U.S. Office of Personnel Management

Multi-State Plan Program Application

For New and Returning Issuers

2018

Last Modified:

April 18, 2017

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

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Organizational Structure

In the Organizational Structure section of the Application Portal, the Applicant Contracting Officer or Contracting Officer Representative will enter information about each State-level issuer you are proposing in this Application.

For all State-level issuers in the Organizational Structure, 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.

Section 1: Applicant Information

1.1 Applicant Information

1.1.Q1 Does the Applicant currently contract with, or participate in a contract with, OPM for the Federal Employees Health Benefits (FEHB) Program?

Tool Tip: A "Yes" answer will suppress certain questions from appearing in your application. If you change your response to this question at any time during the application, you must notify OPM via a Chat Message, and OPM will notify you of any additional Subsections/questions you will need to answer.

○ Yes ○ No

1.1.Q2 Describe your corporate structure and management.

Text Box (6000 Character Maximum)

1.1.Q3 [If No to 1.1.Q1] Provide documentation of your corporate structure. This may include executed articles of incorporation or organization, partnership agreement(s), or any other applicable organization documents.

[File Upload]

1.1.Q4 Will the Applicant also serve as the State-level issuer in all States?

Tool Tip: A "Yes" answer will suppress certain questions from appearing in Subsections 1.4 and 1.5. If you change your response to this question at any time during the application, you must notify OPM via a Chat Message, and OPM will notify you of any additional questions you will need to answer.

○ Yes ○ No

1.1.Q5 [If No to 1.1.Q4] 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.Q6 [If No to 1.1.Q4] Provide documentation about these legal, financial, and organizational relationships.

[File Upload]

1.1.Q7 [If No to 1.1.Q4] 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.Q8 [If No to 1.1.Q1] 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.Q9 Is the Applicant a non-profit entity?

○ Yes ○ No

1.1.Q10 [If Yes to 1.1.Q9] Provide documentation of non-profit status.

[File Upload]

1.1.Q11 [If No to 1.1.Q1] Is the Applicant owned by, affiliated with, or sponsored by another organization that provides management and/or financial support to the Applicant?

○ Yes ○ No

1.1.Q12 [If Yes to 1.1.Q11] 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.Q13 [If No to 1.1.Q1] 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.Q14 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.Q15 [If Yes to 1.1.Q14] Provide details.

Text Box (6000 Character Maximum)

1.1.Q16 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.

[File Upload]

1.1.Q17 [If No to 1.1.Q4] 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.Q18 [If No to 1.1.Q4 and if No to 1.1.Q17] 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)

1.1.Q19 [Optional field] Submit any additional information or documentation as requested by OPM.

[File Upload]

1.2 Group of Issuers

1.2.Q1 Are you applying as a Group of Issuers?

Tool Tip: 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.Q1 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.

Tool Tip: This question is only required if you select No to Question 1 in Subsection 1.1, which asks whether the Applicant currently contract with OPM for the Federal Employees Health Benefits Program, and No to Question 1 in this Subsection. Please make sure that you have answered both of these questions before answering Question 5. If you change your responses to Question 1 in Subsection 1.1 or Question 1 in this Subsection, you must revisit this question to ensure that you have completed all required questions.

[File Upload]

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

[File Upload]

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:

[File Upload]

Contracting Official

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

[File Upload]

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:

[File Upload]

[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:

[File Upload]

[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:

[File Upload]

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.

[File Upload]

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

[File Upload]

1.4 Financial Solvency

Questions 1, 2, and 5 in this Subsection are not required if you answered "Yes" to Question 4 in Subsection 1.1, which asks whether the Applicant will also serve as the State-level issuer in all States. Please ensure that you have completed Question 4 in Subsection in 1.1 prior to completing this Subsection. If you change your responses to that question at any time, you will need to revisit this Subsection.

1.4.Q1 [If No to 1.1.Q4] 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.Q4] 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.

[File Upload]

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

[File Upload]

1.4.Q5 [If No to 1.1.Q4] 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.

[File Upload]

1.5 Oversight, Control, and Consolidation of Functions

Questions in this Subsection are not required if you answered "Yes" to Question 4 in Subsection 1.1, which asks whether the Applicant will also serve as the State-level issuer in all States. Please ensure that you have completed Question 4 in Subsection in 1.1 prior to completing this Subsection. If you change your responses to that question at any time, you will need to revisit this Subsection.

1.5.Q1 [If No to 1.1.Q4] 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 [If No to 1.1.Q4] Responsible entity for enrollment (including acceptance, acknowledgement, and reconciliation of enrollments from Exchanges):

○ Applicant ○ State-level MSP issuer

1.5.Q3 [If No to 1.1.Q4 and if answer to 1.5.Q2 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q4 [If No to 1.1.Q4] 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 [If No to 1.1.Q4 and answer to 1.5.Q4 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q6 [If No to 1.1.Q4] Responsible entity for customer service:

○ Applicant ○ State-level MSP issuer

1.5.Q7 [If No to 1.1.Q4 and answer to 1.5.Q6 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q8 [If No to 1.1.Q4] Responsible entity for marketing and outreach (including website, call center(s), advertising and marketing material):

○ Applicant ○ State-level MSP issuer

1.5.Q9 [If No to 1.1.Q4 and answer to 1.5.Q8 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q10 [If No to 1.1.Q4] Responsible entity for claims processing:

○ Applicant ○ State-level MSP issuer

1.5.Q11 [If No 1.1.Q4 and answer to 1.5.Q10 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q12 [If No to 1.1.Q4] Responsible entity for claims payment:

○ Applicant ○ State-level MSP issuer

1.5.Q13 [If No to 1.1.Q4 is No and answer to 1.5.Q12 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q14 [If No to 1.1.Q4] Responsible entity for claims appeals:

○ Applicant ○ State-level MSP issuer

1.5.Q15 [If No to 1.1.Q4 and answer to 1.5.Q14 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q16 [If No to 1.1.Q4] Responsible entity for clinical quality improvement:

○ Applicant ○ State-level MSP issuer

1.5.Q17 [If No to 1.1.Q4 and answer to 1.5.Q16 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q18 [If No to 1.1.Q4] Responsible entity for fraud and abuse prevention:

○ Applicant ○ State-level MSP issuer

1.5.Q19 [If No to 1.1.Q4 is No and answer to 1.5.Q18 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q20 [If No to 1.1.Q4] 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 [If No to 1.1.Q4 and answer to 1.5.Q20 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuer.

Text Box (6000 Character Maximum)

1.5.Q22 [If No to 1.1.Q4] Responsible entity for care management:

○ Applicant ○ State-level MSP issuer

1.5.Q23 [If No to 1.1.Q4 and answer to 1.5.Q22 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q24 [If No to 1.1.Q4] Responsible entity for subcontractor oversight:

○ Applicant ○ State-level MSP issuer

1.5.Q25 [If No to 1.1.Q4 and answer to 1.5.Q24 is Applicant] Discuss the processes for coordination between the Applicant and the State-level MSP issuers.

Text Box (6000 Character Maximum)

1.5.Q26 [If No to 1.1.Q4] 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.

[File Upload]

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

2.1 Administrative, Licensure, and Accreditation 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, 2016, or 2017 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. A "Yes" answer will suppress certain Subsections/questions from appearing in your application. If you change your response to this question at any time during the application, you must notify OPM via a Chat Message, and OPM will alert you of any additional Subsections/Questions you will need to answer.

○ Yes ○ No

2.1.Q7 [If Yes to 2.1.Q6] Are there any major changes to your organization, licensure, 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.

[File Upload]

2.1.Q11 [If No to 2.1.Q6 and Yes to 2.1.Q9] 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 (75 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.

[File Upload]

2.1.Q17 [If Yes to 2.1.Q15] Does the scope of your license allow you to offer the product(s) you propose for the MSP Program?

○ Yes ○ No

2.1.Q18 [Required for SHOP participants] Are you currently offering health insurance in the small group market in the State?

○ Yes ○ No

2.1.Q19 [If No to 2.1.Q18] 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.Q20 [If No to 2.1.Q18 and Yes to 2.1.Q19] On what date did you last offer health insurance in the small group market in the State?

Text Box (75 Character Maximum)

2.1.Q21 [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.Q22 [If No to 2.1.Q6 and Yes to 2.1.Q21] Please provide documentation.

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

[File Upload]

2.1.Q23 Are you applying to, or do you currently participate on, the Marketplace in this State as a Qualified Health Plan (QHP)?

Tool Tip: A "Yes" answer will require certain questions in your application. If you change your response to this question at any time during the application, you must notify OPM via a Chat Message, and OPM will notify you of any additional questions you will need to answer.

○ Yes ○ No

Answers to the following questions in this Subsection will suppress certain questions from appearing in your application. If you change your responses to these questions at any time during the application, you must notify OPM via a Chat Message, and OPM will alert you of any additional Subsections/Questions you will need to answer.

2.1.Q24 Do you hold accreditation by URAC applicable to your proposed MSP options?

○ Yes ○ No

2.1.Q25 Do you hold accreditation by the National Committee for Quality Assurance (NCQA) applicable to your proposed MSP options?

○ Yes ○ No

2.1.Q26 Do you hold accreditation by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) applicable to your proposed MSP options?

○ Yes ○ No

2.1.Q27 [If No to 2.1.Q24, 2.1.Q25 and 2.1.Q26] 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)

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

[File Upload]

2.2 MSP Overview and Strategy

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

2.2.Q1 Indicate the Essential Health Benefits (EHB) benchmark(s) you will use for your MSP options in 2018 (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 [If yes to 2.1.Q6] What major changes, if any, are you making to your MSP offerings for 2018? (These may include changes to the number of MSP options proposed, product types, network(s), or service area(s).)

Tool Tip: Issuers returning to the MSP Program after not participating in 2017 should describe any product, plan, network, or other high-level differences between their most recent MSP options and their proposed 2018 MSP options.

Text Box (6000 Character Maximum)

2.2.Q6 How many MSP options are you proposing? Provide a breakdown by metal level, product 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 product type (e.g., PPO, POS, HMO, EPO) 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.

[File Upload]

2.3 Quality Improvement Strategy

2.3.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, and have submitted, or will be submitting, our QIS to the Centers for Medicare and Medicaid Services (CMS) or State as part of our 2018 QHP Application.
- ☐ We have a QIS that addresses only our MSP options.
- ☐ We do not have a QIS, because we do not meet the participation criteria.

Tool tip: For State-level issuers who are submitting combined QHP/MSP QIS documents, OPM will defer to State or CMS review, and request only the final version and documentation of approval by the appropriate entity.

If OPM certifies your MSP options, you must submit the final QIS submission with documentation of approval, if available, by the appropriate entity via the MSP Portal Contract Management Issuer Report functionality. OPM recognizes that CMS considers a QIS acceptable via absence of disapproval.

2.3.Q2 [If "We have a QIS that addresses only our MSP options" for 2.3.Q1] Upload the QIS(s) specific to your MSP options.

[File Upload]

2.3.Q3 [If "We do not have a QIS because we do not meet the participation criteria" for 2.3.Q1] Explain why you are not required to submit a QIS.

Text Box (6000 Character Maximum)

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

[File Upload]

2.4 Enrollment and Marketing

Questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

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

○ Yes ○ No

2.4.Q2 [If No to 2.1.Q6 and Yes to 2.4.Q1] In which market(s)? (Check all that apply)

- ☐ Individual
- ☐ Small Group
- ☐ Large Group

2.4.Q3 [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 [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 [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.Q7 [If No to 2.1.Q24 (not URAC Accredited) and No to 2.1.Q25 (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.

Tool Tip: This question is not required if you are accredited by URAC or NCQA. Please ensure that you have completed Subsection 2.1 prior to completing this question. If you change your responses to either of those questions at any time to indicate that you are not accredited by either URAC or NCQA, you will need to answer this question.

Text Box (6000 Character Maximum)

2.4.Q8 [If No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

○ Yes ○ No

2.4.Q9 [If No to 2.1.Q6 and Yes to 2.4.Q8] Provide the subcontractor name(s) and a description of the services to be performed, and the location of the subcontractor(s).

Text Box (6000 Character Maximum)

2.4.Q10 [Optional field] [If No to 2.1.Q6] Submit any additional information or documentation as requested by OPM.

[File Upload]

2.5 Financial

2.5.Q1 Provide your 2016 audited annual financial statement submitted to the State insurance commissioner (or equivalent).

[File Upload]

2.5.Q2 Provide your 2016 NAIC annual statement or other annual statement of your condition and affairs, signed by the appropriate company official(s).

[File Upload]

2.5.Q3 Provide your State-required minimum reserve amount and the total amount of reserves held by your company at the end of 2016.

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 2016.

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.

[File Upload]

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

[File Upload]

2.6 Claims

Questions in this Subsection are dependent on your response to Question 6 in Subsection 2.1, which asks whether you offered MSP options in the Marketplace in plan year 2015 , 2016, or 2017. Please make sure to answer Question 6 in Subsection 2.1 before beginning this subsection, and if you change your response to that question at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

[If No to 2.1.Q6] **Describe your current (and proposed, if it will differ for your MSP options) claims payment system and processes, including:**

2.6.Q1 [If No to 2.1.Q6] Claims system from intake through payment

Text Box (6000 Character Maximum)

2.6.Q2 [If No to 2.1.Q6] Timely processing standards

Text Box (6000 Character Maximum)

2.6.Q3 [If No to 2.1.Q6] 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)

2.6.Q4 [If No to 2.1.Q6] Claims assessment and validation tools

Text Box (6000 Character Maximum)

2.6.Q5 [If No to 2.1.Q6] Prompt payment standards

Text Box (6000 Character Maximum)

2.6.Q6 [If No to 2.1.Q6] Overpayment collections

Text Box (6000 Character Maximum)

2.6.Q7 [If No to 2.1.Q6] Coordination of benefits

Text Box (6000 Character Maximum)

2.6.Q8 [If No to 2.1.Q6] Claims denials

Text Box (6000 Character Maximum)

2.6.Q9 [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 [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 as outlined in Appendix 4 of the Multi-State Plan Program 2018 Application and Renewal Guide.

Text Box (6000 Character Maximum)

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

○ Yes ○ No

2.6.Q12 [If No to 2.1.Q6 and Yes to 2.6.Q11] Provide the subcontractor name(s),a description of the services to be performed, and the location of the subcontractor(s).

Text Box (6000 Character Maximum)

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

[File Upload]

2.7 Member Services

Questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

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

Text Box (6000 Character Maximum)

2.7.Q2 [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 [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 [If No to 2.1.Q24 (not URAC Accredited), and if No to 2.1.Q25 (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 [If No to 2.1.Q24 (not URAC Accredited), if No to 2.1.Q25 (not NCQA Accredited), and if No to 2.1.Q26 (not AAAHC Accredited); and if No to 2.1.Q6]] Provide your member rights and responsibilities policy.

[File Upload]

2.7.Q6 [If No to 2.1.Q24 (not URAC Accredited), if No to 2.1.Q25 (not NCQA Accredited), and if No to 2.1.Q26 (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 [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 [If No to 2.1.Q24 (not URAC Accredited), if No to 2.1.Q25 (not NCQA Accredited), and if No to 2.1.Q26 (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 [If No to 2.1.Q24 (not URAC Accredited), if No to 2.1.Q25 (not NCQA Accredited), and if No to 2.1.Q26 (not AAAHC Accredited); and if No to 2.1.Q6] Describe health risk assessment tools.

Text Box (6000 Character Maximum)

2.7.Q10 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (not NCQA Accredited) and if No to 2.1.Q26 (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 [If No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

○ Yes ○ No

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

Text Box (6000 Character Maximum)

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

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2.8 Utilization/Quality Assurance

Questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

2.8.Q1 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (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 [If No to 2.1.Q24 (not URAC Accredited), if No to 2.1.Q25 (not NCQA Accredited), and if No to 2.1.Q26 (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 [If No to 2.1.Q25 (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 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (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 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (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 [If No to 2.1.Q24 (not URAC Accredited), if No to 2.1.Q25 (not NCQA Accredited), and if No to 2.1.Q26 (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 [If No to 2.1.Q24 (not URAC Accredited), if No to 2.1.Q25 (not NCQA Accredited), and if No to 2.1.Q26 (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 [If No to 2.1.Q25 (not NCQA Accredited) and if No to 2.1.Q26 (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 [If No to 2.1.Q25 (not NCQA Accredited) and if No to 2.1.Q26 (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 [If No to 2.1.Q25 (not NCQA Accredited) and if No to 2.1.Q26 (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)

[If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (not NCQA Accredited); and if No to 2.1.Q6] **Describe your quality assurance program. Include a discussion of:**

2.8.Q11 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (not NCQA Accredited); and if No to 2.1.Q6] 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 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (not NCQA Accredited); and if No to 2.1.Q6] 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 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (not NCQA Accredited); and if No to 2.1.Q6] 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 [If No to 2.1.Q24 (not URAC Accredited) and if No to 2.1.Q25 (not NCQA Accredited); and if No to 2.1.Q6] 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)

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

2.8.Q15 [If No to 2.1.Q6] Employees

Text Box (6000 Character Maximum)

2.8.Q16 [If No to 2.1.Q6] Subcontractors

Text Box (6000 Character Maximum)

2.8.Q17 [If No to 2.1.Q6] Providers

Text Box (6000 Character Maximum)

2.8.Q18 [If No to 2.1.Q6] Enrollees

Text Box (6000 Character Maximum)

2.8.Q19 [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 [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 [If No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

○ Yes ○ No

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

Text Box (6000 Character Maximum)

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

[File Upload]

2.9 IT Systems, Security and Confidentiality

Questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

[If No to 2.1.Q6] **Describe your current and proposed use and support of health information technology, including:**

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

Text Box (6000 Character Maximum)

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

Text Box (6000 Character Maximum)

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

Text Box (6000 Character Maximum)

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

Text Box (6000 Character Maximum)

2.9.Q5 [If No to 2.1.Q6] Use and support of electronic referrals

Text Box (6000 Character Maximum)

2.9.Q6 [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)

Text Box (6000 Character Maximum)

2.9.Q7 [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.Q8 [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.Q9 [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.Q10 [If No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

○ Yes ○ No

2.9.Q11 [If No to 2.1.Q6 and Yes to 2.9.Q10] Provide the subcontractor name(s), a description of the services to be performed, and the location of the subcontract(s).

Text Box (6000 Character Maximum)

2.9.Q12 [Optional field] [If No to 2.1.Q6] Submit any additional information or documentation as requested by OPM.

[File Upload]

2.10 Disaster Recovery/Business Continuity

Questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

2.10.Q1 [If No to 2.1.Q25 (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 [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 [If No to 2.1.Q24 (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 [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), a description of the services to be performed, and the location of the subcontractor(s).

Text Box (6000 Character Maximum)

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

[File Upload]

2.11 Provider Contracts and Networks

Questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

2.11.Q1 [If No to 2.1.Q6] Are you proposing more than one network for your MSP offerings (e.g., different networks for different product 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 [If No to 2.1.Q24 (Not URAC Accredited) and if No to 2.1.Q25 (Not NCQA Accredited) and if No to 2.1.Q26 (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 [If No to 2.1.Q24 (Not URAC Accredited) and if No to 2.1.Q25 (Not NCQA Accredited) and if No to 2.1.Q26 (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 [If No to 2.1.Q24 (Not URAC Accredited) and if No to 2.1.Q25 (Not NCQA Accredited) and if No to 2.1.Q26 (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.Q6 [If No to 2.1.Q6] Describe your system for determining and monitoring the adequacy of your proposed provider network. If you propose to offer more than one MSP network, explain any differences between them. 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.Q7 [If No to 2.1.Q6] Will any of the functions described in this subsection be performed by subcontractors?

○ Yes ○ No

2.11.Q8 [If No to 2.1.Q6 and Yes to 2.11.Q7] Provide the subcontractor name(s), a description of the services to be performed, and the location of the subcontractor(s).

Text Box (6000 Character Maximum)

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

[File Upload]

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 additional network. Continue to add networks until you've created a page for each of the networks you are proposing.

2.11.Q10.1 What is the name and Network ID of this network?

Text Box (6000 Character Maximum)

2.11.Q10.2 What are the names of the proposed MSP options to be covered by this network?

Text Box (6000 Character Maximum)

2.11.Q10.3 In what market(s) do you use this network for your MSP options?

o Individual
o SHOP
o Both

2.11.Q10.4 What is the product type associated with this network?

- o PPO
- o POS
- o HMO
- o EPO

2.11.Q10.5 Is this network unique to your MSP options?

○ Yes ○ No

2.11.Q10.6 [If Yes to 2.11.Q10.5] Describe how and why it differs from other networks for the same product type and/or market.

Text Box (6000 Character Maximum)

2.11.Q10.7 In this network, are there different cost-sharing tiers depending on provider participation type?

○ Yes ○ No

2.11.Q10.8 [If Yes to 2.11.Q10.7] Indicate how many tiers are in this network and provide a description of each tier, including cost sharing, and how enrollees can differentiate between these tiers.

Text Box (6000 Character Maximum)

2.11.Q10.9 Are enrollees required to select a primary care physician (PCP)?

○ Yes ○ No

2.11.Q10.10 [If Yes to 2.11.Q10.9] Describe how you inform enrollees of the requirement.

Text Box (6000 Character Maximum)

2.11.Q10.11 Describe whether in-network and/or out-of-network referrals to specialists are required, and if required, explain under what circumstances.

Text Box (6000 Character Maximum)

2.11.Q10.12 What is the process for enrollees to request an exception to receive care from an out-of-network provider, including, for example, when there are no in-network specialty providers available without unreasonable delay or because an enrollee has a rare or complex medical condition that requires highly specialized care that is not available in network? Include a discussion of how enrollees can appeal a denial of an exception request.

Text Box (6000 Character Maximum)

2.11.Q10.13 If you approve an exception request, describe the reimbursement arrangements, including responses to the following questions.

- 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?

Text Box (6000 Character Maximum)

2.11.Q10.14 Can an enrollee access in-network services, beyond emergency care, outside of the enrollee's service area?

○ Yes ○ No

2.11.Q10.15 [If Yes to 2.11.Q10.14] Describe the in-network services available outside the service area, and how enrollee can access them, including any differences from how they access services within the service area.

Text Box (6000 character maximum)

2.11.Q10.16 [If Yes to 2.11.Q10.14] Are there any limitations on the in-network services available outside of the service area?

○ Yes ○ No

2.11.Q10.17 Describe how you will comply with the out-of-network cost sharing requirements in 45 CFR 156.230(e), including any changes you are making to your current processes to comply.

Text Box (6000 character maximum)

2.12 Service Area and Network Adequacy

Some questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

2.12.Q1 Are you proposing to offer MSP options in the entire State in 2018?

○ 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 2018 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 2018 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 2.1.Q23] Does your service area(s) for your MSP options differ from the service area(s) for your QHPs?

Tool Tip: This question is required if you answer Yes to the question "Are you applying to, or do you currently participate on, the Marketplace in this State as a Qualified Health Plan (QHP)?" in Subsection 2.1. Please answer that question prior to Questions 5 and 6 in this Subsection. If at any time you change your response from No to Yes to the question in Subsection 2.1, you must revisit this Subsection and complete all required questions.

○ 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.

Template IDs should begin with 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.

If 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.

Prior to submitting, you must ensure that the template passes all of the required tools as outlined in the Application and Renewal Guide.

[File Upload]

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.

Template IDs should begin with 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.

Prior to submitting, you must ensure that the template passes all of the required tools as outlined in the Application and Renewal Guide.

[File Upload]

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.

NOTE: OPM will notify you via Chat Message if you are required to submit Network Adequacy data in the template. If you **are not** required to submit the data, **do not** click "Create Individual (MD/DO) Tab" or "Create Facility, Pharmacy, Non-MD/DO Tab" on the User Control tab. This will limit the template requirements to just Essential Community Providers, which all issuers are required to submit.

Tool Tip: Please use the name automatically given when the template produces the ZIP file; there is no additional naming convention required for this template.

Prior to submitting, you must ensure that the template passes all of the required tools as outlined in the Application and Renewal Guides.

[File Upload]

Answer the following questions about your compliance with Essential Community Providers (ECP) standards at 45 C.F.R. § 156.235, and any additional State standards, if applicable.

2.12.Q10 Upload your CMS ECP Measurement Tool results.

Tool Tip: Upload the completed CMS QHP ECP Tool in .XLS format with the "Output" tab showing the results for each of your proposed MSP options.

[File Upload]

2.12.Q11 Do you offer a contract to all Indian healthcare providers in each service area?

○ Yes ○ No

2.12.Q12 Do you offer a contract to at least one ECP in each available ECP category in each county in each service area?

○ Yes ○ No

2.12.Q13 Do each of your proposed networks include a minimum percentage of available ECPs in each service area to meet the Federal standard?

○ Yes ○ No

2.12.Q14 [If No to 2.12.Q11, 2.12.Q12, or 2.12.Q13] Upload a completed Supplementary ECP Response Form with completed responses addressing any No responses to Questions 11, 12, or 13.

[File Upload]

2.12.Q15 Does your State have additional ECP standards than Federal ECP standards at 45 C.F.R. § 156.235?

○ Yes ○ No

2.12.Q16 [If Yes to 2.12.Q15] Upload documentation received from, or provided to where applicable, your State indicating your compliance with your applicable State standards.

[File Upload]

2.12.Q17 [Optional field] Submit any additional information or documentation as requested by OPM.

[File Upload]

2.13 Prescription Drugs

2.13.Q1 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.

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.

Prior to submitting, you must ensure that the template passes all of the required tools as outlined in the Application and Renewal Guide.

[File Upload]

2.13.Q2 Did the Formulary Review Suite or Category & Class Drug Count Tool indicate any deficiencies in your formulary?

Tool Tip: You are required to run the Formulary Review Suite and the Category & Class Drug Count Tool to determine if there are any deficiencies in the formulary.

○ Yes ○ No

2.13.Q3 [If Yes to 2.13.Q2] Complete and submit the appropriate justification(s).

[File Upload]

2.13.Q4 [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.

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.

Prior to submitting, you must ensure that the template passes all of the required tools as outlined in the Application and Renewal Guide.

[File Upload]

2.13.Q5 [Required for SHOP participants] Did the Formulary Review Suite or Category & Class Drug Count Tool indicate any deficiencies in your SHOP formulary?

Tool Tip: You are required to run the Formulary Review Suite and the Category & Class Drug Count Tool to determine if there are any deficiencies in the SHOP formulary.

○ Yes ○ No

2.13.Q6 [If Yes to 2.13.Q5] Complete and submit the appropriate justification(s) for your SHOP options.

[File Upload]

2.13.Q7 Do you propose to contract with a Pharmacy Benefit Manager (PBM) for retail pharmacy services?

○ Yes ○ No

2.13.Q8 [If Yes to 2.13.Q7] Provide the name and location 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 2018, indicate your time frame for selecting a PBM.

Text Box (6000 Character Maximum)

2.13.Q9 [If Yes to 2.13.Q7] Is the contracted PBM fully accredited by URAC for pharmacy benefit management?

○ Yes ○ No

2.13.Q10 Within your retail pharmacy network, describe any different cost-sharing depending on the pharmacy participation type (e.g., preferred or non-preferred).

Text Box (6000 Character Maximum)

2.13.Q11 Do you propose to contract with a Pharmacy Benefit Manager (PBM) for mail order pharmacy services?

○ Yes ○ No

2.13.Q12 [If Yes to 2.13.Q11] Provide the name and location 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 2018, indicate your time frame for selecting a PBM.

Text Box (6000 Character Maximum)

2.13.Q13 [If Yes to 2.13.Q11] Is the contracted PBM fully accredited by URAC for mail order pharmacy?

○ Yes ○ No

2.13.Q14 [If No to 2.13.Q11] Discuss how you intend to provide mail order pharmacy services.

Text Box (6000 Character Maximum)

2.13.Q15 Do you propose to contract with a Pharmacy Benefit Manager (PBM) or independent specialty pharmacy vendor for specialty pharmacy services?

○ Yes ○ No

2.13.Q16 [If No to 2.13.Q15] How do you intend to provide specialty drug services?

Text Box (6000 Character Maximum)

2.13.Q17 [If Yes to 2.13.Q15] Provide the name and location 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 2018, indicate your time frame for selecting a PBM.

Text Box (6000 Character Maximum)

2.13.Q18 [If Yes to 2.13.Q15] Is the contracted PBM or independent specialty pharmacy vendor fully accredited by URAC for specialty pharmacy?

○ Yes ○ No

2.13.Q19 [If No to 2.13.Q9, 2.13.Q13, or 2.13.Q18] In the absence of accreditation, what tools do you use to ensure quality and safety in pharmacy operations?

Text Box (6000 Character Maximum)

2.13.Q20 [If No to 2.13.Q9, 2.13.Q13, or 2.13.Q18] Describe the cost and quality management programs employed (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.Q21 What measures are currently employed and/or planned to deter the misuse of prescription drugs (e.g., opioids and psychotherapeutic drugs)?

Text Box (6000 Character Maximum)

2.13.Q22 [If No to 2.13.Q9, 2.13.Q13, or 2.13.Q18] 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.Q23 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 time frame this occurs.

Text Box (6000 Character Maximum)

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

[File Upload]

2.14 Benefit Proposal

Some questions in this Subsection are only required based on your response to questions in Subsection 2.1. Please make sure to complete Subsection 2.1 before beginning this subsection, and if you change your responses in Subsection 2.1 at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

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

Prior to submitting, you must ensure that the template passes all of the required tools as outlined in the Application and Renewal Guide.

[File Upload]

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).

[File Upload]

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

Prior to submitting, you must ensure that the template passes all of the required tools as outlined in the Application and Renewal Guide.

[File Upload]

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] SHOP AV Level (include tier and metal).

[File Upload]

2.14.Q7 [If Yes to 2.1.Q23] 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: This question is required if you answer Yes to the question "Are you applying to, or do you currently participate on, the Marketplace in this State as a Qualified Health Plan (QHP)?" in Subsection 2.1. Please answer that question prior to Questions 4 and 5 (if only proposing Individual MSP options) or Questions 7 and 8 (if also proposing SHOP MSP options) in this Subsection. If at any time you change your response from No to Yes to the question in Subsection 2.1, you must revisit this Subsection and complete all required questions.

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
- ☐ Product type
- ☐ Child-only vs. non-Child-only coverage offerings
- ☐ Other
- ☐ None

2.14.Q8 [If Yes to 2.1.Q23] Describe in detail the meaningful difference(s) indicated above. If you selected "None," explain why there is no meaningful difference.

Text Box (6000 Character Maximum)

2.14.Q9 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.Q10 [If Yes to 2.14.Q9] 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
- ☐ Product type
- ☐ Child-only vs. non-Child-only coverage offerings
- ☐ Other
- ☐ None

2.14.Q11 [If Yes to 2.14.Q9] Describe in detail the meaningful difference(s) indicated above. If you selected "None," explain why there is no meaningful difference.

Text Box (6000 Character Maximum)

2.14.Q12 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 2018 MSP options cover non-excepted abortion services?

○ Yes ○ No

2.14.Q13 [Optional field] Submit any additional information or documentation to support your benefit package.

[File Upload]

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 time frame 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.

- o 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).

- o 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.

- o 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.

- o 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).

- o 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.

- o 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.

- o 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 Quality Improvement Strategy, Quality Rating Strategy and QHP Enrollee Experience Survey, consistent with 45 C.F.R. § 156.200(b)(5) .

- o 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 found in 45 C.F.R. § 156.1110

- o 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.

- o 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.

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

2.15.Q12 The provider network for each of its MSP options meets the network adequacy requirements specified in 45 C.F.R. § 800.109, including that it has a sufficient number and type of providers to assure that all services are accessible without unreasonable delay, and is consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act.

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

2.15.Q13 The State-level issuer certifies, to the best of its knowledge and belief, that (check one):

Tool Tip: The third option can only be selected after consultation with OPM.

- ☐ 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 time frame 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 time frame, the State has not disapproved the filings, and there are no outstanding objections or impediments to approval.

2.15.Q14 [Optional field] If your form filings have been affirmatively approved by the appropriate State regulatory agency and/or CMS, submit documentation of such approval.

[File Upload]

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

[File Upload]

2.16 Rate Proposal

Some questions in this Subsection are only required based on your response to the question "Do any of your proposed 2018 MSP options cover non-excepted abortion services?" in Subsection 2.14. Please make sure to complete that question before beginning this Subsection, and if you change your response at any time, you will need to revisit this Subsection to ensure that you have answered all of the required questions.

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.

[File Upload]

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.

(INDIVIDUAL) MSP Rate Development Ir

[File Upload]

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.

[File Upload]

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.

(SHOP) MSP Rate Development Inform

[File Upload]

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.

If you are also participating as a QHP issuer in this State, you must use an identical issuer-level business rule across both QHP and MSP templates. You may then specify unique business rules unique to MSP options at the product or plan levels. This will ensure the data will display appropriately on the Marketplaces.

[File Upload]

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.

[File Upload]

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

[File Upload]

2.16.Q10 Indicate the date of your 2018 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.Q12] Provide your segregation plan related to non-excepted 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, which 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, which 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.

Tool Tip: This question is required if you answer Yes to the question "Do any of your proposed 2018 MSP options cover non-excepted abortion services?" in Subsection 2.14. Please answer that question prior to Questions 9 and 10 (if only proposing Individual MSP options) or Questions 12 and 13 (if also proposing SHOP MSP options) in this Subsection. If at any time you change your response from No to Yes to the question in Subsection 2.14, you must revisit this Subsection and complete all required questions.

[File Upload]

2.16.Q13 [If Yes to 2.14.Q12] Please describe how you account for the cost of coverage of non-excepted 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.

[File Upload]

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

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. If there are any questions, please send an OPM Chat Message.

2.17.Q1 This is to certify that the following templates submitted in this application:

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

a. contain information identical to the information submitted to the appropriate State; and

b. (check one):

Tool Tip: Only select the second option after consultation with OPM.

- o have been approved by the appropriate State regulator;
- o are awaiting formal approval by the appropriate State regulator, but all filings were made within the appropriate time frame, the State has not disapproved the filings, and there are no outstanding objections or impediments to approval;
- o were submitted to the appropriate State regulator in a State that does not have rate approval authority, but all filings were made within the appropriate time frame and the State has not disapproved the filings;
- o are subject to approval by OPM on behalf of the Centers for Medicare & Medicaid Services (CMS) in a 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.

o 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.

[File Upload]

2.18 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.

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

[File Upload]

2.18.Q2 Indicate the date of your 2018 form filing to the State regulator and/or CMS.

Text Box (50 Character Maximum)

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

Text Box (50 Character Maximum)

2.18.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)

2.18.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)

2.18.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)

2.18.Q7 Upload your proposed Notice of Final Internal Adverse Benefit Determination for your MSP options. (A Model Notice of Final Internal Adverse Benefits Determination may be found at https://www.opm.gov/forms/pdfimage/opm1842.pdf.)

[File Upload]

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

[File Upload]