QHP Issuer 2015 Renewal Application

The Exchange intends to make this entire application available electronically. Please complete the following:

Issuer Name	
NAIC Company Code	
NAIC Group Code	
Regulator(s)	
Federal Employer ID	
HIOS/Issuer ID	
Corporate Office Address	
City	
State	
ZIP	
Primary Contact Name	
Contact Title	
Contact Phone Number	
Contact E-mail	
Check all applicable categories: ☐Individual Commercial; ☐SHOP	

On behalf of the QHP issuer stated above, I hereby attest that I meet the requirements in this Renewal Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this application and decertify Issuer's Qualified Health Plans offered on the Exchange should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the QHP issuer stated above to the terms of this Renewal Application.

Date: _____
Signature: _____
Printed Name: _____
Title: _____

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
I. Licensed and in Good Standing						
1.1	Confirm that QHP issuer possesses and maintains its license to offer health insurance and is in good standing with applicable state, and federal authorities. (See Appendix A – Definition of Good Standing)	45 CFR §156.200(b)(4)			☐Yes ☐No	
1.2	Are you seeking any material modification of an existing license from the California Department of Managed Health Care for any commercial individual or small group products offered or proposed to be offered through Covered California? If yes, complete Attachment A (Regulatory Filings) to explain what modifications you are seeking and when those are anticipated to be approved?				☐Yes ☐No	
1.3	By submitting this application, QHP issuer agrees to negotiate a contract or contract amendment for 2015 in good faith with Covered California that will establish the terms and conditions of the business relationship.				☐Yes ☐No	
II. Provider Network Adequacy						
2.1	As a general requirement, QHP issuer must maintain continuing compliance with California provider network adequacy standards, laws & regulations established by the applicable regulatory agency. Applicant understands that provider network adequacy for its Covered California products will be determined by the applicable state regulatory agency and verified by Covered California. QHP issuer agrees to maintain a legally compliant provider network for each product offering (PPO,	45 CFR §156.230(a)(2)	Health and Safety Code §1300.67.2.1; 1300.67.2.2; 100,74.73 and Ins. Code§10133.65		☐Yes ☐No	

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
	HMO, EPO) which includes sufficient number and types of providers to ensure that all services are accessible in a timely fashion to its Covered California enrollees. For Plan Year 2015, network adequacy standards applicable to dental provider networks will apply to the embedded pediatric dental benefit.					
2.2	QHP issuer agrees to maintain its provider network and continue to meets regulatory requirements based on QHP's 2015 Covered California projected and actual enrollment. Submit 2015 enrollment projections by product that QHP issuer intends to propose for 2015 by completing Attachment B (QHP 2015 Enrollment Projections).				☐Yes ☐No	
2.3	QHP products proposed for 2015 must cover the entire geographic service area for which the issuer is licensed in a rating region. Provide an updated geographic service area by product type for 2015 and include any changes from your 2014 service area by completing and uploading through SERFF[1] the most current Service Area Template located at: http://www.serff.com/plan_management_data_templates.htm and Attachment C1 - Plan Type by Rating Region (Individual), or if applicable, Attachment C2 – Plan Type by Rating Region (SHOP). Is Applicant making any changes to 2014 service area? If yes, describe briefly.				☐Yes ☐No	
III. Essential Community Provider (ECP) Network Requirements						
3.1	Describe how QHP issuer is continuing to meet or exceed Covered California's ECP network	45 CFR §156.230(a)(1) §156.235(a)				

[1] System for Electronic Rate and Form Filing; developed and owned by the National Association of Insurance Commissioners

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
	requirements as defined in Appendix B (Essential Community Provider Network Requirements).					
3.2	If QHP asserts that it meets the ECP network requirement as defined in Appendix B through the alternate standard, explain the basis for this assertion and how the QHP issuer is continuing to meet the ECP network requirements under the alternate standard.	45 CFR §156.235(a)(2)				
IV. Quality and Delivery System Reform						
4.1	Describe QHP's process to ensure that QHP issuer can comply with QHP Contract Data Submission Requirements (as defined in Appendix C) to Covered California.					
4.2	QHP agrees to submit claims and encounter[2] data in the requested format to a third party vendor selected by Covered California for the purpose of performing clinical analytics.				☐Yes ☐No	
4.3	Confirm that QHP will submit eValue8™ [3] modules found in Section 8.				☐Yes ☐No	
4.4	Specify accrediting organization (National Committee on Quality Assurance, Utilization Review Accreditation Commission, Accreditation Association for Ambulatory Health Care), accreditation status, next scheduled survey date(s), current accreditation status and proposed timeline if full accreditation has not been achieved or maintained.	45 CFR §1045; 45 CFR §156.275				
4.5	Confirm that QHP will submit, upon request, to the Exchange, Healthcare Effectiveness Data				☐Yes	

[2] Claims and encounter data reflect a health care visit by an enrollee to a provider of care or service.
[3] eValue8™ is a tool developed by the National Business Coalition on Health used by health care purchasers to compare health plans.

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
	Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to include the measure numerator, denominator, and rate for the required measures set that is reported to NCQA Quality Compass[4] or as applicable to DHCS, per each product type for which it collects data in California.				☐No	
V. Operational Readiness and Capacity						
5.1	QHP issuer confirms that it can and will accurately, appropriately and timely populate and submit SERFF templates at the request of Covered California for: (1) Rates (2) Service Area (3) Network (4) Benefit Plan Designs				☐Yes ☐No	
5.2	Demonstrate through existing QHP contract compliance or systems testing that QHP issuer operates systems which can accurately and timely report electronic data to Covered California using national standards for electronic transactions.					
5.3	Demonstrate, through submission of a March 2014 audit report or systems testing, as applicable, that QHP issuer can accept 834, 820 and other standard transaction electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information for its intended purpose (see Attachment D1 834 Enrollment File Error Listing & D2 834 Effectuation File Error Listing)					

[4] NCQA Quality Compass is a tool for comparing health plans based on quality improvement and other measures using a benchmark approach.

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
5.4	Provider directory data for both Individual and SHOP Exchange products must be included in this submission.	45 CFR §156.230(b)			☐Yes ☐No	
5.5	Describe how QHP issuer's computer systems can accurately and timely maintain an electronic interface with CalHEERS. Unless applicant can demonstrate this requirement through contract compliance, applicant must be available for testing data interfaces with the Exchange no later than July 1, 2014. QHP must maintain computer systems for testing any future modifications to the interface design and data interchange. Covered California requires QHPs to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.					
5.6	Describe the QHP issuer's systems ability to generate invoices for new members, which must be fully operational no later than October 15, 2014.					
5.7	Describe QHP issuer's systems which must accept premium payments from members no later than October 15, 2014 made using paper checks, cashier's checks, money orders, EFT and all general purpose pre-paid debit cards and credit cards. If such systems are not currently in place, describe plans to implement such systems, including any potential vendors, if applicable, and an implementation work plan with timeline. Note: QHP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.					

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
5.8	Describe how QHP issuer will comply with the federal requirement to serve the unbanked.	45 CFR 156.1240(a)(2)				
5.9	Describe how QHP issuer will maintain sufficient staffing in the customer service center to meet contractual performance goals.					
5.10	Describe QHP issuer's plans that are in place for the purpose of detecting and reporting incidents of fraud, waste and abuse. Provide a description of such plans and their efficacy.					
5.11	Describe any education efforts QHP issuer provides to members to help them identify and report possible fraud scams. Describe QHP's procedures to report fraud scams to law enforcement.					
5.12	Describe QHP issuer's safeguards against Social Security and identity fraud.					
5.13	QHP must comply with applicable federal and state privacy laws and regulations, and has appropriate procedures in place to detect and respond to privacy and security incidents.				☐Yes ☐No	
5.14	QHP issuer must adhere to Covered California naming conventions promulgated through a future administrative rulemaking by Covered California for 2015.					
VI. Rates for 2015						
6.1	Submit premium rates for every proposed QHP by rating region for 2015 by completing and uploading through SERFF the most current Unified Rate Review Template (URRT) and the most current SERFF Rates Template located at: http://www.serff.com/plan_management_data_templates.htm					

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
6.2	Provide information requested about documents filed with the applicable regulator as outlined in Attachment A (Regulatory Filings) for 2015 products proposed to be offered through Covered California. Complete Attachment A and provide updates to this information as additional documents are submitted to the applicable regulator.					
VII. 2015 Standard Benefit Plan Design						
7.1	QHP issuer must adhere to 2015 standard benefit plan designs which will be adopted through a future administrative rulemaking.				☐Yes ☐No	
7.2	QHP issuer agrees to submit its proposed 2015 plans for each metal level and for catastrophic coverage for its licensed geographic service area(s). QHP issuer can satisfy this requirement through either its life and health insurance company offerings or its Knox Keene health care service plans.				☐Yes ☐No	
7.3	Comply with California state benefit plan laws in effect for 2015, including those pertaining to plan design requirements.				☐Yes ☐No	
7.4	The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits including the pediatric Dental Essential Health Benefit. QHP issuer shall indicate if it is prepared to submit proposals that adhere to the 2015 Essential Health Benefit standard plan design adopted through a future administrative rulemaking that includes all ten Essential Health Benefits. Failure to offer a product with all ten Essential Health Benefits will not be grounds to have QHP issuer's renewal application rejected.				☐Yes ☐No	

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
7.5	If QHP issuer answered yes above, describe how issuer intends to meet the plan design described in 7.4. Provide information about any intended subcontractor relationship, if applicable, to offer the pediatric Dental Essential Health Benefit. Include a description of how QHP issuer will ensure subcontractor adheres to Covered California pediatric dental quality measures.					

Section 8. eValue8™ Submission

8.1 Business Profile

8.1.4 Accreditation

8.1.4.1 Please provide the NCQA accreditation status and expiration date of the accreditation achieved for the HMO product identified in this response. Indicate all that apply. For the URAC Accreditation option, please enter each expiration date in the detail box if the Plan has earned multiple URAC accreditations.

This question needs to be answered in entirety by the Plan. Note that plan response about NCQA PHQ Certification should be consistent with plan response in question #2.7.1 in module 2 on the Consumer Disclosure project where PHQ is a response option.

Flagged: CA HIX
Flagged: HMO
Flagged: Regional

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA MCO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: NCQA not used or product not eligible		
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate		
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used		
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used		

NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification		
URAC Accreditations	*Multi, Checkboxes - optional.* 1: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From Dec 31, 1972 to Jan 01, 2023.	
URAC Accreditation - Comprehensive Wellness	Same as above	Same as above	
URAC Accreditations - Disease Management	Same as above	Same as above	
URAC Accreditations - Health Utilization Management	Same as above	Same as above	
URAC Accreditations - Case Management	Same as above	Same as above	
URAC Accreditations - Pharmacy Benefit Management	Same as above	Same as above	

8.1.4.2 PPO version of above

8.1.5 Business Practices and Results (formerly 1.7, Racial, Cultural and Language Competency)

8.1.5.1 Identify the sources of information used to gather commercial members' race/ethnicity, primary language and interpreter need. **The response "Enrollment Form" pertains only to information reported directly by members (or as passed on from employers about specific members).**

Flagged: CA HIX

	Data proactively collected from all new enrollees (specify date started - MM/DD/YYYY)	How data is captured from previously enrolled members(i.e., those who were not new enrollees when respondent started collecting information) - specify method	Members captured as percent of total commercial population (national)
Race/ethnicity	*To the day.* N/A OK.	*Multi, Checkboxes.* 1: Enrollment form, 2: Health Assessment, 3: Information requested upon Website registration, 4: Inquiry upon call to Customer Service, 5: Inquiry upon call to Clinical Service line, 6: Imputed method such as zip code or surname analysis, 7: Other (specify in detail box below. 200 word limit), 8: Data not collected	*Percent.*
Primary language	Same as above	Same as above	Same as above
Interpreter need	Same as above	Same as above	Same as above
Education level	Same as above	Same as above	Same as above

8.1.5.2 Provide an estimate of the percent of network physicians, office staff and Plan personnel in this market for which the plan has identified race/ethnicity, and a language spoken other than English? Plan personnel would be those with member interaction (e.g., customer service, health coaches).

Example of numerator and denominator for network physician estimate: Denominator: all physicians in the network. Numerator: all physicians in network where plan knows what language is spoken by physician If plan has 100 physicians in the network and knows that 50 speak only English, 10 speak Spanish and 2 are bilingual in English and Spanish, the numerator would be 62.

Flagged: CA HIX
Flagged: Regional

	Physicians in this market	Physician office staff in this market	Plan staff in this market
Race/ethnicity	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.
Languages spoken			

8.4 Helping Members become Good Consumers

8.4.1 Instructions and Definitions

8.4.2 Addressing language and health literacy needs (formerly 1.7, Racial, Cultural and Language Competency)

8.4.2.1 It is estimated that 50% of adult Americans lack *functional health literacy*, which the U.S. Department of Health and Human Services defines as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy is separate from cultural competency and literacy. *An example may be that members understand they need to go to the radiology department to get an X-ray.*

Please describe below plan activities to address health literacy.

Flagged: CPR
Flagged: CA HIX

Single, Radio group.
1: No activities currently,
2: Plan addresses health literacy of members – Describe how health literacy is addressed, including testing of materials: [200 words]

8.4.2.2 Indicate how racial, ethnic, and/or language data is used? Check all that apply.

Flagged: CA HIX
Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate HEDIS or other clinical quality performance measures by race, ethnicity, or language,
3: Calculate CAHPS or other measures of member experience by race, ethnicity, or language,
4: Identify areas for quality improvement/disease management/ health education/promotion,
5: Share with enrollees to enable them to select concordant clinicians,
6: Share with provider network to assist them in providing language assistance and culturally competent care,

7: Set benchmarks (e.g., target goals for reducing measured disparities in preventive or diagnostic care),
8: Determine provider performance bonuses and/or contract renewals (e.g. based on evidence of disparity outlier status),
9: Analyze disenrollment patterns,
10: Develop disease management or other outreach programs that are culturally sensitive (provide details on program in detail box below),
11: : Other (describe in detail box below),
12: Racial, ethnic, language data is not used

8.4.2.3 How does the Plan support the needs of members with limited English proficiency? Check all that apply.

Flagged: CA HIX

Multi, Checkboxes.
1: Test or verify proficiency of bilingual non-clinical Plan staff,
2: Test or verify proficiency of bilingual clinicians,
3: Certify professional interpreters,
4: Test or verify proficiency of interpreters to understand and communicate medical terminology,
5: Train practitioners to work with interpreters,
6: Distribute translated lists of bilingual clinicians to members,
7: Distribute a list of interpreter services and distribute to provider network,
8: Pay for in-person interpreter services used by provider network,
9: Pay for telephone interpreter services used by provider network,
10: Pay for in-person interpreter services for non-clinical member interactions with plans,
11: Negotiate discounts on interpreter services for provider network,
12: Train ad-hoc interpreters,
13: Provide or pay for foreign language training,
14: Formulate and publicize policy on using minor children, other family, or friends as interpreters,
15: Notify members of their right to free language assistance,
16: Notify provider network of members' right to free language assistance,
17: Develop written policy on providing language services to members with limited English proficiency,
18: Provide patient education materials in different languages. Percent in a language other than English: [Percent] Media: [Multi, Checkboxes] ,
19: Other (describe in detail box below):,
20: Plan does not implement activities to support needs of members with limited English proficiency

8.4.2.4 Indicate which of the following activities the Plan undertook in 2013 to assure that culturally competent health care is delivered. This shall be evaluated with regard to language, culture or ethnicity, and other factors. Check all that apply.

Flagged: CA HIX
Multi, Checkboxes.
1: Assess cultural competency needs of members,
2: Conduct an organizational cultural competence assessment of the Plan,
3: Conduct a cultural competence assessment of physician offices,
4: Employ a cultural and linguistic services coordinator or specialists,
5: Seek advice from a Community Advisory Board or otherwise obtain input from community-based organizations,

6: Collaborate with statewide or regional medical association groups focused on cultural competency issues,
7: Tailor health promotion/prevention messaging to particular cultural groups (summarize groups targeted and activity in detail box),
8: Tailor disease management activities to particular cultural groups (summarize activity and groups targeted in detail box),
9: Public reporting of cultural competence programs, staffing and resources,
10: Sponsor cultural competence training for Plan staff,
11: Sponsor cultural competence training for physician offices,
12: Other (describe in detail box below):,
13: No activities in year of this response

8.4.2.5 Has the Plan evaluated or measured the impact of any language assistance activities? If yes, describe the detail box below the evaluation results of the specific disparities that were reduced and provide a description of the intervention if applicable.

Flagged: CA HIX

8.4.8 Price Transparency - Helping Members Pay the Right Price (Understand Cost) (formerly 2.7 Claims Management and Price Transparency)

8.4.8.1 Describe activities to identify for members/consumers those providers (hospitals and/or physicians) that are more efficient and/or lower cost.

Single, Radio group.
1: Description,
2: Plan does not identify those providers (hospitals and/or physicians) that are more efficient and/or lower cost

8.4.8.2 Describe the web-based cost information that the Plan makes available for physician and hospital services. Check all that apply.

	Physicians	Hospitals	Ambulatory surgery or diagnostic centers
Procedure-based cost	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to

	members, 8: Information available to public	members, 8: Information available to public	members, 8: Information available to public
Episode of care based cost (e.g. vaginal birth, bariatric surgery)	Same as above	Same as above	Same as above

8.4.8.3 Indicate the functionality available in the Plan's cost calculator. Check all that apply. If any of the following five (5) features are selected, documentation for the procedure KNEE REPLACEMENT must be provided in following question as Consumer 8:

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)
2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,
3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,
4) Supports member customization of expected ***professional*** services utilization or medication utilization,
5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

	Answer
	Multi, Checkboxes - optional. 1: The Plan does not support a cost calculator.
Content	*Multi, Checkboxes.* 1: Medical cost searchable by procedure (indicate number of procedures in detail box below), 2: Medical cost searchable by episode of care (indicate number of care episodes in detail box below), 3: Medication costs searchable by drug, 4: Medication costs searchable by episode of care, 5: None of the above
Functionality	*Multi, Checkboxes.* 1: Compare costs of alternative treatments, 2: Compare costs of physicians, 3: Compare costs of hospitals, 4: Compare costs of ambulatory surgical or diagnostic centers, 5: Compare drugs, e.g. therapeutic alternatives, 6: Compare costs based on entire bundle of care, allowing user to substitute lower cost or higher quality equivalent elements of bundle, 7: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions, 2: Cost information considers members benefit design relative to accumulated deductibles, Out of Pocket max, lifetime, services limits (e.g. number of physical therapy visits covered),

	3: Cost information considers members benefit design relative to pharmacy benefit, e.g. brand/generic and retail/mail, 4: Separate service category sets result for user, other adult household members and for children, 5: Explains key coverage rules such as family-level versus individual-level annual accumulation and general rules about portability, accrual, tax allowances, etc, 6: Provides summary plan benefits description as linked content with explanatory note about IRS-allowed expenses vs. deductible-applicable covered expenses, 7: Supports member customization of expected services or medications utilization, i.e. member can adjust the default assumptions, 8: None of the above
Account management / functionality	*Multi, Checkboxes.* 1: Supports member entry of tax status/rate to calculate federal/state tax ramifications, 2: Member can view multi-year HSA balances, 3: Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses, 4: None of the above

8.4.8.4 If any of the following five (5) features are selected in question 4.8.3 above, actual report(s) or illustrative screen prints for the procedure KNEE REPLACEMENT must be attached as Consumer 8:

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)
2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,
3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,
4) Supports member customization of expected ***professional*** services utilization or medication utilization,
5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

The functionality demonstrated in the attachment must be clearly marked. Do NOT include attachments that do not specifically demonstrate one of these features

Single, Pull-down list.
1: Consumer 8a is provided,
2: Consumer 8b is provided,
3: Consumer 8c is provided,
4: Consumer 8d is provided,
5: Consumer 8e is provided,
6: Not provided

Appendix A: Definition of Good Standing

Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
• Approved for lines of business sought in the Exchange (e.g. commercial, small group, individual)	DMHC
• Approved to operate in what geographic service areas	DMHC
• Most recent financial exam and medical survey report reviewed	DMHC
•Most recent market conduct exam reviewed	CDI
Affirmation of no material[5] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:	
• Financial solvency and reserves reviewed	DMHC and CDI
• Administrative and organizational capacity acceptable	DMHC
• Benefit Design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential health benefits (State required)	DMHC and CDI
• Basic health care services	CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (using 2015 Federal Actuarial Value Calculator)	DMHC and CDI
• Network adequacy and accessibility standards are met	DMHC and CDI
• Provider contracts	DMHC and CDI
• Language Access	DMHC and CDI
• Uniform disclosure (summary of benefits and coverage)	DMHC and CDI
• Claims payment policies and practices	DMHC and CDI
• Provider complaints	DMHC and CDI
• Utilization review policies and practices	DMHC and CDI
• Quality assurance/management policies and practices	DMHC
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI
• Independent medical review	DMHC and CDI
• Marketing and advertising	DMHC and CDI
• Guaranteed issue individual and small group	DMHC and CDI
• Rating Factors	DMHC and CDI
• Medical Loss Ratio	DMHC and CDI
• Premium rate review	DMHC and CDI
• Geographic rating regions	
• Rate development and justification is consistent with ACA requirements	DMHC and CDI

[5]Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

Appendix B: Essential Community Provider Network Requirement

Except if QHP issuer has qualified under the alternate standard for essential community providers provided by the Affordable Care Act as has been determined by the Exchange, QHP issuer shall maintain a network that includes a sufficient geographic distribution of essential community providers ("ECP") that are available through QHP issuer to provide reasonable and timely access to Covered Services to low-income populations in each geographic region where QHP issuer provides services to Enrollees.

(a) For purposes of this Section, "sufficient geographic distribution" of ECP shall be determined by the Exchange in its reasonable discretion in accordance with the conditions set forth in the Solicitation and based on a consideration of various factors, including, (i) the nature, type and distribution of QHP issuer's ECP contracting arrangements in each geographic region in which QHP issuer's QHP products provide Covered Services to Enrollees, (ii) the balance of hospital and non-hospital ECPs in each geographic region, (iii) the inclusion in Contractor's provider contracting network of at least 15% of entities in each applicable geographic region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B) ("340B Entity"), (iv) the inclusion of at least one ECP hospital in each region, (v) the inclusion of Federally Qualified Health Centers, school-based health centers and county hospitals, and (vi) other factors as mutually agreed upon by the Exchange and the QHP issuer regarding QHP issuer's ability to serve the low income population.

(b) "Low-income populations" shall be defined as families living at or below 200% of Federal poverty level. ECPs shall consist of participating entities in the following programs: (i) 340B, per the providers list as of November 9, 2012, (ii) California Disproportionate Share Hospital Program, per the Final DSH Eligibility List FY (CA DHCS 2011-12), (iii) Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs, (iv) Community Clinic or health centers licensed as either a "community clinic" or "free clinic", by the State under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code Section 1206, and (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program. Lists named in this paragraph are available here: http://www.healthexchange.ca.gov/Solicitations/Documents/Essential%20Community%20Providers.pdf

(c) During all times QHP issuer offers a product on the Exchange, QHP issuer shall notify the Exchange with respect to any material changes to its contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g., 340B), and other information relating to ECPs from prior disclosures made by QHP issuer.

(d) QHP issuer shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including, those rules set forth at 45 C.F.R. § 156.235.

Appendix C: QHP Contract Data Submission Requirements

QHP issuer shall provide to the Exchange information regarding QHP issuer's membership through the Exchange in a consistent manner to that which QHP issuer currently provides to its major purchasers. QHP issuer and the Exchange shall work together in good faith to further define mutually agreeable information and formats for QHP issuer to provide to the Exchange, in all cases to remain generally consistent with the information shared by QHP issuer with its major purchasers.

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment A- Regulatory Filings

Issuer Name:

Instructions:
Please provide the requested details associated with any Regulatory and/or Product filings necessary to obtain approval of products/plans that are to be submitted in response to this application.

Type of Filing	Regulatory Agency	Regulatory Filing Number (if applicable)	Product Filing Number (if applicable)	Date of Submission	Expected Date for Review / Approval	Amendment Number (If applicable)	Initial Filing Date (If applicable)	Comments

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment B - QHP 2015 Enrollment Projections

Issuer Name:
Product:
Market:

Please complete Attachment B enrollment projection for each product and market type. Enrollment projection should reflect anticipated enrollment January 1, 2015 through December 1, 2015

Rating Region	County	Product (HMO/EPO/PPO)	2015 Enrollment Projections
Region 1	Alpine		
Region 1	Del Norte		
Region 1	Siskiyou		
Region 1	Modoc		
Region 1	Lassen		
Region 1	Shasta		
Region 1	Trinity		
Region 1	Humboldt		
Region 1	Tehama		
Region 1	Plumas		
Region 1	Nevada		
Region 1	Sierra		
Region 1	Mendocino		
Region 1	Lake		
Region 1	Butte		
Region 1	Glenn		
Region 1	Sutter		
Region 1	Yuba		
Region 1	Colusa		
Region 1	Amador		
Region 1	Calaveras		
Region 1	Tuolumne		
Region 2	Napa		
Region 2	Sonoma		
Region 2	Solano		
Region 2	Marin		
Region 3	Sacramento		
Region 3	Placer		
Region 3	El Dorado		
Region 3	Yolo		
Region 4	San Francisco		
Region 5	Contra Costa		
Region 6	Alameda		
Region 7	Santa Clara		
Region 8	San Mateo		
Region 9	Santa Cruz		
Region 9	Monterey		
Region 9	San Benito		
Region 10	San Joaquin		
Region 10	Stanislaus		

Rating Region	County	Product (HMO/EPO/PPO)	2015 Enrollment Projections
Region 10	Merced		
Region 10	Mariposa		
Region 10	Tulare		
Region 11	Fresno		
Region 11	Kings		
Region 11	Madera		
Region 12	San Luis Obispo		
Region 12	Ventura		
Region 12	Santa Barbara		
Region 13	Mono		
Region 13	Inyo		
Region 13	Imperial		
Region 14	Kern		
Region 15	Los Angeles		
Region 16	Los Angeles		
Region 17	San Bernardino		
Region 17	Riverside		
Region 18	Orange		
Region 19	San Diego		

California Health Benefit Exchange

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Attachment C1 - Plan Type by Rating Region (Individual)

If an Issuer currently sells Small Group and Individual, the Issuer must respond for SHOP in order to bid for Individual. Selecting a box below means Issuer will submit a QHP Bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan. The 19 regions, shown below, are defined based on recent California legislation. Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels.

INDIVIDUAL								
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 1	Alpine							
Region 1	Del Norte							
Region 1	Siskiyou							
Region 1	Modoc							
Region 1	Lassen							
Region 1	Shasta							
Region 1	Trinity							
Region 1	Humboldt							
Region 1	Tehama							
Region 1	Plumas							
Region 1	Nevada							
Region 1	Sierra							
Region 1	Mendocino							
Region 1	Lake							
Region 1	Butte							
Region 1	Glenn							
Region 1	Sutter							
Region 1	Yuba							
Region 1	Colusa							
Region 1	Amador							
Region 1	Calaveras							
Region 1	Tuolumne							
Region 2	Napa							
Region 2	Sonoma							

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 2	Solano							
Region 2	Marin							
Region 3	Sacramento							
Region 3	Placer							
Region 3	El Dorado							
Region 3	Yolo							
Region 4	San Francisco							
Region 5	Contra Costa							
Region 6	Alameda							
Region 7	Santa Clara							
Region 8	San Mateo							
Region 9	Santa Cruz							
Region 9	Monterey							
Region 9	San Benito							
Region 10	San Joaquin							
Region 10	Stanislaus							
Region 10	Merced							
Region 10	Mariposa							
Region 10	Tulare							
Region 11	Fresno							
Region 11	Kings							
Region 11	Madera							
Region 12	San Luis Obispo							
Region 12	Ventura							
Region 12	Santa Barbara							
Region 13	Mono							
Region 13	Inyo							
Region 13	Imperial							
Region 14	Kern							
Region 15	Los Angeles							
Region 16	Los Angeles							
Region 17	San Bernardino							
Region 17	Riverside							
Region 18	Orange							
Region 19	San Diego							

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Attachment C2 - Plan Type by Rating Region (SHOP)

If an Issuer currently sells Small Group and Individual, the Issuer must respond for SHOP in order to bid for Individual. Selecting a box below means Issuer will submit a QHP Bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan or propose an Alternate Plan. The 19 regions, shown below, are defined based on recent California legislation. Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels.

SHOP										
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 1	Alpine									
Region 1	Del Norte									
Region 1	Siskiyou									
Region 1	Modoc									
Region 1	Lassen									
Region 1	Shasta									
Region 1	Trinity									
Region 1	Humboldt									
Region 1	Tehama									
Region 1	Plumas									
Region 1	Nevada									
Region 1	Sierra									
Region 1	Mendocino									
Region 1	Lake									
Region 1	Butte									
Region 1	Glenn									
Region 1	Sutter									
Region 1	Yuba									
Region 1	Colusa									
Region 1	Amador									
Region 1	Calaveras									
Region 1	Tuolumne									
Region 2	Napa									
Region 2	Sonoma									
Region 2	Solano									
Region 2	Marin									
Region 3	Sacramento									
Region 3	Placer									
Region 3	El Dorado									

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 3	Yolo									
Region 4	San Francisco									
Region 5	Contra Costa									
Region 6	Alameda									
Region 7	Santa Clara									
Region 8	San Mateo									
Region 9	Santa Cruz									
Region 9	Monterey									
Region 9	San Benito									
Region 10	San Joaquin									
Region 10	Stanislaus									
Region 10	Merced									
Region 10	Mariposa									
Region 10	Tulare									
Region 11	Fresno									
Region 11	Kings									
Region 11	Madera									
Region 12	San Luis Obispo									
Region 12	Ventura									
Region 12	Santa Barbara									
Region 13	Mono									
Region 13	Inyo									
Region 13	Imperial									
Region 14	Kern									
Region 15	Los Angeles									
Region 16	Los Angeles									
Region 17	San Bernardino									
Region 17	Riverside									
Region 18	Orange									
Region 19	San Diego									

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment D1 - 834 Enrollment File Error Listing

March 2014 834 Enrollment File Error Listing				
834 Enrollment Files Sent to Carrier - File Names	**Number of Members in File**	**Carrier 999 Response File Sent to CalHEERS**	**No. of Rejected Files in 999 Response Due to Carrier Issues**	**Error Rate**
ex: TO_999999_IND_2014030515897.edi	500	ex: FROM_99999_IND_2014030565	4	0.8%

California Health Benefit Exchange
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Attachment D2 - 834 Effectuation File Error Listing

March 2014 834 Effectuation File Error Listing				
834 Effectuation Files Sent from the Carrier - File Names	**Number of Members in File**	**CalHEERS 999 Response File Sent to CalHEERS**	**No. of Rejected Files in 999 Response Due to Carrier Issues**	**Error Rate**
ex: FROM_99999_IND_2014030515897.edi	500	ex:TO_99999_IND_201403056577899.edi	4	0.8%