

U.S. Office of Personnel Management



Multi-State Plan Program Application For New and Returning Issuers

2017

**Last Modified:
March 21, 2016**

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

Table of Contents

| | |
|--------------------------------------------------------------|----|
| Organizational Structure | 3 |
| Application Questions | 3 |
| Section 1: Applicant | 3 |
| 1.1 Applicant Information | 3 |
| 1.2 Group of Issuers | 6 |
| 1.3 Managerial Capabilities | 7 |
| 1.4 Financial Solvency | 8 |
| 1.5 Oversight, Control, and Consolidation of Functions | 9 |
| 1.6 Application Attestations | 13 |
| Section 2: State-level MSP Issuer Information | 14 |
| 2.1 Administrative and Licensure Information | 14 |
| 2.2 MSP Overview and Strategy | 16 |
| 2.3 Accreditation Status | 18 |
| 2.4 Enrollment and Marketing | 19 |
| 2.5 Financial | 22 |
| 2.6 Claims | 22 |
| 2.7 Member Services | 24 |
| 2.8 Utilization/Quality Assurance | 26 |
| 2.9 IT Systems, Security and Confidentiality | 30 |
| 2.10 Disaster Recovery/Business Continuity | 32 |
| 2.11 Provider Contracts and Networks | 32 |
| 2.12 Service Area and Network Adequacy | 40 |
| 2.13 Prescription Drugs | 41 |
| 2.14 Benefit Proposal | 46 |
| 2.15 Benefits Attestation | 48 |
| 2.16 Rate Proposal | 51 |
| 2.17 Rate Attestation | 54 |
| 2.18 Additional SHOP Information | 55 |
| 2.19 State Filing and Other Information | 55 |
| 2.20 Quality Improvement Strategy | 57 |

Organizational Structure

In the Organizational Structure section of the Application Portal, you will enter information about each State-level issuer you are proposing in this Application. In this section, also indicate whether this State-level issuer is proposing to offer MSP options in SHOP. Once a State-level issuer is entered into the Organizational Structure, application questions will be enabled.

Application Questions

Section 1: Applicant

1.1 Applicant Information

1.1.Q1 Provide an introductory overview of your organization. Include your short-term and long-term vision of how your participation as an MSP issuer would benefit the MSP Program and the Health Insurance Marketplaces. What solutions, efficiencies, economies of scale, or unique approaches do you propose to provide that will distinguish your MSP offerings from other offerings on the Marketplaces?

Text box (6000 character maximum)

1.1.Q2 Does the Applicant currently contract with OPM for the Federal Employees Health Benefits (FEHB) Program? **Tool Tip: Answer “yes” if your organizational structure is exactly the same as for FEHB. A “yes” answer will suppress certain questions from appearing in your application. If your planned organizational structure for the MSP Program is different from your FEHB structure, contact us to discuss how you should answer this question.**

- Yes No

1.1.Q3 Describe your corporate structure and management.

Text box (6000 character maximum)

1.1.Q4 If No to 1.1.Q2: Provide documentation of your corporate structure. This may include executed articles of incorporation or organization, partnership agreement(s), or any other applicable organization documents.



1.1.Q5 Will the Applicant also serve as the State-level issuer in all States?

- Yes No

1.1.Q6 If No to 1.1.Q5: Describe the legal, financial, and organizational relationship between the Applicant and the State-level MSP issuers that will provide health insurance under this contract.

Text box (6000 character maximum)

1.1.Q7 If No to 1.1.Q5: Provide documentation about these legal, financial, and organizational relationships.



1.1.Q8 If No to 1.1.Q5: Describe how the Applicant interacts with the State-level MSP issuers, including decision-making processes, lines of authority, funding arrangements, and how the Applicant will ensure that State-level MSP issuers comply with the terms of the MSP Program contract.

Text box (6000 character maximum)

1.1.Q9 If No to 1.1.Q2: Describe the Applicant's history of health insurance operations, including previous experience and lines of business in State insurance markets. Describe any reorganizations, mergers, changes of ownership, and name changes that have taken place within the last 10 years.

Text box (6000 character maximum)

1.1.Q10 Is the Applicant a non-profit entity?

- Yes No

1.1.Q11 If Yes to 1.1.Q10: Provide documentation of non-profit status.



1.1.Q12 If No to 1.1.Q2: Is the Applicant owned by, affiliated with, or sponsored by another organization that provides management and/or financial support to the Applicant?

- Yes No

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

1.1.Q13 If Yes to 1.1.Q12: Provide details including legal relationship, administrative, management, financial or other services the other organization provides. In what ways, if any, is the other organization financially responsible for the Applicant?

Text box (6000 character maximum)

1.1.Q14 If No to 1.1.Q2: Describe any significant legal actions or ongoing investigations that may impact the Applicant's ability to fulfill the terms of a contract for the MSP Program.

Text box (6000 character maximum)

1.1.Q15 Has the Applicant and/or any of its State-level MSP issuers been sanctioned or penalized by conviction, civil judgment, or otherwise, for engaging in fraudulent, criminal, or other improper activity in any government program?

- Yes No

1.1.Q16 If Yes to 1.1.Q15: Provide details.

Text box (6000 character maximum)

1.1.Q17 Provide a signed opinion by legal counsel that the Applicant and State-level MSP issuers are not debarred, suspended, or ineligible to participate in Federal Government contracting for any reason, including fraudulent health care practices in other Federal health care programs. This includes members of the board of directors, any key management or executive staff, major stockholders, affiliated companies, subsidiaries, subcontractors, and subcontractor staff.



1.1.Q18 Are the Applicant's State-level issuers currently actively writing health insurance policies in all 50 States and the District of Columbia?

- Yes No

1.1.Q19 If No to 1.1.Q18: Provide your plan and timeline for ensuring that your State-level issuers are appropriately licensed to offer MSP options in each State. Do you anticipate any issues in obtaining licensure in any State? If so, please explain.

Text box (6000 character maximum)

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

1.1.Q20 [Optional field] Submit any additional information or documentation as requested by OPM.



1.2 Group of Issuers

1.2.Q1 Are you applying as a Group of Issuers? **Tool Tip: a Group of Issuers is defined as: (1) a group of health insurance issuers that are affiliated either by common ownership and control or by common use of a nationally licensed service mark or (2) an affiliation of health insurance issuers and an entity that is not an issuer but that owns a nationally licensed service mark. A nationally licensed service mark means a word, name, symbol, or device, or any combination thereof, that an issuer or group of issuers uses consistently nationwide to identify itself.**

- Yes No

1.2.Q2 If Yes to 1.2.Q1: Describe the managerial organization, control, funding, and decision-making structures for the group.

Text box (6000 character maximum)

1.2.Q3 If Yes to 1.2.Q1: Describe any contractual, agency, fiduciary or other relationship between affiliated issuers that will ensure that the Applicant complies with the terms of its MSP Program contract.

Text box (6000 character maximum)

1.2.Q4 If Yes to 1.2.Q1: Describe how conflicts between affiliated issuers are resolved.

Text box (6000 character maximum)

1.2.Q5 [If No to 1.1.Q2 and yes to 1.2.Q1] If applicable, provide a copy of the contract or other documents relating to the use and ownership of the service mark.



1.2.Q6 [Optional field] Submit any additional information or documentation as requested by OPM.



1.3 Managerial Capabilities

Provide the names, titles, and resumes (or summary of relevant experience) of key personnel at the Applicant level that would be assigned to this contract in the following critical areas: **Tool Tip: Please note that this does not include key personnel at the State-level issuer level. We expect the persons named here will be those who oversee and coordinate with corresponding personnel at the State-level issuers and can speak for the Applicant as a whole to OPM regarding the subject matter.**

Chief Executive Officer

- 1.3.Q1 Name:
- 1.3.Q2 Employee Title:
- 1.3.Q3 Phone:
- 1.3.Q4 Email:
- 1.3.Q5 Resume:



Contracting Official

- 1.3.Q6 Name:
- 1.3.Q7 Employee Title:
- 1.3.Q8 Phone:
- 1.3.Q9 Email:
- 1.3.Q10 Resume:



Overall Management/OPM Contact

- 1.3.Q11 Name:
- 1.3.Q12 Employee Title:
- 1.3.Q13 Phone:
- 1.3.Q14 Email:
- 1.3.Q15 Resume:



[Optional fields] State-level MSP Issuer Liaison/Oversight/Coordination (if applicable)

- 1.3.Q16 Name:
- 1.3.Q17 Employee Title:
- 1.3.Q18 Phone:
- 1.3.Q19 Email:

1.3.Q20 Resume:



[Optional fields] Other (if applicable)

- 1.3.Q21 Name:
- 1.3.Q22 Employee Title:
- 1.3.Q23 Phone:
- 1.3.Q24 Email:
- 1.3.Q25 Resume:



1.3.Q26 Provide a chart of the Applicant’s entire organizational structure. Highlight which sections of the organizational structure will be involved in managing the MSP Program contract. Identify where the key personnel listed above reside in the organizational structure.



1.3.Q27 [Optional field] Submit any additional information or documentation as requested by OPM.



1.4 Financial Solvency

1.4.Q1 If No to 1.1.Q5: Describe any fiduciary, agency, or trust relationship that exists between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.4.Q2 If No to 1.1.Q5: Specify how the Applicant would guarantee contract performance in a State where a State-level MSP issuer becomes insolvent or becomes unable to fulfill its responsibilities under an MSP Program contract.

Text box (6000 character maximum)

1.4.Q3 Provide evidence of the financial ability of the Applicant to sustain operations in the future and to meet obligations under the MSP Program, including any commitment from an outside entity. This includes audited financial statements for the last 3 years, including balance sheet, income statement,

and statement of cash flow. Include any qualified opinions and steps taken to resolve them. Provide a projected balance sheet for the current fiscal year.



1.4.Q4 Provide your current and two prior financial ratings from A.M. Best, Moody's, Standard and Poor's, Fitch, and Weiss, as available, by completing the Financial Ratings Template.




Financial Rating
Template.xlsx

1.4.Q5 Describe measures you would implement in the event you became insolvent while you are an MSP issuer.

Text box (6000 character maximum)

1.4.Q6 [Optional field] Submit any additional information or documentation as requested by OPM.



1.5 Oversight, Control, and Consolidation of Functions

1.5.Q1 [Required if answer to 1.1.Q5 is No] Describe oversight and control over State-level MSP issuers. Include a discussion of how you intend to oversee and coordinate the delivery of a consistent level of performance. **Tool Tip: When the Applicant is the responsible entity for a listed function, we expect a coordinated response to relevant questions in Section 2. For example, if marketing and outreach will be conducted on a corporate level on behalf of all State-level issuers, then there should be no difference in each State-level issuer's answers to the marketing questions in Section 2.**

Text box (6000 character maximum)

Please indicate which entity would be primarily responsible for performing the function listed:

1.5.Q2 [Required if answer to 1.1.Q5 is No] Responsible entity for enrollment (including acceptance, acknowledgement, and reconciliation of enrollments from Exchanges):

- Applicant
- State-level MSP issuer

1.5.Q3 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q2 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q4 [Required if answer to 1.1.Q5 is No] Responsible entity for premium collection and reconciliation (including receipt of advance payment of premium tax credits and cost sharing reduction payments):

- Applicant
- State-level MSP issuer

1.5.Q5 [Required if answer to 1.5.Q4 is Applicant and if answer to 1.1.Q5 is No] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q6 [Required if answer to 1.1.Q5 is No] Responsible entity for customer service:

- Applicant
- State-level MSP issuer

1.5.Q7 [Required if answer to 1.1.Q5 is No and answer to 1.5.Q6 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q8 [Required if answer to 1.1.Q5 is No] Responsible entity for marketing and outreach (including website, call center(s), advertising and marketing material)

- Applicant
- State-level MSP issuer

1.5.Q9 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q8 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q10 [Required if answer to 1.1.Q5 is No] Responsible entity for claims processing:

- Applicant
- State-level MSP issuer

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

1.5.Q11 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q10 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q12 [Required if answer to 1.1.Q5 is No] Responsible entity for claims payment:

- Applicant
- State-level MSP issuer

1.5.Q13 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q12 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q14 [Required if answer to 1.1.Q5 is No] Responsible entity for claims appeals:

- Applicant
- State-level MSP issuer

1.5.Q15 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q14 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q16 [Required if answer to 1.1.Q5 is No] Responsible entity for clinical quality improvement:

- Applicant
- State-level MSP issuer

1.5.Q17 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q16 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q18 [Required if answer to 1.1.Q5 is No] Responsible entity for fraud and abuse prevention:

- Applicant
- State-level MSP issuer

1.5.Q19 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q18 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

Text box (6000 character maximum)

1.5.Q20 [Required if answer to 1.1.Q5 is No] Responsible entity for written communication to enrollees (including explanation of benefits forms, correspondence regarding claims, enrollment, and premium payments)

- Applicant
- State-level MSP issuer

1.5.Q21 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q20 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuer.

Text box (6000 character maximum)

1.5.Q22 [Required if answer to 1.1.Q5 is No] Responsible entity for care management

- Applicant
- State-level MSP issuer

1.5.Q23 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q22 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q24 [Required if answer to 1.1.Q5 is No] Responsible entity for subcontractor oversight

- Applicant
- State-level MSP issuer

1.5.Q25 [Required if answer to 1.1.Q5 is No and if answer to 1.5.Q24 is Applicant] If the Applicant is the responsible entity, discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text box (6000 character maximum)

1.5.Q26 [Required if answer to 1.1.Q5 is No] Describe how State-level MSP issuers' systems will interact to share information when required, e.g., when an enrollee receives care in a different State.

Text box (6000 character maximum)

1.5.Q27 Describe your process for developing medical policy, including the development and implementation of policy by State-level issuers, deciding whether and when to provide benefits for a new procedure/technology, and reconciling regional differences in practice patterns.

Text box (6000 character maximum)

1.5.Q28 [Optional field] Submit any additional information or documentation as requested by OPM.



1.6 Application Attestations

Submit this subsection only after final submission of all subsections, including the Benefits Attestation (Subsection 2.15) and Rate Attestation (Subsection 2.17) for all State-level issuers.

1.6.Q1. By submitting this Subsection, you hereby acknowledge and agree that:

- The information you have provided in this application is true, correct, and complete to the best of your knowledge and belief;
 - You must inform OPM if, after you submit this application, the information you have provided changes in any material way. Material changes include, but are not limited to, changes to provider networks, financial solvency or ratings, licensure, market conduct reviews, accreditation status, non-profit status, key personnel, corporate structure or ownership, and agreements involving a Group of Issuers or use of a service mark;
 - If you knowingly misrepresent your organization's qualifications in the application by providing false information, failing to inform OPM of material changes to the information provided in your application in accordance with paragraph (b), or omitting required information, and OPM enters into a contract with you based on one or more of these misrepresentations, you may be subject to penalty, including but not limited to termination of your contract;
 - Unless restricted by law, any information you submit may be subject to disclosure to the public pursuant to the provisions of the Freedom of Information Act (5 U.S.C. § 552). If you wish to request privileged or confidential treatment of any materials you submit, you have marked them pursuant to 5 C.F.R. § 294.112. In determining whether information must be publicly released, OPM will comply with the procedures set forth in 5 C.F.R. § 294.112. OPM assumes no liability for disclosure or use of marked or unmarked data, and may disclose or use submitted data for any purpose permitted under law;
 - If you, or a State-level Issuer you represent, are accredited by NCQA, URAC, or AAAHC, you and each State-level Issuer hereby authorize the accrediting organization(s) to release to OPM, HHS, and any Marketplaces on which you or the State-level Issuer participates a copy of the most recent accreditation survey, as well as corrective action plans and summaries of findings; and
 - To the best of your knowledge and belief, there are no relevant facts or circumstances which could give rise to an organizational conflict of interest (OCI), as defined in FAR 9.5, Organizational and Consultant Conflicts of Interest, or you have disclosed all such relevant information.
- Yes, the Applicant agrees to this attestation.

Section 2: State-level MSP Issuer Information

In the sections below, “you” and “issuer” refer to the State-level MSP issuer(s).

2.1 Administrative and Licensure Information

Provide a staff-level contact at the State Department of Insurance for confirmation of licensure and good standing status: **Tool Tip: Please provide information for a staff-level contact, not the State Insurance Commissioner.**

2.1.Q1 Name:

2.1.Q2 Title:

2.1.Q3 Agency/bureau:

2.1.Q4 Email:

2.1.Q5 Phone:

2.1.Q6 Did you offer MSP options in the Marketplace in plan year 2015 under the HIOS Issuer ID listed in the Organizational Structure for this application? **Tool Tip: Issuers should complete this question and subsection before beginning the rest of the application.**

- Yes No

2.1.Q7 [If Yes to 2.1.Q6] Are there any major changes to your organization or operations since you last participated in the MSP Program?

- Yes No

2.1.Q8 [If Yes to 2.1.Q6 and 2.1.Q7] Describe these changes.

Text box (6000 character maximum)

2.1.Q9 [Required if No to 2.1.Q6] Are you currently licensed in the State to offer health insurance in the individual market?

- Yes No

2.1.Q10 If No to 2.1.Q6 and Yes to 2.1.Q9: Upload a copy of your license or certificate of authority.



2.1.Q11 [Required if No to 2.1.Q6] Does the scope of your license allow you to offer the product(s) you propose for the MSP Program?

- Yes No

2.1.Q12 Are you currently offering health insurance in the individual market in the State?

- Yes No

2.1.Q13 If No to 2.1.Q12: Have you offered health insurance in the individual market in the State at any time in the last 5 years?

- Yes No

2.1.Q14 If No to 2.1.Q6 and Yes to 2.1.Q13: On what date did you last offer coverage in the individual market in the State?

Text box (10 character maximum)

2.1.Q15 [Required for SHOP participants] Are you currently licensed in the State to offer health insurance in the small group market?

- Yes No

2.1.Q16 If Yes to 2.1.Q15: Upload a copy of your license or certificate of authority.



2.1.Q17 [Required for SHOP participants] Are you currently offering health insurance in the small group market in the State?

- Yes No

2.1.Q18 If No to 2.1.Q17, have you offered health insurance in the small group market in the State at any time in the last 5 years?

- Yes No

2.1.Q19 If No to 2.1.Q17 and yes to 2.1.Q18: On what date did you last offer health insurance in the small group market in the State?

Text box (10 character maximum)

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

2.1.Q20 [Required if No to 2.1.Q6] In the last 3 years, have you been or are you currently under supervision, a corrective action plan, a market conduct review, or special monitoring by State licensing authority or other regulatory body?

- Yes No

2.1.Q21 If No to 2.1.Q6 and Yes to 2.1.Q20: Describe the supervision, corrective action plan, market conduct review, or special monitoring.

Text box (6000 character maximum)

2.1.Q22 If No to 2.1.Q6 and Yes to 2.1.Q20: Provide any relevant reports or documentation related to the supervision, corrective action plan, market conduct review, or special monitoring.



2.1.Q23 [Required if No to 2.1.Q6] Are you a non-profit entity?

Tool Tip: Non-profit entity means: (1) an organization that is incorporated under State law as a non-profit entity and licensed under State law as a health insurance issuer; or (2) A group of health insurance issuers licensed under State law, a substantial portion of which are incorporated under State law as non-profit entities.

- Yes No

2.1.Q24 If No to 2.1.Q6 and Yes to 2.1.Q23: Please supply documentation.

Tool Tip: A CO-OP may provide documentation of its approval as a tax-exempt organization under section 501(c)(29), if available.



2.1.Q25 [Optional field] Submit any additional information or documentation as requested by OPM.



2.2 MSP Overview and Strategy

Provide an overview of your MSP proposed offerings by answering the following questions:

2.2.Q1 Indicate the Essential Health Benefits (EHB) benchmark(s) you will use for your MSP options in 2017 (check all that apply):

- The State EHB-benchmark plan
- The Federal Employees Health Benefits (FEHB) Program Blue Cross and Blue Shield (BCBS) Standard Option, as supplemented for pediatric vision services, plus State-required benefits enacted before December 31, 2011
- The FEHB BCBS Basic Option, as supplemented for pediatric vision services, plus State-required benefits enacted before December 31, 2011
- The FEHB Government Employees Health Association (GEHA) Standard Option plus State-required benefits enacted before December 31, 2011

Note: The BCBS Standard and Basic Options supplement pediatric vision services with the BCBS FEP BlueVision High Option as offered through the Federal Employees Dental and Vision Insurance Program (FEDVIP).

2.2.Q2 If selection in 2.2.Q1 is BCBS Standard: For MSP options using the BCBS Standard benchmark, indicate whether you propose a managed formulary.

- Yes
- No

2.2.Q3 If selection in 2.2.Q1 is BCBS Basic: For MSP options using the BCBS Basic benchmark, indicate whether you propose a managed formulary.

- Yes
- No

2.2.Q4 If selection in 2.2.Q1 is GEHA Standard: For MSP options using the GEHA Standard benchmark, indicate whether you propose a managed formulary.

- Yes
- No

2.2.Q5 State your overall strategy for your MSP options. In doing so, respond to the following questions:

- What are the major challenges you face in your State’s Marketplace?
- How do you expect your proposed 2017 MSP options to address those challenges?
- What major changes, if any, are you making to your MSP offerings for 2017? (These may include changes to the number of MSP options proposed, plan types, network(s), or service area(s).)
- If you are an issuer in a State using the Federal platform, discuss the rationale behind your decision to use or not to use the standardized plan design (as defined at 45 CFR §156.20) for your MSP options. **Tool Tip: Issuers that are new to the MSP Program should not answer “What major changes, if any, are you making to your MSP offerings for 2017?” Issuers returning to the MSP Program should describe any differences between their 2015 MSP options and their proposed 2017 MSP options.**

Text box (6000 character maximum)

2.2.Q6 How many MSP options are you proposing? Provide a breakdown by metal level, plan type (e.g., PPO, POS, HMO, EPO), market (Individual/SHOP), and benchmark selection.

Text box (6000 character maximum)

2.2.Q7 Are you proposing to offer more than one plan type in this State?

- Yes No

2.2.Q8 If Yes to 2.2.Q7: Provide your rationale for doing so.

Text box (6000 character maximum)

2.2.Q9 [Optional field] Submit any additional information or documentation as requested by OPM.



2.3 Accreditation Status

2.3.Q1 Do you hold accreditation by URAC applicable to your proposed MSP options?

- Yes No

2.3.Q2 If Yes to 2.3.Q1: Indicate the level of accreditation:

- Full Provisional Conditional

2.3.Q3 If Yes to 2.3.Q1: Provide the most recent accreditation letter, certificate, and summary report for your URAC accreditation.



2.3.Q4 Do you hold accreditation by the National Committee for Quality Assurance (NCQA) applicable to your proposed MSP options?

- Yes No

2.3.Q5 If Yes to 2.3.Q4: Indicate the level of accreditation:

- Excellent Commendable Accredited Interim

2.3.Q6 If Yes to 2.3.Q4: Provide the most recent accreditation letter, certificate, and summary report for your NCQA accreditation.



2.3.Q7 Do you hold accreditation by the Accreditation Association for Ambulatory Health Care, Inc. (AAHC) applicable to your proposed MSP options?

- Yes No

2.3.Q8 If Yes to 2.3.Q7: Provide the most recent accreditation letter, certificate, and summary report for your AAHC accreditation.



2.3.Q9 If No to 2.3.Q1, 2.3.Q4 and 2.3.Q7: Provide your plan and timeline for achieving accreditation, including your application status if you have applied for but not received accreditation.

Text box (6000 character maximum)

2.3.Q10 If Yes to 2.3.Q1 or 2.3.Q4 or 2.3.Q7: Provide the date(s) on which your accreditation(s) expires. If the expiration date is before March 1, 2017, also provide your timeline for renewing your accreditation.

Text box (6000 character maximum)

2.3.Q11 [Optional field] Submit any additional information or documentation as requested by OPM.



2.4 Enrollment and Marketing

2.4.Q1 [Required if No to 2.1.Q6] Are you actively marketing health insurance in the State?

- Yes No

2.4.Q2 [Required if No to 2.1.Q6 and if Yes to 2.4.Q1] In which market(s)?

- Individual Small Group Large Group

2.4.Q3 [Required if No to 2.1.Q6] Describe your experience in providing health insurance or as a third-party administrator in the individual, small group and large group markets. If available, include the number of enrollees in each market in this State.

Text box (6000 character maximum)

2.4.Q4 [Required if No to 2.1.Q6] Do you have experience with Federal and State government contracts, such as Medicare, Medicaid, Children’s Health Insurance Program, Federal Employees Health Benefits Program, Indian Health Service, TRICARE, State high risk pools, Pre-Existing Condition Insurance Plan, or special State subsidized health insurance programs?

- Yes
- No

2.4.Q5 If No to 2.1.Q6 and Yes to 2.4.Q4: Describe your experience:

Text box (6000 character maximum)

2.4.Q6 [Required if No to 2.1.Q6] Do you currently have the ability to accept premium and cost-sharing payments on behalf of enrollees from the Ryan White HIV/AIDS Program, Indian tribes, tribal organizations or urban Indian organizations and State and Federal Government programs in accordance with [45 CFR 156.1250](#)?

- Yes
- No

2.4.Q7 If No to 2.1.Q6 and No to 2.4.Q6: Describe how you will develop the capacity to accept these payments by January 1, 2017.

Text box (6000 character maximum)

2.4.Q8 [Required if No to 2.1.Q6] Describe your open enrollment strategy for your MSP options, including advertising, outreach to different demographic and socioeconomic subgroups, outreach and training to Navigators and in-person assistors, materials, website functionality, and call center staffing and hours of operation.

Text box (6000 character maximum)

2.4.Q9 [Required if No to 2.1.Q6] Describe how your marketing strategy will differ for times other than open enrollment.

Text box (6000 character maximum)

2.4.Q10 [Required if No to 2.1.Q6] Do you intend to use agents or brokers?

- Yes No

2.4.Q11 If No to 2.1.Q6 and Yes to 2.4.Q10: Describe your proposal for complying with laws, regulations, and rules set forth by a State and/or Exchange regarding the use and compensation of agents and brokers for products offered through an Exchange.

Text box (6000 character maximum)

2.4.Q12 If No to 2.1.Q6 and Yes to 2.4.Q10: Describe your proposal for selection, training, oversight, and compensation of agents and brokers.

Text box (6000 character maximum)

2.4.Q13 [Required if No to 2.3.Q1 (not URAC Accredited) and No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] Describe how you ensure that marketing materials fairly and accurately describe plan benefits, exclusions, limitations, restrictions, cost-sharing requirements, procedures for obtaining benefits, and provider access.

Text box (6000 character maximum)

2.4.Q14 Do you anticipate a need to cap enrollment at a certain level?

- Yes No

2.4.Q15 If Yes to 2.4.Q14: Indicate your proposed enrollment cap(s).

Text box (6000 character maximum)

2.4.Q16 [Required if No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

- Yes No

2.4.Q17 If No to 2.1.Q6 and Yes to 2.4.Q16: Provide the subcontractor name(s) and a description of the services to be performed.

Text box (6000 character maximum)

2.4.Q18 [Optional field] Submit any additional information or documentation as requested by OPM.



2.5 Financial

2.5.Q1 Provide your 2015 audited annual financial statement submitted to the State insurance commissioner (or equivalent).



2.5.Q2 Provide your 2015 NAIC annual statement or other annual statement of your condition and affairs, signed by the appropriate company official(s).



2.5.Q3 Provide your State-required minimum reserve amount and the total amount of reserves held by your company at the end of 2015.

Text box (6000 character maximum)

2.5.Q4 Provide the minimum risk-based capital (RBC) amount/percentage required by your State and the amount/percentage of RBC held by your company at the end of 2015.

Text box (6000 character maximum)

2.5.Q5 Describe the insolvency protection measures you have in place, including insurance, reinsurance, stop loss provisions, bonding provisions, or other protections.

Text box (6000 character maximum)

2.5.Q6 Provide documentation of those measures.



2.5.Q7 [Optional field] Submit any additional information or documentation as requested by OPM.



2.6 Claims

Describe your current (and proposed, if it will differ for your MSP options) claims payment system and processes, including:

- [Required if No to 2.1.Q6] 2.6.Q1 Claims system from intake through payment

Text box (6000 character maximum)

- [Required if No to 2.1.Q6] 2.6.Q2 Timely processing standards

Text box (6000 character maximum)

- [Required if No to 2.1.Q6] 2.6.Q3 The geographic location and staffing level for each of your claims processing facilities. If any of the facilities are located outside of the United States, please describe the specific claims processing functions performed there and how you ensure the protection of personally identifiable information (PII).

Text box (6000 character maximum)

- [Required if No to 2.1.Q6] 2.6.Q4 Claims assessment and validation tools

Text box (6000 character maximum)

- [Required if No to 2.1.Q6] 2.6.Q5 Prompt payment standards

Text box (6000 character maximum)

- [Required if No to 2.1.Q6] 2.6.Q6 Overpayment collections

Text box (6000 character maximum)

- [Required if No to 2.1.Q6] 2.6.Q7 Coordination of benefits

Text box (6000 character maximum)

- [Required if No to 2.1.Q6] 2.6.Q8 Claims denials

Text box (6000 character maximum)

2.6.Q9 [Required if No to 2.1.Q6] Describe your internal claims and appeals processes, including compliance with [45 CFR §147.136\(b\)](#).

Text box (6000 character maximum)

2.6.Q10 [Required if No to 2.1.Q6] Describe any changes you would need to make to your claims systems or procedures to comply with the MSP Program External Review Process (outlined in Appendix 4 of the Multi-State Plan Program 2017 Application and Renewal Guide).

Text box (6000 character maximum)

2.6.Q11 For each of the past three years, provide the total number and dollar amount of claims you processed.

Text box (6000 character maximum)

2.6.Q12 For each of the last three years, provide the total number and dollar amount of penalties you incurred (if any) for exceeding State-mandated prompt payment standards.

Text box (6000 character maximum)

2.6.Q13 [Required if No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

- Yes No

2.6.Q14 If No to 2.1.Q6 and Yes to 2.6.Q13: Provide the subcontractor name(s) and a description of the services to be performed.

Text box (6000 character maximum)

2.6.Q15 [Optional field] Submit any additional information or documentation as requested by OPM.



2.7 Member Services

2.7.Q1 [Required if No to 2.1.Q6] Provide the URL to your member website.

Text box (75 character maximum)

2.7.Q2 [Required if No to 2.1.Q6] Describe member services that would be available by telephone and the plan website. Include self-service capabilities, self-management tools, health information, advice lines, access for urgent matters, premium payments, claims status, provider status, and other tools.

Text box (6000 character maximum)

2.7.Q3 [Required if No to 2.1.Q6] What is the geographic location and staffing level for each of your customer service (call center) facilities? If any of the facilities are located outside of the United States, please describe the specific functions performed there and how you ensure the protection of personally identifiable information (PII).

Text box (6000 character maximum)

2.7.Q4 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] Describe your capacity to provide customer service, access to information that is critical for obtaining insurance coverage, and access to care for individuals with disabilities or who have limited English proficiency.

Text box (6000 character maximum)

2.7.Q5 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6]] Provide your member rights and responsibilities policy.



2.7.Q6 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] How is the member rights and responsibility policy communicated to members and providers?

Text box (6000 character maximum)

2.7.Q7 [Required if No to 2.1.Q6] Describe patient education programs, with particular emphasis on programs that highlight the value of preventive care (in particular the availability of those services that have no cost-sharing requirements) and programs that address the needs of individuals who are new to the health care system.

Text box (6000 character maximum)

2.7.Q8 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe the enrollee complaint process, including timelines for response.

Text box (6000 character maximum)

2.7.Q9 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe health risk assessment tools.

Text box (6000 character maximum)

2.7.Q10 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe how you measure your wellness programs and health risk assessment tools for effectiveness and the results of those programs on influencing enrollee behavior.

Text box (6000 character maximum)

2.7.Q11 [Required if No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

- Yes No

2.7.Q12 [Required if No to 2.1.Q6 and Yes to 2.7.Q11] If yes, provide the subcontractor name(s) and a description of the services to be performed.

Text box (6000 character maximum)

2.7.Q13 [Optional field] [Required if No to 2.1.Q6] Submit any additional information or documentation as requested by OPM.



2.8 Utilization/Quality Assurance

2.8.Q1 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] Describe the management of patient care through the use of prospective review (e.g., pre-certification, pre-authorization).

Text box (6000 character maximum)

2.8.Q2 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] How are prospective review decisions

communicated to enrollees and providers? Are there expedited procedures for the review of urgent cases? Provide your definition of an urgent case.

Text box (6000 character maximum)

2.8.Q3 [Required if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] Describe your programs or procedures for ensuring appropriate utilization of emergency care services. Provide your definition of emergency care.

Text box (6000 character maximum)

2.8.Q4 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] Describe the management of patient care through the use of concurrent review. If a claim can be denied as a result of a concurrent review, describe the member's responsibility for a denied claim.

Text box (6000 character maximum)

2.8.Q5 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] Describe the management of patient care through the use of retrospective review. If a claim can be denied as a result of a retrospective review, describe the member's responsibility for a denied claim.

Text box (6000 character maximum)

2.8.Q6 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe the management of patient care through the use of case management and care coordination, including any use of patient-centered medical homes.

Text box (6000 character maximum)

2.8.Q7 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe the management of patient care through the use of disease management, including what types of disease management programs are available.

Text box (6000 character maximum)

2.8.Q8 [Required if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe the management of patient care through the use of medical necessity determinations, including who makes these determinations and how the criteria for these determinations are developed.

Text box (6000 character maximum)

2.8.Q9 [Required if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6]] Describe the management of patient care through the use of clinical practice guidelines, including how these guidelines are developed and enforced.

Text box (6000 character maximum)

2.8.Q10 [Required if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6]] Describe the review of under- and over-utilization of services by physicians and hospitals. Describe your program to correct utilization that does not fall within evidence-based clinical guidelines or treatment patterns.

Text box (6000 character maximum)

[Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] **Describe your quality assurance program. Include a discussion of:**

- 2.8.Q11 The use of data, including the results of clinical quality measurement and enrollee satisfaction surveys, to inform quality improvement efforts

Text box (6000 character maximum)

- 2.8.Q12 How and when you provide information on health plan quality measures to enrollees, prospective enrollees, or others (e.g., employers, providers)

Text box (6000 character maximum)

- 2.8.Q13 Quality strategies as articulated in section 1311(g) of the Affordable Care Act, through a payment structure that provides increased reimbursement or other market-based incentives

- Text box (6000 character maximum)

- 2.8.Q14 How you monitor facilities for patient safety, including what measurements you or facilities use, and how you hold facilities accountable for patient safety

Text box (6000 character maximum)

[Required if No to 2.1.Q6] **Describe your processes and programs for preventing, detecting, and eliminating fraud and abuse by:**

- 2.8.Q15 Employees

Text box (6000 character maximum)

- 2.8.Q16 Subcontractors

Text box (6000 character maximum)

- 2.8.Q17 Providers

Text box (6000 character maximum)

- 2.8.Q18 Enrollees

Text box (6000 character maximum)

2.8.Q19 [R required if No to 2.1.Q6] If you intend to make any changes to your fraud and abuse prevention programs for your proposed MSP options, describe those changes here.

Text box (6000 character maximum)

2.8.Q20 [R required if No to 2.1.Q6] How do you measure and assess the effectiveness of your fraud and abuse programs (e.g., cost versus recovery amount)?

Text box (6000 character maximum)

2.8.Q21 [R required if No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

- Yes No

2.8.Q22 [Required if No to 2.1.Q6 and Yes to 2.8.Q21] Provide the subcontractor name(s) and a description of the services to be performed.

Text box (6000 character maximum)

2.8.Q23 [Optional field] [Required if No to 2.1.Q6] Submit any additional information or documentation as requested by OPM.



2.9 IT Systems, Security and Confidentiality

Describe your current and proposed use and support of health information technology, including:

- 2.9.Q1 [Required if No to 2.1.Q6] Use and support of electronic medical records

Text box (6000 character maximum)

- 2.9.Q2 [Required if No to 2.1.Q6] Use and support of personal health records

Text box (6000 character maximum)

- 2.9.Q3 [Required if No to 2.1.Q6] Use and support of e-prescribing

Text box (6000 character maximum)

- 2.9.Q4 [Required if No to 2.1.Q6] Use and support of cost and quality transparency tools

Text box (6000 character maximum)

- 2.9.Q5 [Required if No to 2.1.Q6] Use and support of electronic referrals

Text box (6000 character maximum)

2.9.Q6 [Required if No to 2.1.Q6] Describe how your system would maintain statistical records regarding MSP enrollment and operations separate from other lines of business.

Text box (6000 character maximum)

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

2.9.Q7 [Required if No to 2.1.Q6] Describe your system infrastructure’s capacity to manage the anticipated increase in enrollment, claims, and encounter volume.

Text box (6000 character maximum)

2.9.Q8 [Required if No to 2.1.Q6] Describe security and confidentiality measures, including your compliance with Federal privacy and information security standards (e.g., NIST, HIPAA). **Tool Tip: Visit www.healthit.gov for more information about protecting health information.**

Text box (6000 character maximum)

2.9.Q9 [Required if No to 2.1.Q6] Describe your operational, technical, administrative and physical safeguards, consistent with any applicable laws and regulations, to ensure that personally identifiable information (PII) created, collected, used, and/or disclosed under the MSP Program is:

- protected against any reasonably anticipated threats or hazards to its confidentiality, integrity, and availability (including return information, as such term is defined by [26 U.S.C. 6103\(b\)\(2\)](#));
- only used by or disclosed to those authorized to receive or view it;
- protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and
- securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules.

Text box (6000 character maximum)

2.9.Q10 [Required if No to 2.1.Q6] Describe how you monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls, including how you ensure your workforce complies with these controls.

Text box (6000 character maximum)

2.9.Q11 [Required if No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

- Yes No

2.9.Q12 [Required if No to 2.1.Q6 and if Yes to 2.9.Q11: Provide the subcontractor name(s) and a description of the services to be performed.

Text box (6000 character maximum)

2.9.Q13 [Required if No to 2.1.Q6] Submit any additional information or documentation as requested by OPM.



2.10 Disaster Recovery/Business Continuity

2.10.Q1 [Required if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6]] Describe your plan for providing continued medical coverage and prescription drug dispensing for MSP enrollees affected by a major disaster.

Text box (6000 character maximum)

2.10.Q2 [Required if No to 2.1.Q6] Describe your disaster recovery plan. Include testing of crucial business systems and testing frequency.

Text box (6000 character maximum)

2.10.Q3 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.1.Q6] Describe your business continuity plan. Include testing of crucial business systems and testing frequency.

Text box (6000 character maximum)

2.10.Q4 [Required if No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

- Yes No

2.10.Q5 If No to 2.1.Q6 and Yes to 2.10.Q4: Provide the subcontractor name(s) and a description of the services to be performed.

Text box (6000 character maximum)

2.10.Q6 [Optional field] [Required if No to 2.1.Q6] Submit any additional information or documentation as requested by OPM.



2.11 Provider Contracts and Networks

2.11.Q1 [Required if No to 2.1.Q6] Are you proposing more than one network for your MSP offerings (e.g., different networks for different plan types, metal levels, or service areas)?

- Yes No

2.11.Q2 If No to 2.1.Q6 and Yes to 2.11.Q1: Provide a rationale for proposing different networks.

Text box (6000 character maximum)

2.11.Q3 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe your credentialing/ recredentialing policies and processes for your MSP network(s), including what data sources you use to make credentialing decisions and how frequently providers are re-credentialed. Describe your policies/processes for de-credentialing a provider. If you propose to offer more than one MSP network, explain any differences in policies and procedures based on the type of network.

Text box (6000 character maximum)

2.11.Q4 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe how you ensure the quality of your MSP provider network(s) through such factors as recruitment, accreditation, customer satisfaction surveys, and attainment of quality or efficiency recognition designations. If you propose to offer more than one MSP network, explain any differences based on the type of network.

Text box (6000 character maximum)

2.11.Q5 [Required if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.1.Q6] Describe ongoing education of providers, including training, best practices, and peer review. If you propose to offer more than one MSP network, explain any differences based on the type of network.

Text box (6000 character maximum)

2.11.Q6 [Required if No to 2.3.Q1 (not URAC Accredited) and if No to 2.3.Q4 (not NCQA Accredited) and if No to 2.3.Q7 (not AAAHC Accredited) and if No to 2.1.Q6] Describe how you ensure provider compliance with contract terms and other requirements, including corrective action plans. If you propose to offer more than one MSP network, explain any differences based on the type of network.

Text box (6000 character maximum)

2.11.Q7 [Required if No to 2.1.Q6] Describe how you ensure that consumers have ready access to up-to-date, accurate, and complete provider directories, both before and after they are enrolled. This includes:

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

- ensuring that URLs link directly to the directory for a particular MSP option’s network, and that consumers do not have to log on, enter a policy number, or otherwise navigate the website before locating the directory;
- updating the provider directory at least monthly;
- ensuring that, if you have multiple networks, consumers can easily see the provider networks and MSP options in which each provider participates; and
- if a network has multiple tiers, ensuring that the provider directory clearly indicates in which tier a provider is included.

If your provider directory does not comply with these provisions, describe your plans to comply by January 1, 2017.

Text box (6000 character maximum)

2.11.Q8 Does the directory indicate all of the following elements: provider location, contact information, specialty, medical group, institutional affiliations, whether provider is accepting new patients, languages spoken, credentials, and Indian health care provider designation?

- Yes No

2.11.Q9 If No to 2.11.Q8: When will your directory include all of these data elements?

Text box (6000 character maximum)

2.11.Q10 [Required if No to 2.1.Q6] Describe your processes for provider terminations, including requirements for enrollee notification of provider terminations (e.g., whether advance notice is required, who provides the notice, and timelines for providing notice). Discuss provisions for transitional care for enrollees undergoing treatment for chronic or disabling conditions or in the second or third trimester of pregnancy. If you propose to offer more than one MSP network, explain any differences based on type of network.

Text box (6000 character maximum)

Describe how you ensure enrollee access to covered services not available from network providers, facilities, or pharmacies, either because there are none available in a particular geographic location or because an enrollee has a rare or complex medical condition that requires highly specialized care. If you propose to offer more than one MSP network, explain any differences based on type of network. Specifically:

2.11.Q11 [Required if No to 2.1.Q6] What is the process for enrollees to request an exception to receive care from an out-of-network provider? Include a discussion of whether/how providers can submit a request on an enrollee's behalf.

Text box (6000 character maximum)

2.11.Q12 [Required if No to 2.1.Q6] How and when do you inform enrollees about the availability of an exceptions process?

Text box (6000 character maximum)

2.11.Q13 [Required if No to 2.1.Q6] What clinical and/or geographic access standards do you use to evaluate exception requests (i.e., how do you determine that an enrollee requires care outside of the network)?

Text box (6000 character maximum)

2.11.Q14 [Required if No to 2.1.Q6] What is your timeframe for processing such requests?

Text box (6000 character maximum)

2.11.Q15 [Required if No to 2.1.Q6] Can enrollees appeal a denial of an exception request? If so, describe the appeals process, including timeframes for action by the enrollee and the issuer.

Text box (6000 character maximum)

2.11.Q16 [Required if No to 2.1.Q6] If you approve an exception request, describe the reimbursement arrangements, including:

- Is the claim paid as if it were in-network and does it apply to the in-network out-of-pocket maximum?
- Is the enrollee subject to balance billing?
- Is the enrollee responsible for filing the claim, or is the provider?

Text box (6000 character maximum)

2.11.Q17 [Required if No to 2.1.Q6] How do you ensure enrollee access to emergency care, both inside and outside of the service area?

Text box (6000 character maximum)

2.11.Q18 [Required if No to 2.1.Q6] How do you ensure enrollee access to care in medically underserved areas?

Text box (6000 character maximum)

2.11.Q19 [Required if No to 2.1.Q6] Describe your system for determining and monitoring the adequacy of this provider network. If you propose to offer more than one MSP network, explain any differences based on type of network. Include the following:

- Frequency of your network adequacy analysis;
- Tools used;
- Adequacy standards applied in your analysis;
- Procedures to react to network changes and/or enrollment increases that impair adequacy, including recruitment of providers to fill gaps in access to care;
- How you ensure adequate participation of primary care providers, specialists, hospitals, and tertiary care providers; and
- How you ensure the network meets the health care needs of the enrolled population, including those with special needs and those with limited English proficiency and literacy.

Text box (6000 character maximum)

2.11.Q20 [Required if No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

- Yes No

2.11.Q21 If No to 2.1.Q6 and if Yes to 2.11.Q20: Provide the subcontractor name(s) and a description of the services to be performed.

Text box (6000 character maximum)

2.11.Q22 [If Yes to 2.1.Q6] For your 2017 MSP options, are you proposing to use networks other than those you used for your 2015 MSP options?

- Yes No

2.11.Q23 [If Yes to 2.1.Q6] Describe any significant changes to the provisions of your provider contracts and/or network policies from those you described in your 2015 application. Examples of significant changes include but are not limited to changes in exceptions processes, payment policies, tiering, and provider incentives.

Text box (6000 character maximum)

2.11.Q24 [Optional field] Submit any additional information or documentation as requested by OPM.



[If No to 2.1.Q6 OR if Yes to 2.11.Q22] **Complete the following questions for each network you are proposing. If you are proposing more than one network, click “Add Network” at the bottom of this page which will add a page with the same set of questions to be answered for the newly added network. Continue to add networks until you’ve created a page for each of the networks you are proposing.**

2.11.Q25.1 What is the name and Network ID of this network?

Text box (6000 character maximum)

2.11.Q25.2 What are the names of the proposed MSP options to be covered by this network?

Text box (6000 character maximum)

2.11.Q25.3 In what market(s) do you use this network for your MSP options?

- Individual SHOP Both

2.11.Q25.4 What are the plan types associated with this network?

- PPO
 POS
 HMO
 EPO

2.11.Q25.5 Is this network unique to your MSP options?

- Yes No

2.11.Q25.6 If yes to 2.11.Q25.5: Describe how and why it differs from other networks for the same plan type and/or market.

Text box (6000 character maximum)

2.11.Q25.7 What is the percentage of available (licensed and practicing) primary care providers in the service area included in this network?

Text box (5 character maximum)

2.11.Q25.8 What is the percentage of available (licensed and practicing) specialists in the service area included in this network?

Text box (5 character maximum)

2.11.Q25.9 What is the percentage of available licensed general acute care hospitals in the service area included in this network?

Text box (5 character maximum)

2.11.Q25.10 Discuss major contract terms and provisions, including hold harmless provisions, risk sharing arrangements, and any exclusivity clauses.

Text box (6000 character maximum)

2.11.Q25.11 In multi-provider group contracts, is there a requirement for the group to guarantee participation of all providers in that group?

- Yes No

2.11.Q25.12 In this network, are there different cost-sharing tiers depending on provider participation type?

- Yes No

2.11.Q25.13 If yes to 2.11.Q25.12: Indicate how many tiers are in this network and provide a description of each tier, including cost sharing. If there are multiple tiers, to which tiers do the out-of-pocket maximum and deductible apply?

Text box (6000 character maximum)

2.11.Q25.14 Are enrollees required to select a primary care physician (PCP)?

- Yes No

2.11.Q25.15 If yes to 2.11.Q25.14: Describe the process for changing selection and whether there is a limit to the number of changes allowed.

Text box (6000 character maximum)

2.11.Q25.16 Are referrals to specialists required?

- Yes No

2.11.Q25.17 If yes to 2.11.Q25.16: Specify whether In-network and/or out-of-network referrals are required.

Text box (6000 character maximum)

2.11.Q25.18 What is your reimbursement policy when an enrollee receives services from non-network providers during treatment at a network hospital?

Text box (6000 character maximum)

2.11.Q25.19 Are dental providers included?

- Yes No

2.11.Q25.20 If no to 2.11.Q25.19: Describe how you will deliver pediatric dental services required by section 1302 of the Affordable Care Act.

Text box (6000 character maximum)

In each of the circumstances listed below, describe whether and how an enrollee or dependent in an MSP option in this network would be able to access in-network providers and/or facilities in the following scenarios. State whether there would be any changes in standard operating procedures for claims payment, preauthorization, etc.

2.11.Q25.21 The enrollee has a dependent who needs services while attending college outside the service area or State.

Text box (6000 character maximum)

2.11.Q25.22 The enrollee or dependent needs services while traveling or temporarily residing out of the service area or State.

Text box (6000 character maximum)

2.11.Q25.23 The enrollee or dependent needs highly specialized care that can best be provided out of the service area or State (for example, at a Center of Excellence).

Text box (6000 character maximum)

2.11.Q25.24 The enrollee or dependent prefers to receive care outside the service area or State.

Text box (6000 character maximum)

2.12 Service Area and Network Adequacy

2.12.Q1 Are you proposing to offer MSP options in the entire State in 2017?

- Yes No

2.12.Q2 If No to 2.12.Q1: Do you propose to offer your MSP options in all area(s) in which you are authorized to market and sell?

- Yes No

2.12.Q3 If No to 2.12.Q1 and Yes to 2.12.Q2: Describe the service area(s) in which you propose to offer your 2017 MSP options. Provide a general description of the service area (e.g., Eastern half of State, including the New York City and Albany metropolitan areas). Identify any excluded areas of the State. If your service area(s) include any partial counties, explain why.

Text box (6000 character maximum)

2.12.Q4 If No to 2.12.Q1 and No to 2.12.Q2: Describe the areas in which you are authorized to market and sell but which are excluded from your proposed 2017 MSP service area and your rationale for this exclusion. In addition, if you are authorized to market and sell throughout the entire State, describe your timeline for offering MSP options statewide.

Text box (6000 character maximum)

2.12.Q5 If Yes to 2.14.Q7: Does your service area(s) for your MSP options differ from the service area(s) for your QHPs?

- Yes No

2.12.Q6 If Yes to 2.12.Q5: Describe the differences, and the rationale for them.

Text box (6000 character maximum)

2.12.Q7 Complete and upload the Service Area Template, using the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] Service Area Template. Also, when creating IDs in the Service Area template, State-level issuers should begin with an ID of 201 and higher for MSP options. This rule applies regardless of whether a State-level issuer's QHP and MSP service areas are identical. This will ensure that MSP and QHP data display**

correctly. Finally, if you indicate in the Service Area template that your service area includes one or more partial counties, a pop-up box will appear stating that CMS will consider exception requests. You do not need to send an exception request.



2.12.Q8 Complete and upload the Network Template, using the prescribed file naming convention. **Tool Tip:** Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] Network Template. Also, when creating IDs in the Network template, State-level issuers should begin with an ID of 201 and higher for MSP options. This rule applies regardless of whether a State-level issuer's QHP and MSP networks are identical. This will ensure that MSP and QHP data display correctly.



2.12.Q9 Complete and upload the Essential Community Provider/Network Adequacy Template, using the prescribed file naming convention. For this template, the finalized template will be a .ZIP file and that should be uploaded as the Template Attachment. You should not upload an .XML file to this question. **Tool Tip:** Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] ECP-NA Template.



2.12.Q10 Provide documentation of compliance with Essential Community Providers (ECP) standards at [45 C.F.R. § 156.235](#), or any applicable State standards if more stringent than Federal standards. Issuers in FFM/SPM States must include an upload of the CMS ECP measurement tool results or a screen shot of the measurement tool results and the Supplementary ECP Response Form provided below. Issuers in SBM States must provide these forms of documentation or documentation provided to or received from your State indicating your compliance with applicable State standards.



2.12.Q11 [Optional field] Submit any additional information or documentation as requested by OPM.



2.13 Prescription Drugs

2.13.Q1 Do you propose to contract with a Pharmacy Benefit Manager (PBM) for retail pharmacy services?

- Yes No

2.13.Q2 If Yes to 2.13.Q1 Provide the name of the PBM and describe the contract arrangement you propose to have, including the length and expiration date of your contract with the PBM and whether you have a similar contract arrangement in place for your existing plans. If you are currently negotiating your PBM contract for 2017, indicate your timeframe for selecting a PBM.

Text box (6000 character maximum)

2.13.Q3 If Yes to 2.13.Q1: Is the contracted PBM fully accredited by URAC for pharmacy benefit management?

- Yes No

2.13.Q4 If Yes to 2.13.Q1 and No to 2.13.Q3: Provide the key performance standards under which the PBM provides call center services, including average time to answer and abandonment rate. Provide the call center's hours of operation.

Text box (6000 character maximum)

2.13.Q5 If No to 2.13.Q1: Discuss how you intend to provide retail pharmacy services, including how you will ensure an adequate network.

Text box (6000 character maximum)

2.13.Q6 Do you propose to contract with a Pharmacy Benefit Manager (PBM) for mail order pharmacy services?

- Yes No

2.13.Q7 If Yes to 2.13.Q6: Provide the name of the PBM and describe the contract arrangement you propose to have, including the length and expiration date of your contract with the PBM and whether you have a similar contract arrangement in place for your existing plans. If you are currently negotiating your PBM contract for 2017, indicate your timeframe for selecting a PBM.

Text box (6000 character maximum)

2.13.Q8 If Yes to 2.13.Q6: Is the contracted PBM fully accredited by URAC for mail order pharmacy?

- Yes No

2.13.Q9 If No to 2.13.Q6: Discuss how you intend to provide mail order pharmacy services.

DISCLAIMER: The U.S. Office of Personnel Management reserves the right to modify this application, as necessary, and to request additional information from applicants.

Text box (6000 character maximum)

2.13.Q10 If No to 2.13.Q6 **OR** 2.13.Q8: Provide the key performance standards for mail order pharmacy, including turn-around time for “clean” new orders and refills, as well as standards for exception processing of orders that require physician consultation.

Text box (6000 character maximum)

2.13.Q11 If No to 2.13.Q6 **OR** 2.13.Q8: Describe the policies regarding mail order pharmacy orders that are damaged or lost in shipment.

Text box (6000 character maximum)

2.13.Q12 Do you propose to contract with a Pharmacy Benefit Manager (PBM) or independent specialty pharmacy vendor for specialty pharmacy services?

- Yes
- No

2.13.Q13 If No to 2.13.Q12: How do you intend to provide specialty drug services?

Text box (6000 character maximum)

2.13.Q14 If Yes to 2.13.Q12: Provide the name of the PBM or independent specialty pharmacy vendor and describe the contract arrangement you propose to have, including the length and expiration date of your contract with the PBM and whether you have a similar contract arrangement in place for your existing plans. If you are currently negotiating your PBM or independent specialty pharmacy vendor contract for 2017, indicate your timeframe for selecting a PBM.

Text box (6000 character maximum)

2.13.Q15 If Yes to 2.13.Q12: Is the contracted PBM or independent specialty pharmacy vendor fully accredited by URAC for specialty pharmacy?

- Yes
- No

2.13.Q16 If No to 2.13.Q12 **OR** 2.13.Q15: Provide key performance standards for specialty pharmacy, including time to make initial contact with patient.

Text box (6000 character maximum)

2.13.Q17 If No to 2.13.Q12 **OR** 2.13.Q15: Describe policies regarding specialty pharmacy orders that are damaged or lost in shipment.

Text box (6000 character maximum)

2.13.Q18 Describe how you ensure quality and safety in pharmacy operations.

Text box (6000 character maximum)

2.13.Q19 What point-of-sale and retrospective claims review measures do you currently employ and/or plan to employ to deter the misuse of prescription drugs?

Text box (6000 character maximum)

2.13.Q20 [Required if No to 2.1.Q6] Describe the processes or programs you would use to promote generic drug utilization. Include your generic drug utilization rate.

Text box (6000 character maximum)

2.13.Q21 Describe the cost and quality management programs you employ (e.g., prior approval, step therapy, quantity limits, medication therapy management). Are these programs subject to P&T Committee review and/or approval?

Text box (6000 character maximum)

2.13.Q22 How do you inform enrollees of formulary changes? If you provide notice directly to enrollees who are affected by a formulary change, please note how and on what timeframe this occurs.

Text box (6000 character maximum)

2.13.Q23 Submit your proposed prescription drug benefit information, including cost-sharing requirements and benefit limitations, by completing the Prescription Drug Template, using the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] Prescription Drug Template. Also, when creating IDs in the Prescription Drug template, State-level issuers should begin with an ID of 201 and higher for MSP options. This rule applies regardless of whether a State-level issuer's QHP and MSP prescription drug benefit information is identical. This will ensure that MSP and QHP data display correctly.**



2.13.Q24 Did the category/class count or non-discrimination tool(s) indicate any deficiencies in your formulary? **Tool Tip: You are required to run the following three tools:**

- (a) Category Class Drug Count Tool,
- (b) Non-Discrimination Formulary Outlier Tool, and
- (c) Non-Discrimination Clinical Appropriateness Tool.

Yes No

2.13.Q25 If Yes to 2.13Q24: Complete and submit the appropriate justification(s).



2.13.Q26 [Required for SHOP participants] Submit your proposed prescription drug benefit information for the SHOP market, including cost-sharing requirements and benefit limitations, by completing the SHOP Prescription Drug Template, using the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] SHOP Prescription Drug Template. Also, when creating IDs in the Prescription Drug template, State-level issuers should begin with an ID of 201 and higher for MSP options. This rule applies regardless of whether a State-level issuer's QHP and MSP prescription drug benefit information is identical. This will ensure that MSP and QHP data display correctly.**



2.13.Q27 [Required for SHOP participants] Did the category/class count or non-discrimination tools indicate any deficiencies in your SHOP formulary?

Tool Tip: You are required to run the following three tools:

- (a) Category Class Drug Count Tool,
- (b) Non-Discrimination Formulary Outlier Tool, and
- (c) Non-Discrimination Clinical Appropriateness Tool.

Yes No

2.13.Q28 If Yes to 2.13.Q27: Complete and submit the appropriate justification(s) for your SHOP options.



2.13.Q29 [Optional field] Submit any additional information or documentation as requested by OPM.



2.14 Benefit Proposal

2.14.Q1 Submit your proposed benefits package with detailed benefit information, including cost-sharing requirements and benefit limitations, by completing the Plans and Benefits Template. Be sure to:

- Complete all relevant fields, including those marked “optional”
- Include State-mandated benefits
- Submit only MSP options (do not include QHPs)
- Offer family coverage and self-only coverage at the silver and gold metal levels
- Use the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] P&B Template**



2.14.Q2 Have you indicated on the benefits package tab that one or more MSP options has a unique plan design that requires alternative calculation of the actuarial value?

- Yes No

2.14.Q3 If Yes to 2.14.Q2: Provide documentation and justification to support the Actuarial Value (AV) level. This may include an AV calculator screenshot for the unique plan and/or the Unique AV Plan Justification. Use the prescribed naming convention for each file uploaded.

Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] AV Level (include tier and metal).



2.14.Q4 [Required for SHOP participants] Submit your proposed benefits package for the SHOP market with detailed benefit information, including cost-sharing requirements and benefit limitations, by completing the SHOP Plans and Benefit Template. Be sure to:

- Complete all relevant fields, including those marked “optional”
- Include State-mandated benefits
- Submit only MSP options (do not include QHPs)
- Offer family coverage and self-only coverage at the silver and gold metal levels
- Use the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] SHOP P&B Template**



2.14.Q5 [Required for SHOP participants] Have you indicated on the benefits package tab that one or more MSP SHOP options has a unique plan design that requires alternative calculation of the actuarial value?

- Yes No

2.14.Q6 [Required for SHOP participants] If Yes to 2.14.Q5: Provide documentation and justification to support the AV level for your SHOP options. This may include an AV calculator screenshot for the unique plan and/or the Unique AV Plan Justification. Use the prescribed naming convention for each file uploaded.

Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] AV Level (include tier and metal).



2.14.Q7 Are you applying to, or do you currently participate on, the Marketplace in this State as a Qualified Health Plan (QHP)?

- Yes No

2.14.Q8 If Yes to 2.14.Q7: Indicate the area(s) of meaningful difference between your MSP options and QHP offerings with the same service area, metal level and market type (individual/SHOP).

Tool Tip: A plan is considered meaningfully different from another plan in the same service area and metal tier if a reasonable consumer would be able to identify two or more material differences among the characteristics listed below between the plan and other plan offerings.

- Cost sharing
- Provider networks
- Covered benefits
- Plan type
- Child-only vs. non-Child-only coverage offerings
- Other
- None of the above

2.14.Q9 If Yes to 2.14.Q7: Describe in detail the meaningful difference(s) indicated above. If there is no meaningful difference, describe how you intend to establish meaningful difference(s) in future plan years.

Text box (6000 character maximum)

2.14.Q10 Are you proposing more than one MSP option at a metal level (e.g., two Gold plans), in the same service area and the same market (i.e., individual or SHOP)?

- Yes No

2.14.Q11 If Yes to 2.14.Q10: Indicate the area(s) of meaningful difference between your MSP options with the same metal level, service area, and market type (Individual/SHOP).

Tool Tip: A plan is considered meaningfully different from another plan in the same service area and metal tier if a reasonable consumer would be able to identify two or more material differences among the characteristics listed below between the plan and other plan offerings.

- Cost sharing
- Provider networks
- Covered benefits
- Plan type
- Child-only vs. non-Child-only coverage offerings
- Other
- None of the above

2.14.Q12 If Yes to 2.14.Q10: Describe in detail the meaningful difference(s) indicated above.

Text box (6000 character maximum)

2.14.Q13. Pursuant to the Affordable Care Act, OPM requires that each MSP issuer offer, in each MSP service area, at least one silver and one gold MSP option that excludes coverage of abortion services, except in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed. If you have met the requirement of at least one silver and one gold MSP option that excludes non-excepted abortion services, you may offer additional MSP options that provide coverage of non-excepted abortion services.

Do any of your proposed 2017 MSP options cover non-excepted abortion services?

- Yes No

2.14.Q14 [Optional field] Submit any additional information or documentation to support your benefit package.



2.15 Benefits Attestation

Submit this subsection AFTER your form filings have:

- **received an affirmative approval from the appropriate State regulator;**

- not received disapproval; or
- met the required filing timeframe that deems the form approved for sale.

In a State where CMS has direct enforcement authority, please submit this subsection after receiving form approval from CMS. **Tool Tip: If there is any reason why you can't answer "Yes" to any of these questions, please inform us via OPM Chat before submitting the subsection.**

By submitting this subsection, the State-level Multi-State Plan (MSP) issuer attests that:

2.15.Q1 It does not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs or pre-existing conditions in Multi-State Plan (MSP) options consistent with [45 CFR § 156.225](#).

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q2 It complies with all applicable Federal and State laws and regulations relating to nondiscrimination, including the standards set forth at [45 CFR §§ 156.125](#) and [156.200\(e\)](#).

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q3 It complies with all applicable benefit design standards, including Federal and State laws and regulations on benefit substitutions, and State-required benefits for all services.

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q4 It abides by all cost-sharing limits consistent with [45 CFR § 800.106](#):

- a. the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) for emergency department services is the same regardless of provider network status, as applicable, consistent with [45 CFR §147.138](#);
- b. it will make available enrollee cost sharing under an individual's plan or coverage for a specific item or service, consistent with [45 CFR § 156.220](#).

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q5 It complies with all applicable Federal and State laws and regulations relating to cost sharing and cost-sharing reductions, including the standards set forth at [45 CFR part 156, subpart E](#) and [45 CFR §§ 800.106, 800.107\(d\)](#).

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q6 It follows all Actuarial Value requirements, as described in [45 CFR part 156](#).

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q7 Its catastrophic MSP options, if any, enroll individuals under the age of 30 or individuals deemed exempt from the individual mandate.

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q8 It complies with the specific quality reporting and implementation requirements related to the QRS and QHP Enrollee Survey, consistent with [45 C.F.R. § 156.200\(b\)\(5\)](#) .

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q9 It will comply with the patient safety standards for plan years beginning on or after January 1, 2017 found in [45 C.F.R. § 156.1110](#)

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options benefit submissions

2.15.Q10 Its MSP options provide coverage for each of the ten statutory categories of essential health benefits (EHB) in accordance with the applicable EHB-benchmark plan and Federal and State laws and regulations:

- a. its MSP options provide benefits and limitations on coverage that are substantially equal to those covered by the EHB-benchmark plan, as described in [45 C.F.R. § 156.115](#);
- b. it complies with the requirements described in [45 C.F.R. § 146.136](#) with regard to mental health and substance use disorder services, including behavioral services;
- c. it provides coverage for preventive services described in [45 C.F.R. § 147.130](#);
- d. it complies with EHB requirements with respect to prescription drug coverage, as described in [45 C.F.R. § 156.122](#);
- e. any benefits substituted in designing MSP option benefits are actuarially equivalent to those offered by the EHB-benchmark plan, as described in [45 C.F.R. § 156.115](#);
- f. its MSP options' benefits reflect an appropriate balance among the EHB categories, so that benefits are not unduly weighted toward any category;
- g. its MSP options include all applicable State-required benefits.

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q11 The data in the templates submitted to OPM, including but not limited to the Plans & Benefits Template and Prescription Drug Template contain information identical to the information submitted to the State regulator.

- Yes, the State-level issuer agrees to adhere to the above attestation for its MSP options' benefit submissions

2.15.Q12 The State-level issuer certifies, to the best of its knowledge and belief, that (check one):

- The form filings have been affirmatively approved by the appropriate State regulatory agency and/or CMS.
- The State is a file-and-use State that does not issue formal approvals. All filings were made within the appropriate timeframe and the State has not disapproved the filings.
- The form filings are awaiting formal approval by the appropriate State regulator, but all filings were made within the appropriate timeframe, the State has not disapproved the filings, and there are no outstanding objections or impediments to approval. **Tool Tip: The third option can only be selected after consultation with OPM.**

2.15.Q13 [optional] If your form filings have been affirmatively approved by the appropriate State regulatory agency and/or CMS, submit documentation of such approval.



2.15.Q14 [Optional field] Submit any additional information or documentation as requested by OPM.



2.16 Rate Proposal

2.16.Q1. Submit your completed Rate Table Template, using the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] Rate Template**



2.16.Q2 Submit your proposed base premium rates and factors using the MSP Rate Development Information—Individual Template. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] MSP Rate Development Individual Template**



2.16.Q3.[Required for SHOP participants] Submit your SHOP Rate Table Template, using the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] SHOP Rate Template**



2.16.Q4 [Required for SHOP participants] Submit your proposed base premium rates and factors for the SHOP market using the MSP Rate Development--SHOP Template . **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] MSP Rate Development SHOP Template**



2.16.Q5 Have you submitted the Unified Rate Review Template (URRT) for the individual market to CMS? This template must include all plans you offer in the individual market, including your proposed MSP options.

- Yes No

2.16.Q6 [Required for SHOP participants] Have you submitted the Unified Rate Review Template (URRT) for the SHOP market to CMS? This template must include all plans you offer in the SHOP market, including your proposed MSP options.

- Yes No

2.16.Q7 Submit the Rating Business Rules Template, using the prescribed file naming convention. **Tool Tip: Follow this naming convention for your file: [Year-Month-Day] [State] [Issuer Marketing Name] Business Rules Template**



2.16.Q8 Submit a signed and dated actuarial memorandum that includes:

1. A discussion of assumptions, factors, calculations, rate tables, and any other information pertinent to the proposed rate; and
2. A dated signature from the qualified health actuary who reviewed the rate proposal.



2.16.Q9 Submit your rate filing filed with the State regulator and/or CMS.



2.16.Q10 Indicate the date of your 2017 rate filing to the State regulator and/or CMS.

Text box (10 character maximum)

2.16.Q11 List the System for Electronic Rate and Form Filing (SERFF) tracking number for your rate filing.

Text box (50 character maximum)

2.16.Q12 If Yes to 2.14.Q13: Provide your segregation plan related to non-expected abortion services as required by section 1303(b)(2)(C), (D), and (E) of the Affordable Care Act and [45 C.F.R. § 156.280](#). This segregation plan should describe:

1. Your financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of these services from those received for coverage of all other services;
2. Your financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for these services are reimbursed from the appropriate account; and
3. An explanation of how your systems, accounting documentation, and controls meet the requirements for segregation accounts under the law.



2.16.Q13 If Yes to 2.14.Q13: Please describe how you account for the cost of coverage of non-expected abortion services in the premiums proposed.

Text box (6000 character maximum)

2.16.Q14 [Optional field] Submit any additional rate information or documentation to support your rates.



For information about your rate submission, we should contact:

2.16.Q15 Primary contact name, phone number, and email

Text box (6000 character maximum)

2.16.Q16 Secondary contact name, phone number, and email

Text box (6000 character maximum)

2.17 Rate Attestation

NOTE: DO NOT SUBMIT THIS SUBSECTION UNTIL THE STATE REVIEW PROCESS FOR THESE RATES HAS BEEN COMPLETED AND THE FINAL VERSION OF THE URRT HAS BEEN SUBMITTED TO CMS.

2.17.Q1 This is to certify that the

- Business Rules Template
- Rates Template(s) and
- Actuarial Memorandum

submitted in this application:

(a) contain information identical to the information submitted to the appropriate State; and

(b) (check one):

- have been approved by the appropriate State regulator;
- are awaiting formal approval by the appropriate State regulator, but all filings were made within the appropriate timeframe, the State has not disapproved the filings, and there are no outstanding objections or impediments to approval;
- were submitted to the appropriate State regulator in a State that does not issue formal approvals, but all filings were made within the appropriate timeframe and the State has not disapproved the filings; **Tool Tip: The third option can only be selected after consultation with OPM.**
- are subject to approval by OPM on behalf of the Centers for Medicare & Medicaid Services (CMS) in a direct enforcement/non-Effective Rate Review State;

and

(c) are consistent with the Uniform Rate Review Template(s) (URRTs) submitted to CMS; and

(d) support the MSP options in the Plans & Benefits Template(s) submitted in this application; and

(e) are the final set of premiums for those MSP options.

- Yes, I certify

2.17.Q2 Name and title of person completing certification:

Text box (200 character maximum)

2.17.Q3 If selected “have been approved by the appropriate State regulator” in 2.17.Q1, enter the date of the approval.

Text box (200 character maximum)

2.17.Q4 [Optional field] Submit any additional information or documentation as requested by OPM.



2.18 Additional SHOP Information

The following questions are only applicable for issuers proposing to offer MSP options in the SHOP market.

2.18.Q1. [Required for SHOP participants] Does the scope of your license allow you to offer the product(s) you propose for MSP SHOP participation?

- Yes No

2.18.Q2 [Required for SHOP participants] Describe your capacity to accept aggregated premium payments from employers.

Text box (6000 character maximum)

2.18.Q3 [Optional field] Submit any additional information or documentation as requested by OPM.



2.19 State Filing and Other Information

Provide the draft form filing for each of your MSP options and answer the questions related to that form filing. If you need to submit additional form filings, click “Add Filing” at the bottom of this page, which will add a page with the same set of questions to be answered for the newly added filing. Continue to add filings until you’ve created a page for each form filing relevant to your MSP options.

2.19.Q1 Submit the draft form filing as filed with your State regulator and/or CMS. This may be extracted in PDF form from SERFF.



2.19.Q2 Indicate the date of your 2017 form filing to the State regulator and/or CMS.

Text box (50 character maximum)

2.19.Q3 List the SERFF tracking number for this form filing.

Text box (50 character maximum)

2.19.Q4 List the HIOS Plan ID for each of your MSP options included in this form filing. Include standard plans only (not variants).

Text box (6000 character maximum)

2.19.Q5 Indicate the page number(s) of the form filing on which you define abortion services and describe the scope of abortion services that are covered and/or excluded. If you have bracketed this language in your form filing, provide the language that will be included in the policy contract you provide to enrollees.

Text box (6000 character maximum)

2.19.Q6 Indicate the page number(s) of the form filing on which you describe external review, including external review for the prescription drug exceptions process. If you have bracketed this language in your form filing, provide the language that will be included in the policy contract you provide to enrollees.

Text box (6000 character maximum)

2.19.Q7 Upload your proposed Notice of Final Internal Adverse Benefit Determination for your MSP options. **Tool Tip: A Model Notice of Final Internal Adverse Benefits Determination may be found at: <https://www.opm.gov/forms/pdfimage/opm1842.pdf>.**



2.19.Q8 [Optional field] Submit any additional information or documentation as requested by OPM.



2.20 Quality Improvement Strategy

2.20.Q1 Select the statement(s) that most accurately describes your Quality Improvement Strategy (QIS) for each plan type included in your MSP offerings:

- We address both QHPs and MSP options within the same QIS.
- We have a QIS that addresses only our MSP options.
- We do not have a QIS because we do not meet the participation criteria.

2.20.Q2 [If both QHPs/MSPs covered in the same QIS] Upload the QIS(s) that address(es) your MSP options once approved by CMS or your State, as applicable.

Tool tip: If you offer MSP options with more than one plan type, and therefore have more than one QIS applicable to your MSP options, upload all applicable QIS documents.



2.20.Q3 [If both QHPs/MSPs covered in single QIS] Upload evidence of approval of the QIS(s) submitted in 2.20.Q2.



2.20.Q4 [If MSP-specific QIS] Upload the QIS(s) specific to your MSP options.



2.20.Q5 [If not required to submit a QIS] Explain why you are not required to submit a QIS.

Text box (6000 character maximum)

2.20.Q6 [Optional field] Submit any additional information or documentation as requested by OPM.

