerations and other unallocated deposits that incorporate any mortality or morbidity risk and are not reported as direct premiums, direct annuity considerations or deposit-type contract funds.

Other Liability - coverage protecting the insured against legal liability resulting from negligence, carelessness, or a failure to act resulting in property damage or personal injury to others.

Other Underwriting Expenses - allocable expenses other than loss adjustment expenses and investment expenses.

Owner Occupied - homeowners insurance sold to owners occupying the described property.

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P

Package Policy - two or more distinct policies combined into a single contract.

Par Value - the nominal or face value of a stock or bond.

Peril - the cause of property damage or personal injury, origin of desire for insurance. "Cause of Loss"

Permanent Life Insurance - policy that remains active for the life of the insured.

Personal Auto Policy - coverage designed to insure private passenger automobiles and certain types of trucks owned by an individual or husband and wife.

Personal Earthquake - earthquake property coverage for personal, family or household purposes.

Personal Flood - separate flood insurance policy sold for personal, family or household purposes.

Personal GAP Insurance - credit insurance that insures the excess of the outstanding indebtedness over the primary property insurance benefits in the event of a total loss to a collateral asset.

Personal Injury Liability - liability coverage for those who have been discriminated against, falsely arrested, illegally detained, libeled, maliciously prosecuted, slandered, suffered from identity theft, mental anguish or alienation of affections, or have had their right of privacy violated.

Personal Injury Protection Coverage/PIP - automobile coverage available in states that have enacted no-fault laws or other auto reparation reform laws for treatment of injuries to the insured and passengers of the insured.

Personal Property - single interest or dual interest credit insurance (where collateral is not a motor vehicle, mobile home, or real estate) that covers perils to goods purchased or used as collateral and that concerns a creditor's interest in the purchased goods or pledged collateral either in whole or in part; or covers perils to goods purchased in connection with an open-end credit transaction.

Pet Insurance Plans - veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.

Policy - a written contract ratifying the legality of an insurance agreement.

Policy Dividend - a refund of part of the premium on a participating life insurance policy. Amount of payment is determined by subtracting the actual premium expense from the premium charged. The payment can be taken as cash, applied to a purchase an increment of paid-up insurance, left on deposit with the insurance company or applied to purchase term insurance for one year.

Policy Period - time period during which insurance coverage is in effect.

Policy Reserve - the amount of money allocated specifically for the fulfillment of policy obligations by a life insurance company; reserves are in place to safeguard that the company is able to pay all future claims.

Policyholders Surplus - assets in excess of the liabilities of a company or net income above any monies indebted to legal obligation.

Pollution - environmental contamination.

Pool - an association organized for the purpose of absorbing losses through a risk-sharing mechanism thereby limiting individual exposures.

Preferred Provider Organization (PPO) - arrangement, insured or uninsured, where contracts are established by Health Plan Companies (typically, commercial insurers, and, in some circumstances, by self-insured employers) with health care providers. The Health Plans involved will often designate these contracted providers as "preferred" and will provide an incentive, usually in the form of lower deductibles or co-payments, to encourage covered individuals to use these providers. Members are allowed benefits for non-participating provider services on an indemnity basis with significant copayments and providers are often, but not always, paid on a discounted fee for service basis.

Preferred Risk - insured, or applicant for insurance, who presents likelihood of risk lower than that of the standard applicant.

Premises and Operations - policies covering the liability of an insured to persons who have incurred bodily injury or property damage on an insured's premises during normal operations or routine maintenance, or from an insured's business operations either on or off of the insured's premises.

Premium - Money charged for the insurance coverage reflecting expectation of loss.

Premiums Earned - the portion of premium for which the policy protection or coverage has already been given during the now-expired portion of the policy term.

Premiums Net - is the amount calculated on the basis of the interest and mortality table used to calculate the reporting entity's statutory policy reserves.

Premiums Written - total premiums generated from all policies (contracts) written by an insurer within a given period of time.

Primary Insurance - coverage that takes precedence when more than one policy covers the same loss.

Prior Approval Law - a state regulatory requirement for pre-approval of all insurance rates and forms.

Private Passenger Auto (PPA) - filings that include singularly or in any combination coverage such as the following: Auto Liability, Personal Injury Protection (PIP), Medical Payments (MP), Uninsured/Underinsured (UM/UIM); Specified Causes of Loss, Comprehensive, and Collision.

Producer - an individual who sells, services, or negotiates insurance policies either on behalf of a company or independently.

Product Liability - insurance coverage protecting the manufacturer, distributor, seller, or lessor of a product against legal liability resulting from a defective condition causing personal injury, or damage, to any individual or entity, associated with the use of the product.

Professional Errors and Omissions Liability - coverage available to pay for liability arising out of the performance of professional or business related duties, with coverage being tailored to the needs of the specific profession. Examples include abstracters, accountants, insurance adjusters, architects, engineers, insurance agents and brokers, lawyers, real estate agents, stockbrokers.

Property - coverage protecting the insured against loss or damage to real or personal property from a variety of perils, including but not limited to fire, lightening, business interruption, loss of rents, glass breakage, tornado, windstorm, hail, water damage, explosion, riot, civil commotion, rain, or damage from aircraft or vehicles.

Pro-rata (proportional) Reinsurance - portion of the losses and premium reinsurer shares with the ceding entity.

Protected Cell - an insurance-linked security retained within the insurance or reinsurance company and is used to insulate the proceeds of the securities offering from the general business risks of the insurer, granting an additional comfort level for investors of the securitized instrument.

Protection and Indemnity (P&I) Insurance - a broad form of marine legal liability insurance coverage.

Provider Sponsored Network (PSN) - formal affiliations of providers, sometimes called "integrated delivery systems", organized and operated to provide an integrated network of health care providers with which third parties, such as insurance companies, HMOs, or other Health Plan Companies, may contract for health care services to covered individuals. Some models of integration include Physician Hospital Organizations, Management Service Organizations, Group Practices Without Walls, Medical Foundations, and Health Provider Cooperatives.

Provisions - contingencies outlined in an insurance policy.

Proximate Cause - event covered under insured's policy agreement.

Public Adjuster - independent claims adjuster representing policyholders instead of insurance companies.

Pure Premium - that portion of the premium equal to expected losses void of insurance company expenses, premium taxes, contingencies, or profit margin.

Pure Risk - circumstance including possibility of loss or no loss but no possibility of gain.

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Qualified Actuary - a person who meets the basic education, experience and continuing education requirements (these differ by line of business) of the Specific Qualification Standard for Statements of Actuarial Opinion, NAIC Property and Casualty Annual

Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States, promulgated by the American Academy of Actuaries, and is in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries.

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R

Rate - value of insured losses expressed as a cost per unit of insurance.

Risk Based Capital (RBC) Ratio - ratio used to identify insurance companies that are poorly capitalized. Calculated by dividing the company's capital by the minimum amount of capital regulatory authorities have deemed necessary to support the insurance operations.

Rebate - a refund of part or all of a premium payment.

Reinsurance - a transaction between a primary insurer and another licensed (re) insurer where the reinsurer agrees to cover all or part of the losses and/or loss adjustment expenses of the primary insurer. The assumption is in exchange for a premium. Indemnification is on a proportional or non-proportional basis.

Reinsurer - company assuming reinsurance risk.

Renewable Term Insurance - insurance that is renewable for a limited number of successive terms by the policyholder and is not contingent upon medical examination.

Renters Insurance - liability coverage for contents within a renter's residence. Coverage does not include the structure but does include any affixed items provided or changed by the renter.

Replacement Cost - the cost of replacing property without a reduction for depreciation due to normal wear and tear.

Reported Losses - Includes both expected payments for losses relating to insured events that have occurred and have been reported to the insurance company, but not yet paid.

Reserve - A portion of the premium retained to pay future claims

Reserve Credit - reduction of reserve amounts for reinsurance ceded. Reductions may include the claim reserve and/or the unearned premium reserve.

Residence - the domicile location of a member as shown by his or her determination as a resident.

Residual Market Plan - method devised for coverage of greater than average risk individuals who cannot obtain insurance through normal market channels.

Retention - a mechanism of internal fund allocation for loss exposure used in place of or as a supplement to risk transfer to an insurance company.

Retention Limit - maximum amount of medical and hospital expense an insurer will carry on its own. The limit can be for an individual claim and/or for the insurers total claims, depending upon the terms of the reinsurance contract.

Retrocession - the portion of risk that a reinsurance company cedes or amount of insurance the company chooses not to retain.

Retrospective Rating - the process of determining the cost of an insurance policy based on the actual loss experience determined as an adjustment to the initial premium payment.

Rider - an amendment to a policy agreement.

Risk - Uncertainty concerning the possibility of loss by a peril for which insurance is pursued.

Risk Retention Act - a 1986 federal statute amending portions of the Product Liability Risk Retention Act of 1981 and enacted to make organization of Risk Retention Groups and Purchasing Groups more efficient.

Risk Retention Group - group-owned insurer organized for the purpose of assuming and spreading the liability risks to its members.

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S

Salvage - value recoverable after a loss.

Statutory Accounting Principles (SAP) - a set of accounting principles set forth by the National Association of Insurance Commissioners used to prepare statutory financial statements for insurance companies.

Securitization of Insurance Risk - a method for insurance companies to access capital and hedge risks by converting policies into securities that can be sold in financial markets.

Security - a share, participation, or other interest in property or in an enterprise of the issuer or an obligation of the issuer.

Self-Insurance - type of insurance often used for high frequency low severity risks where risk is not transferred to an insurance company but retained and accounted for internally.

Separate Account - segregated funds held and invested independently of other assets by an insurer for the purpose of a group retirement fund.

Short-term Disability - a company standard defining a period of time employees are eligible for short-term disability coverage, typically for 2 years or less.

Short-Term Medical - policies that provide major medical coverage for a short period of time, typically 30 to 180 days. These policies may be renewable for multiple periods.

Situs of Contract - the jurisdiction in which the contract is issued or delivered as stated in the contract.

Social Insurance - compulsory insurance plan administered by a federal or state government agency with the primary emphasis on social adequacy.

Soft Market - a buyer's market characterized by abundant supply of insurance driving premiums down.

Special revenue bond - any security, or other instrument under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a substantial public purpose and not payable from the sources in connection with the payment of municipal obligation bonds.

Specified Disease Coverage - coverage that provides primarily pre-determined benefits for expenses of the care of cancer and/or other specified diseases.

Specified/Named Disease - policies that provide benefits only for the diagnosis and/or treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem or as a principal sum.

Standard Risk - a person who, according to a company's underwriting standards, is considered a normal risk and insurable at standard rates. High or low risk candidates may qualify for extra or discounted rates based on their deviation from the standard.

State Children's Health Insurance Program - policies issued in association with the Federal/State partnership created by title XXI of the Social Security Act.

State of Domicile - the state where a company's home office is located.

State Page - Exhibit of Premiums and Losses for each state a company is licensed. The state of domicile receives a schedule for each jurisdiction the company wrote direct business, or has amounts paid, incurred or unpaid.

Statement Type - refers to the primary business type under which the company files its annual and quarterly statement, such as Life, Property, Health, Fraternal, Title.

Statement Value - the Statutory Accounting Principle book value reduced by any valuation allowance and non-admitted adjustment applied to an individual investment or a similar group of investments, e.g., bonds, mortgage loans, common stock.

Statutory Accounting - method of accounting standards and principles used by state regulatory authorities to measure the financial condition of regulated companies and other insurance enterprises. This method tends to be more conservative than the Generally Accepted Accounting Principles used by most businesses. Compliance with solvency and other standards is determined using financial documents prepared in accordance with Statutory Accounting Principles.

Stock Insurance Company - business owned by stockholders.

Stop Loss/Excess Loss - individual or group policies providing coverage to a health plan, a self-insured employer plan, or a medical provider providing coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.

Structured Securities - loan-backed securities that have been divided into two or more classes of investors where the payment of interest and/or principal of any class of securities has been allocated in a manner that is not proportional to interest and/or principal received by the issuer from the mortgage pool or other underlying securities.

Structured Settlements - periodic fixed payments to a claimant for a determinable period, or for life, for the settlement of a claim.

Subrogation - situation where an insurer, on behalf of the insured, has a legal right to bring a liability suit against a third party who caused losses to the insured. Insurer maintains the right to seek reimbursement for losses incurred by insurer at the fault of a third party.

Subrogation Clause - section of insurance policies giving an insurer the right to take legal action against a third party responsible for a loss to an insured for which a claim has been paid.

Subsequent Event - events or transactions that occur subsequent to the balance sheet date, but before the issuance of the statutory financial statements and before the date the audited financial statements are issued, or available to be issued.

Substandard Risk - (impaired risk) risks deemed undesirable due to medical condition or hazardous occupation requiring the use of a waiver, a special policy form, or a higher premium charge.

Superfund - federal act mandating retroactive liability for environmental pollution where responsible party maintains accountability for environmental clean-up regardless of length of time since polluting event occurred.

Surety Bond - a three-party agreement whereby a guarantor (insurer) assumes an obligation or responsibility to pay a second party (obligee) should the principal debtor (obligor) become in default.

Surplus - insurance term referring to retained earnings.

Surplus Line - specialized property or liability coverage available via nonadmitted insurers where coverage is not available through an admitted insurer, licensed to sell that particular coverage in the state.

Swap - an agreement to exchange or net payments as the buyer of an Option, Cap or Floor and to make payments as the seller of a different Option, Cap or Floor.

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Tenants - homeowners insurance sold to tenants occupying the described property.

Term - period of time for which policy is in effect.

Term Insurance - life insurance payable only if death of insured occurs within a specified time, such as 5 or 10 years, or before a specified age.

Third Party - person other than the insured or insurer who has incurred losses or is entitled to receive payment due to acts or omissions of the insured.

Title Insurance - coverage that guarantees the validity of a title to real and personal property. Buyers of real and personal property and mortgage lenders rely upon the coverage to protect them against losses from undiscovered defects in existence when the policy is issued.

Total Liabilities - total money owed or expected to be owed by the insurance company.

Total Revenue - premiums, revenue, investment income, and income from other sources.

Travel Coverage - covers financial loss due to trip cancellation/interruption; lost or damaged baggage; trip or baggage delays; missed connections and/or changes in itinerary; and casualty losses due to rental vehicle damage.

Treaty - a reinsurance agreement between the ceding company and reinsurer.

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U

Unallocated Loss Adjustment Expense (ULAE) - loss adjustment expenses that cannot be specifically tied to a claim.

Umbrella and Excess (Commercial) - coverage for the liability of a commercial venture above a specific amount set forth in a basic policy issued by the primary insurer; or a self-insurer for losses over a stated amount; or an insured or self-insurer for known or unknown gaps in basic coverages or self-insured retentions.

Umbrella and Excess (Personal) - non-business liability protection for individuals above a specific amount set forth in a basic policy issued by the primary insurer; or a self-insurer for losses over a stated amount; or an insured or self-insurer for known or unknown gaps in basic coverages or self-insured retentions.

Unauthorized Reinsurance - reinsurance placed with a company not authorized in the reporting company's state of domicile.

Underinsured Motorist Coverage - policy option for bodily injury or property losses caused by a motorist with coverage insufficient to cover total dollar amount of losses. Compensation for the injured party is equal to the difference between the losses incurred and the liability covered by the motorist at fault.

Underlying Interest - the asset(s), liability(ies) or other interest(s) underlying a derivative instrument, including, but not limited to, any one or more securities, currencies, rates indices, commodities, derivative instruments, or other financial market instruments.

Underwriter - person who identifies, examines and classifies the degree of risk represented by a proposed insured in order to determine whether or not coverage should be provided and, if so, at what rate.

Underwriting - the process by which an insurance company examines risk and determines whether the insurer will accept the risk or not, classifies those accepted and determines the appropriate rate for coverage provided.

Underwriting Risk - section of the risk-based capital formula calculating requirements for reserves and premiums.

Unearned Premium - amount of premium for which payment has been made by the policyholder but coverage has not yet been provided.

Unearned Premium Reserve - all premiums (fees) received for coverage extending beyond the statement date; appears as a liability on the balance sheet.

Universal Life Insurance - adjustable life insurance under which premiums and coverage are adjustable, company expenses are not specifically disclosed to the insured but a financial report is provided to policyholder's annually.

Unpaid Losses - claims that are in the course of settlement. The term may also include claims that have been incurred but not reported.

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Valued Policy - an insurance contract for which the value is agreed upon in advance and is not related to the amount of the insured loss.

Valued Policy Law - state legislation which specifies that the insured shall receive the face amount of the policy in the event of a total loss to a dwelling rather than the actual cash value regardless of the principle of indemnity.

Variable Annuity - an annuity contract under which the premium payments are used to purchase stock and the value of each unit is relative to the value of the investment portfolio.

Variable Life Insurance - life insurance whose face value and/or duration varies depending upon the value of underlying securities.

Variable Universal Life - combines the flexible premium features of universal life with the component of variable life in which excess credited to the cash value of the account depends on investment results of separate accounts. The policyholder selects the accounts into which the premium payments are to be made.

Viatical Settlements - contracts or agreements in which a buyer agrees to purchase all or a part of a life insurance policy.

Vision - limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.

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Warrant - an agreement that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times according to a schedule or warrant agreement.

Warranty - coverage that protects against manufacturer's defects past the normal warranty period and for repair after breakdown to return a product to its originally intended use. Warranty insurance generally protects consumers from financial loss caused by

the seller's failure to rectify or compensate for defective or incomplete work and cost of parts and labor necessary to restore a product's usefulness. Includes but is not limited to coverage for all obligations and liabilities incurred by a service contract provider, mechanical breakdown insurance and service contracts written by insurers.

Whole Life - life insurance that may be kept in force for a person's entire life and that pays a benefit upon the person's death, whenever that may be.

Whole Life Insurance - life insurance that may be kept in force for the duration of a person's life and pays a benefit upon the person's death. Premiums are made for same time period.

Workers' Compensation - insurance that covers an employer's liability for injuries, disability or death to persons in their employment, without regard to fault, as prescribed by state or federal workers' compensation laws and other statutes.

Written Premium - the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the coverage provided by the terms of the insurance contract.

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NAIC
COMMONLY USED ACRONYMS / ABBREVIATIONS

AAA	American Academy of Actuaries or American Agents Association
AAC/MIS	Americas Association of Cooperative/Mutual Insurance Societies (Formerly North American Association of the ICIF)
AACB	American Association for Consumer Benefits
AACI	American Association of Crop Insurers
AAHA	American Association of Homes for the Aging
AAHP	American Association of Health Plans (merger of GHAA and American Managed Care & Review Association)
AAHSA	American Association of Home and Services for the Aging
AAI	Accredited Adviser in Insurance (AAI designation)
AAI	Alliance of American Insurers (PCI as of spring 2004 merger with NAII)
AAIMCO	American Association of Insurance Management Consultants
AAIS	American Association of Insurance Services
AALTCI	American Association for Long-Term Care Insurance
AALU	Association for Advanced Life Underwriting
AAM	Associate in Automation Management (AAM designation)
AAMGA	American Association of Managing General Agents
AAPPO	American Association of Preferred Provider Organizations
AARP	American Association of Retired Persons
AASCIF	American Association of State Compensation Insurance Funds
ABA	American Bar Association or American Banking Association
ABAIA	American Banker Association Insurance Association (now ABIA)
ABC	American Benefits Council
ABCD	Actuarial Board on Counseling and Discipline
ABI	Association of Banks in Insurance (now ABIA)
ABIA	American Bankers Insurance Association (formed from ABI and ABAIA)
ABIG	American Banker Insurance Group
ABS	Asset-Backed Security
ACA	Affordable Care Act
ACAS	Associate of the Casualty Actuarial Society
ACFE	Association of Certified Fraud Examiners
ACL	Authorized Control Level (regarding RBC) or Audit Command Language
ACLI	American Council of Life Insurers
ACORD	Agency Company Operations Research & Development Corporation
ACORN	Association of Community Organizations for Reform Now
ACSSS	American Council of State Savings Supervisors
ACV	Acceptable Credit Variations
ADA	American Dental Association
ADD	Accidental Death and Dismemberment
ADL	Activities of Daily Living
ADP	Automatic Data Processing
ADQIP	Aggregate Data Quality Incentive Program
ADR	American Depositary Receipt
AEI	American Educational Institute
AES	Automated Examiner Specialists
AFE	Accredited Financial Examiner
AFGI	Association of Financial Guaranty Insurers
AFLAC	American Family Life Assurance Company of Columbus
AFL-CIO	American Federation of Labor-Congress of Individual Organizations
AFP	Association for Financial Professionals
AFSA	American Financial Services Association
AHAS	Advocates for Highway and Auto Safety
AHCA	American Health Care Association
AHIA	Association of Health Insurance Agents
AHIP	America's Health Insurance Plans (formerly Health Insurance Association of America)
AHP	Association Health Plans

AHRQ	Agency for HealthCare Research and Quality
AI	Artificial Intelligence
AIA	American Insurance Association
AIAF	Associate in Insurance Accounting and Finance (AIAF designation)
AIB	Automobile Insurers Bureau of Massachusetts
AIC	Associate in Claims (AIC designation)
AICP	Association of Insurance Compliance Professionals
AICPA	American Institute of Certified Public Accountants
AICPCU	American Institute for CPCU
AIDA	International Association for Insurance Law in the United States
AIDS	Acquired Immune Deficiency Syndrome
AIE	Associate Insurance Examiner or Accredited Insurance Examiner (IRES designation)
AIHSA	American Insurers Highway Safety Alliance
AIM	Associate in Management (AIM designation)
AIMU	American Institute of Marine Underwriters
AIPAGIA	American Institute of Professional Association Group Insurance Administrator
AIPSO	Automobile Insurance Plan Service Office
AIR	Applied Insurance Research or Americans for Insurance Reform
AISG	American Insurance Services Group (A Unit of Insurance Services Office, Inc.)
ALAE	Allocated Loss Adjustment Expense
ALCM	Associate in Loss Control Management (ALCM designation)
ALEC	American Legislative Exchange Council
ALERT	Accelerated Licensure Evaluation Review Techniques
ALIA	American Life Insurance Association
ALIC	Association of Life Insurance Counsel
ALM	Asset Liability Matching
ALTA	American Land Title Association
AMA	American Medical Association
AMCP	Academy of Managed Care Pharmacy
AMCRA	American Managed Care and Review Association
AMIA	American Mutual Insurance Alliance
AMIM	Associate in Marine Insurance Management (AMIM designation)
AMIS	The Mexican Insurance Association (*English translation*)
AML	Anti-Money Laundering
ANSI	American National Standards Institute
AOMR	Actuarial Opinion and Memorandum Regulation
AOS	Actuarial Opinion Summary (P&C)
APA	Associate in Premium Auditing (APA designation)
APhA	American Pharmaceutical Association
APIR	Associate Professional in Insurance Regulation
APPM	Accounting Practices and Procedures Manual
APPP	American Preferred Provider Plan
APPWP	Association of Private Pension and Welfare Plans
ARe	Associate in Reinsurance (ARe designation)
ARIA	American Risk and Insurance Association
ARIS	Alien Reporting Information System
ARM	Associate in Risk Management (ARM designation)
ARMI	Associated Risk Managers International
ARP	Associate in Research and Planning (ARP designation)
ARS	Advanced Rating Service
ASA	Associate of the Society of Actuaries
ASB	Actuarial Standards Board
ASC	Administrative Service Contract
ASIS	Annual Statement Investment Schedule
ASO	Administrative Services Only
ASOP	Actuarial Standard of Practice
ASSAL	Association of Insurance Superintendents of Latin America (*English translation*)
ASSURE	Alliance for Sound State Uniform Regulatory Efficiency
AST	Annual Statement

ASTHO	Association of State and Territorial Health Officers
AU	Associate in Underwriting (AU designation)
AVR	Asset Valuation Reserve
AVS	Automated Valuation Service
BCBSA	Blue Cross and Blue Shield Association
BIC	Bank Investment Contract
BIPA	Benefits Improvement and Protection Act of 2000
BOLI	Bank Owned Life Insurance
BP	Basis Points
BSA	Bank Secrecy Act
CAD	Collaborative Action Designee
CAIF	Coalition Against Insurance Fraud
CALPERS	California Public Employers Retirement System
CAMEL	Capital Asset Management Expenses and Liquidity (elements of risk assessment prioritization)
CAMELS	Capital Asset Management Expenses Liquidity and Sensitivity (elements of risk assessment prioritization)
CAPM	Capital Asset Pricing Model
CAPP	Conference of Actuaries in Public Practice
CARFRA	Coordinated Advertising, Rate, and Form Review Authority
CARRMEL	Capital Adequacy, Asset Quality, Reinsurance, Reserve Adequacy, Management Quality, Earnings and Liquidity (elements of risk assessment prioritization)
CARRMELS	Capital Adequacy, Asset Quality, Reinsurance, Reserve Adequacy, Management Quality, Earnings, Liquidity and Sensitivity (elements of risk assessment prioritization)
CARVM	Commissioners Annuity Reserve Valuation Method
CAS	Casualty Actuarial Society
CASE	Computer Aided Software Engineering
CAT	Consumer Assistance Training
CBO	Collateralized Bond Obligation
CBUR	Credit-Based Underwriting and Rating
CCA	Conference of Consulting Actuaries (formerly Conference of Actuaries in Public Practice)
CCCS	Consumer Credit Counseling Service
CCIA	Consumer Credit Insurance Association
CCIC	Conference of Casualty Insurance Companies
CCIIO	Center for Consumer Information and Insurance Oversight
CCN	Competitive Care Network
CCRC	Continuing Care Retirement Community
CD	Certificate of Deposit
CDO	Collateralized Debt Obligation
CDS	Complaints Database System
CERA	Chartered Enterprise Risk Analyst
CERCLA	Comprehensive Environmental Response, Compensation and Liability Act (Superfund)
CFA	Consumer Federation of America or Chartered Financial Analyst
CFE	Certified Financial Examiner
CFPB	Consumer Financial Protection Bureau
CFT	Combating the Financing of Terrorism
CFTC	Commodity Futures Trading Commission
CGL	Commercial General Liability or Comprehensive General Liability
CGPA	Council of Governors' Policy Advisors
CHA	California Health Advocates
CHAMPUS	Civilian Health and Medical Program for Uniformed Services (now Tricare) (Federal Program)
CHIP	Children's Health Insurance Program
CIAB	Council of Insurance Agents and Brokers
CIC	Certified Insurance Counselor
CICA	Captive Insurance Companies Association
CIEE	Credit Insurance Experience Exhibit
CIIG	Consumer Insurance Interest Group
CINS	CUSIP International Numbering System
CIPR	The Center for Insurance Policy and Research
CIR	Center for Insurance Research

CIRB	Crop Insurance Research Bureau
CIRC	China Insurance Regulatory Commission
CIS	Consumer Information Source
CLE	Continuing Legal Education
CLEAR	Consolidated Licensure for Entities Accepting Risk
CLO	Collateralized Loan Obligation
CLU	Chartered Life Underwriter
CLUE	Comprehensive Loss Underwriting Exchange
CMBS	Commercial Mortgage-Backed Securities
CMO	Collateralized Mortgage Obligation
CMP	Competitive Medical Plans or Commercial Multi-Peril Insurance Plans
CMS	Centers for Medicare & Medicaid Services (formerly HCFA) (Federal Agency)
CNHI	Committee for National Health Insurance
CNSF	National Insurance and Surety Commission
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1986 (Federal Act)
COGEL	Council on Governmental Ethics Laws
COLI	Corporate-Owned Life Insurance
COPLFR	Committee on Property and Liability Financial Reporting, AAA
CPA	Certified Public Accountant
CPCU	Chartered Property Casualty Underwriter (CPCU designation)
CPE	Continuing Professional Education
CPI	Consumer Price Index
CPIW	Certified Professional Insurance Woman
CPP	Commercial Package Policy
CR	Conditionally Renewable
CREF	College Retirement Equities Fund
CRVM	Commissioners Reserve Valuation Method
CSBS	Conference of State Bank Supervisors
CSG	Council of State Governments
CSIO	Centre for Studies in Insurance Operations
CSO	Commissioners Standard Ordinary (mortality tables)
CTL	Credit Tenant Loan
CUSIP	Committee on Uniform Securities Identification Procedures
DAC	Deposit Administration Contract
DBMS	Database Management Systems
DCA	Debt Cancellation Agreement
DCBS	Department of Consumer and Business Services
DCI	Detailed Claim Information
DEA	Drug Enforcement Administration
DFI	Department of Financial Institutions
DHC	Diversified Holding Company
DI	Disability Income
DMIC	Direct Marketing Insurance & Financial Services Council
DOI	Department of Insurance or Division of Insurance
DOJ	Department of Justice
DOL	U.S. Department of Labor (Federal Agency)
DRA	Deficit Reduction Act of 2005
DRG	Diagnosis Related Groups
DTI	Department of Trade and Industry (United Kingdom regulatory agency)
DWL	Defense Within Limits
EAP	Employee Assistance Program
EBNR	Earned But Not Reported
EBRI	Employee Benefit Research Institute
EBUP	Earned But Unbilled Premiums
EC	European Community
ECP	Exempt Commercial Policyholder
ECU	European Currency Unit
EDI	Electronic Data Interchange

EDP	Electronic Data Processing
EDS	Electronic Data Systems Corporation
E&E	Effectiveness and Efficiency Project (of the NAIC/SVO)
EEC	European Economic Community
EEOC	Equal Employment Opportunity Commission
EFT	Electronic Funds Transfer
EIL	Environmental Impairment Liability
EITF	Emerging Issues Task Force (a FASB task force)
ELANY	Excess Lines Association of New York
EPA	Environmental Protection Agency
EPICC	Equity in Prescription Insurance Contraceptive Coverage Act
EPO	Exclusive Provider Organization
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERISA	Employee Retirement Income Security Act (Federal Act)
E&S	Excess & Surplus Lines
E-Sign	Electronic Commerce and Transactions Act
ESOP	Employee Stock Ownership Plan
ETS	Educational Testing Service or Examination Tracking System
EU	European Union
FAIR	Fair Access to Insurance Requirements
FASB	Financial Accounting Standards Board
FAST	Financial Analysis Solvency Tools
FATF	Financial Action Task Force on Money Laundering (inter-governmental body)
FBI	Federal Bureau of Investigation (U.S. Government)
FCAS	Fellow of the Casualty Actuarial Society
FCIC	Federal Crop Insurance Corporation
FCRA	Fair Credit Reporting Act (Federal Act)
FDIC	Federal Deposit Insurance Corporation
FDR	Financial Database Repository
FEETS	Financial Exam Electronic Tracking System
FEIN	Federal Employer Identification Number
FEMA	Federal Emergency Management Agency
FHLMC or Freddie Mac	Federal Home Loan Mortgage Corporation
FIA	Federal Insurance Administration
FICA	Federal Insurance Contributions Act
FICC	Federation of Insurance & Corporate Counsel
FIIA	Financial Institutions Insurance Association
FINRA	Financial Industry Regulatory Authority
FIO	Federal Insurance Office
FIREA	Financial Institutions Reform, Recovery & Enforcement Act
FIT	Federal Income Tax
FLTCIP	Federal Long-Term Care Insurance Program
FLUX	Flow Uncertainty Index
FNMA or Fannie Mae	Federal National Mortgage Association
FOIA	Freedom of Information Act
FORC	Federation of Regulatory Counsel
FPDA	Flexible Premium Deferred Annuity
FPRA	Flexible Premium Retirement Annuity
FPSH	Forum on Privacy and Security in Healthcare
FRC	Federal Records Center
FRSAC	Financial Regulation Standards and Accreditation Committee
FSA	Fellow of the Society of Actuaries
FSLIC	Federal Savings and Loan Insurance Corporation
FSF	Financial Stability Forum
FSOC	Financial Stability Oversight Council
FTB	FASB Technical Bulletin
FTC	Federal Trade Commission
GAAP	Generally Accepted Accounting Principles
GAAS	Generally Accepted Auditing Standards

GAM	Group Annuity Mortality
GAMA	General Agents & Managers Association
GAO	Government Accountability Office (formerly General Accounting Office)
GAR	Group Annuity Reserving
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GDP	Gross Domestic Product
GERP	Geographic Expense Reimbursement Plan
GFMS	Guaranty Fund Management Services
GIC	Guaranteed Investment Contract
GLB	Guaranteed Living Benefits
GLBA	Gramm-Leach-Bliley Act (Fin. Services Modernization Act of 1999, P.L. 106-102) (Federal Act)
GMAB	Guaranteed Minimum Accumulation Benefit
GMDB	Guaranteed Minimum Death Benefit
GMIB	Guaranteed Minimum Income Benefit
GNAIE	Group of North American Insurance Enterprises
GNMA or Ginnie Mae	Government National Mortgage Association
GNP	Gross National Product
GR	Guaranteed Renewable
GRET	Generally Recognized Expense Table
GRID	Global Receivership Information Database
HA	Health Alliance
HCCA	Health Care Compliance Association
HCDA	Health Care Delivery Assets
HCFA	Health Care Financing Administration (renamed CMS on June 19, 2001) (Federal Agency)
HDN	Health Delivery Network
HEDIS	Health Plan Employer Data and Information Set
HHS	U.S. Department of Health and Human Services
HIAA	Health Insurance Association of America (now America's Health Insurance Plans (AHIP))
HICAP	Health Insurance Consumer Assistance Program
HIN	Health Insurance Network
HIPAA	Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (Federal Act)
HIPDB	Healthcare Integrity and Protection Data Bank
HIPG	Health Insurance Purchasing Group
HLDI	Highway Loss Data Institute
HMDI	Hospital, Medical and Dental Service or Indemnity Corporation
HMO	Health Maintenance Organization
HOLUA	Home Office Life Underwriters Association
HPPC	Health Plan Purchasing Corporation
HSAC	Health Security Action Council
HSC	Center for Studying Health System Change
HUD	U.S. Department of Housing and Urban Development
I/O	Interest Only
IAA	International Actuarial Association
IADCA	Insurance Advertising Compliance Association
IADL	Instrumental Activities of Daily Living
IAFP	International Association for Financial Planning
IAIABC	International Association of Industrial Accident Boards and Commissions
IAIFA	International Association of Insurance Fraud Agencies, Inc.
IAIR	International Association of Insurance Receivers
IAIS	International Association of Insurance Supervisors
IAM	Individual Annuity Mortality
IASA	Insurance Accounting and Systems Association
IASB	International Accounting Standards Board
IBHS	Institute for Business and Home Safety
IBNR	Incurred But Not Reported
ICA	International Claims Association
ICAC	Insurance Committee for Arson Control
ICHEIC	International Commission on Holocaust Era Insurance Claims

ICIS	Insurance Company Information System
ICJ	Institute for Civil Justice
ICMIF	International Cooperative and Mutual Insurance Federation
IDMA	Insurance Data Management Association
IDS	Integrated Delivery System
IEA	Insurance Education Association
IEE	Insurance Expense Exhibit
IEF	Insurance Education Foundation
IHIP	Institute for Health Policy (an education foundation formed by HIAA)
IHPS	Institute for Health Policy Solutions
IIA	Insurance Institute of America
IIAA	Independent Insurance Agents of America
IIAC	International Insurance Advisory Council
IIC	International Insurance Council
IICAR	Inter-Industry Conference on Auto Collision Repair
IID	International Insurers Department
IIHS	Insurance Institute for Highway Safety
III	Insurance Information Institute
IIPLR	Insurance Institute for Property Loss Reduction
IIPRC	Interstate Insurance Product Regulation Commission
IIR	Insurance Institute for Research, Inc.
IIS	International Insurance Society
ILCA	Insurance Loss Control Association
ILU	Institute of London Underwriters (merged into IUA)
IMCA	Insurance Marketing Communications Association
IMF	International Monetary Fund
IMR	Interest Maintenance Reserve
IMSA	Insurance Marketplace Standards Association
IMUA	Inland Marine Underwriters Association
IOSCO	International Organization of Securities Commissioners
IPA	Individual Practice Association
IPG	Immediate Participation Guarantee
IPO	Initial Public Offering
IRC	Insurance Research Council
IRDA	Insurance Regulatory and Development Authority
IRES	Insurance Regulatory Examiners Society (for non-financial examiners)
IRIN	Insurance Regulatory Information Network (now NIPR)
IRIS	Insurance Regulatory Information System
IRMI	International Risk Management Institute Incorporation
ISDN-BRI	Integrated Services Digital Network - Basic Rate Interface
ISI	Insurance Solvency International
ISIS	Integrated Securities Information System
I-SITE	Internet State Interface Technology Enhancement
ISN	Integrated Service Network
ISO	Insurance Services Office, Inc.
ISS	Independent Statistical Service, Inc.
IUA	International Underwriting Association of London
IUL	Indexed Universal Life
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JIR	*Journal of Insurance Regulation*
JRI	Journal of Risk and Insurance
JUA	Joint Underwriting Association
LAE	Loss Adjustment Expense
LAN	Local Area Network
LBO	Leveraged Buyout
LCA	Life Communicators Association
LHSO	Limited Health Service Organization
L/H	Life Health
LIAA	Life Insurance Association of America

LIBOR	London InterBank Offering Rate (an ARM index, a common financial term)
LIC	Life Insurance Corporation of India or Life Insurers Council
LICONY	Life Insurance Companies of New York
LIFE	Life and Health Insurance Foundation for Education
LIRMA	London International Insurance and Reinsurance Market Association (now IUA)
LOC	Letter of Credit
LOMA	Life Office Management Association
LRG	Loss Ratio Guarantees
LRRA	Liability Risk Retention Act
LTC	Long-Term Care
LUTC	Life Underwriter Training Council
MAC	Market Analysis Chief
MAI	Member Appraisal Institute or Multilateral Agreement on Investments
MAP	Market Analysis Profile
MAPR	Market Analysis Profile Reports
MAPT	Market Analysis Prioritization Tool
MAR	Minimum Asset Requirement
MARS	Market Analysis Review System
MBA	Mortgage Banker Association of America
MCAS	Market Conduct Annual Statement
MCHIP	Managed Care Health Insurance Plan
MCO	Managed Care Organization
MCSU	Market Conduct Statistical Utilities
MDA	Management Discussion & Analysis
MEAF	Mortgage Experience Adjustment Factor
Medigap	Medicare Supplement Insurance
MedSupp	Medicare Supplement Insurance
MET	Multiple Employer Trust
MEWA	Multiple Employer Welfare Arrangement
MGA	Managing General Agent or Mortgage Guaranty Association
MGDB	Minimum Guaranteed Death Benefit
MHC	Mutual Holding Company
MHPA	Mental Health Parity Act of 1996
MIB	Medical Information Bureau
MIS	Market Information Systems
MITI	Ministry of International Trade and Industry
MITS	Market Initiative Tracking System
MLR	Medical Loss Ratio
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MOU	Memorandum of Understanding
MRA	Mutual Recognition Agreement
MSA	Medical Savings Account
MSVR	Mandatory Securities Valuation Reserve
NAAG	National Association of Attorneys General
NACIA	National Association Of Crop Insurance Agents
NAEHCA	National Association of Employers on Health Care Action
NAFTA	North American Free Trade Agreement
NAG	National Association of Governors
NAHDO	National Association of Health Data Organizations
NAHU	National Association of Health Underwriters
NAIA	National Association of Insurance Agents
NAIB	National Association of Insurance Brokers
NAIC	National Association of Insurance Commissioners
NAIFA	National Association of Insurance and Financial Advisors
NAII	National Association of Independent Insurers (PCI as of spring 2004 merger with the Alliance of American Insurers)
NAIIA	National Association of Independent Insurance Adjusters
NAILBA	National Association of Independent Life Brokerage Agencies
NALC	National Alliance of Life Companies

NAMCR	National Association of Managed Care Regulators
NAMIA	National Association of Mutual Insurance Agents
NAMIC	National Association of Mutual Insurance Companies
NAPSLO	National Association of Professional Surplus Lines Offices
NARAB	National Association of Registered Agents and Brokers (a proposed federal agency to ensure uniform regulation under the Gramm-Leach-Bliley Act)
NASAA	North American Securities Administrators Association
NASD	(formerly National Association of Securities Dealers, now merely "NASD")
NASVA	North American Securities Valuation Association
NC	Noncancelable
NCCI	National Council on Compensation Insurance
NCCUSL	National Conference of Commissioners on Uniform State Laws
NCIC	National Crime Information Center
NCIGF	National Conference on Insurance Guaranty Funds
NCIS	National Crop Insurance Services
NCLC	National Consumer Law Center
NCOA	National Council on Aging
NCOIL	National Conference of Insurance Legislators
NCPI	National Committee on Property Insurance
NCQA	National Committee for Quality Assurance
NCSL	National Conference of State Legislatures
NCVHS	National Committee on Vital and Health Statistics
NFCA	National Fraternal Congress of America
NFIA	National Flood Insurers Association
NFIB	National Federation of Independent Business
NFIP	National Flood Insurance Program
NGA	National Governors' Association
NHCAA	National Health Care Anti-Fraud Association
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIARS	National Insurance Advertising Regulation Service
NICB	National Insurance Crime Bureau
NICO	National Insurance Consumer Organization
NIHCM	National Institute for Health Care Management
NILS	National Insurance Law Service
NIPA	National Institute of Pension Administrators
NIPC	National Insurance Producers Council
NIPR	National Insurance Producer Registry
NISS	National Independent Statistical Services
NITCH	Nonadmitted Insurers Tax Clearinghouse
NOLHGA	National Organization of Life and Health Insurance Guaranty Associations
NP	Network Plans
NPC	National Pharmaceutical Council
NPN	National Producer Number
NR	Nonrenewable
NRL	Non Resident Licensing
NRRA	National Risk Retention Association
NRSRO	Nationally Recognized Statistical Rating Organization
NSLA	National Staff Leasing Association
OBRA	Omnibus Budget Reconciliation Act of 1993
OCBOA	Other Comprehensive Basis of Accounting
OCC	Office of the Comptroller of the Currency
ODS	Organized Delivery Systems
OECD	Organisation for Economic Co-operation and Development
OFRS	Online Fraud Reporting Service or Online Fraud Reporting System
OHMO	Office of Health Maintenance Organizations
OPCH	Office of Prepaid Health Care
OR	Optionally Renewable
OSHA	Occupational Safety & Health Administration

OTC	Over the Counter
OTS	Office of Thrift Supervision
PACE	Program for All-inclusive Care for the Elderly
PBGC	Pension Benefit Guaranty Corporation
PBM	Pharmacy Benefit Manager
PBR	Principle-Based Reserves or Principle-Based Reserving
P/C	Property/Casualty
PCAOB	Public Company Accounting Oversight Board
PCI	Property Casualty Insurers Association of America (as of spring 2004 merger of NAII and the Alliance of American Insurers)
PCMA	Pharmaceutical Care Management Association
PDB	Producer Database
PDP	Prescription Drug Plans
PEO	Professional Employer Organization
PG	Purchasing Group
PHO	Physician Hospital Organization
PHSA	Public Health Service Act
PIA	Professional Insurance Agents
PIAA	Physicians Insurers Association of America
PICS	Policy Issue Capture System
PILR	Property Insurance Loss Register
PIMA	Professional Insurance Mass Marketing Association
PIN	Producer Information Network (NIPR Gateway as of January 2001)
PIP	Personal Injury Protection
PIPSO	Property Insurance Plans Service Office
PLIA	Pollution Liability Insurance Association
PLMA	Producer Licensing Model Act
PLRB	Property Loss Research Bureau
P/O	Principal Only
POC	Proof of Claim
POS	Point of Service
PPA	Preferred Provider Arrangement
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PRIMA	Public Risk & Insurance Management Association
PSN	Provider-Sponsored Network
PSO	Provider-Sponsored Organization
PUD	Planned Unit Development
QHP	Qualified Health Plan
QMB	Qualified Medicare Beneficiary
QUEST	Health Care Quality Education Security and Trust Act (S 1712 in 1998)
RAA	Reinsurance Association of America
RBC	Risk-Based Capital
RBRVS	Resource-Based Relative Value Scale
RCRA	Resource Conservation and Recovery Act
REIT	Real Estate Investment Trust
Re-REMIC	Resecuritizations of Real Estate Mortgage Investment Conduits
RERP	Revised Experience Rating Plan
RFP	Request for Proposal
RICO	Racketeer Influenced and Corrupt Organization
RIMS	Risk and Insurance Management Society
RIRS	Regulatory Information Retrieval System
RMBS	Residential Mortgage-Backed Securities
RML	Residual Market Loads
RMS	Risk Management Solutions, Inc.
ROA	Reinsurance Office Association or Return on Assets
ROP	Return of Premium
RRG	Risk Retention Group
RUGS	Resource Utilization Groups

SAD	Special Activities Database
SAFE-T	Solvency and Financial Enforcement Trust
SAO	Statement of Actuarial Opinion (P&C)
SAP	Statutory Accounting Practices
SAR	Securities Acquisition Report
SAS	Statement of Auditing Standards
SBP	Shortened Benefit Period
SCA	Subsidiary, Controlled or Affiliated Company
SCAE	Special Claim Adjustment Expense
SCHIP	State Children's Health Insurance Program
SEC	Securities and Exchange Commission
SERFF	System for Electronic Rate and Form Filing
SHIP	State Health Insurance Assistance Program
SIA	Securities Industry Association
SIC	Standard Industrial Classification
SIIA	Self-Insurance Institute of America
SILA	Society of Licensing Administrators
SILN	State Insurance Licensing Network
SIPC	Securities Investor Protection Corporation
SIR	Society of Insurance Research
SIU	Special Investigative Unit
SLMB	Specified Low-Income Medicare Beneficiary
SMI	Solvency Modernization Initiative
SMMEA	Secondary Mortgage Market Enhancement Act
SNF	Skilled Nursing Facility
SNFL	Standard Nonforfeiture Law
SOA	Society of Actuaries
SOGCA	Society of Group Contract Analysts
SOFE	Society of Financial Examiners
SOP	Statement of Position
SPDA	Single Premium Deferred Annuity
SPIA	Single Premium Immediate Annuity
SPRA	Special Pooled Risk Administrators
SRA	Society for Risk Analysis or Specific Risk Analysis (section of *Financial Condition Examiners Handbook*)
SSAP	Statement of Statutory Accounting Principles
STOLI	Stranger Owned Life Insurance
SVL	Standard Valuation Law
SVO	Securities Valuation Office
TAC	Total Adjusted Capital (regarding RBC)
TEFRA	Tax Equity and Fiscal Responsibility Act
TIAA	Teachers Insurance Annuities Association
TPA	Third Party Administrator
TRIA	Terrorism Risk Insurance Act
TRICARE	Health insurance program for military personnel (formerly CHAMPUS) (Federal Program)
TRO	Temporary Restraining Order
TSAG	Technical Staff Actuarial Group
UALAE	Unallocated Loss Adjustment Expense
UCAA	Uniform Certificate of Authority Application
UCITA	Uniform Computer Information Transactions Act
UETA	Uniform Electronic Transaction Act
UL	Universal Life
ULSG	Universal Life with Secondary Guarantees
UNCTAD	United Nations Conference on Trade and Development
UPPL	Uniform Policy Provisions Law
URAC	Utilization Review Accreditation Committee
URC	Unit Report Control
URQ	Unit Report Quality
URTT	Uniform Regulation Through Technology

U.S.	United States
USAA	United Services Automobile Association
USA PATRIOT Act	Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001
UTPA	Unfair Trade Practices Act
VA	Variable Annuity
VAGLB	Variable Annuity with Guaranteed Living Benefits
VDI	Vendor Dual Interest
VM	Valuation Manual
VSI	Vendor Single Interest
VUL	Variable Universal Life
WCDM	Workers' Compensation Data Monitoring System
WCIO	Workers Compensation Insurance Organization
WCIRB	Workers' Compensation Insurance Rating Bureau
WCRI	Workers' Compensation Research Institute
WCSP	Workers' Compensation Statistical Plan
WEDI	Workgroup on Electronic Data Interchange
WTO	World Trade Organization