

# 1 **Program Attestations**

## 2 **General Issuer Attestations**

3 1.) Applicant attests that it will adhere to all requirements contained in 45 CFR 156, and all  
4 applicable federal and state law.

5 2.) Applicant attests that it will have a license by the end of the certification period, be in good  
6 standing, and be authorized to offer each specific type of insurance coverage offered in each  
7 State in which the issuer offers a QHP.

8 3.) Applicant attests that it will be bound by 2 CFR 376 and that no individual or entity that is a  
9 part of the Applicant's organization is excluded by the Department of Health and Human  
10 Services Office of the Inspector General or by the General Services Administration. This  
11 attestation includes any member of the board of directors, key management or executive staff or  
12 major stockholder of the applicant and its affiliated companies, subsidiaries or subcontractors.

13 4.) Applicant attests that it will inform HHS, based on its best information, knowledge and  
14 belief, of any federal or state government current or pending legal actions, criminal or civil,  
15 convictions, administrative actions, investigations or matters subject to arbitration against the  
16 applicant (under a current or former name), its principals, or any of its subcontractors. The  
17 applicant also attests that, based on its best information, knowledge and belief, none of its  
18 principals, nor any of its affiliates is presently debarred, suspended, proposed for debarment, or  
19 declared ineligible to participate in Federal programs by HHS or another Federal agency under 2  
20 CFR 180.970 or any other applicable statute or regulation, and should such actions occur, it will  
21 inform HHS within 5 working days of learning of such action.

22 5.) Applicant attests that it will not discriminate on the basis of race, color, national origin,  
23 disability, age, sex, gender identity or sexual orientation.

24 6.) Applicant attests that it will market its QHPs in accordance with all applicable state laws and  
25 regulations and will not employ discriminatory marketing practices in accordance with 45 CFR  
26 156.225.

27 7.) Applicant attests that it will adhere to all non-renewal and decertification requirements in  
28 accordance with 45 CFR 156.290.

29 8.) Applicant attests that it will adhere to requirements related to the segregation of funds for  
30 abortion services consistent with 45CFR 156.280 and all applicable guidance, as applicable.

31 9.) Applicant attests that it will adhere to provisions addressing payment of federally-qualified  
32 health centers in 45 CFR 156.235(e).

## 33 **Compliance Plan**

34 Applicant attests that it has a compliance plan that adheres to all applicable laws, regulations,  
35 and guidance, that the compliance plan is ready for implementation, and that the applicant agrees

36 to reasonably adhere to the compliance plan provided. Any changes to the compliance plan will  
37 be submitted to HHS for review.

38 Applicant will upload a copy of the applicant's compliance plan.

### 39 **Organizational Chart**

40 Applicant attests that it is providing its organizational chart and that it will inform HHS of any  
41 significant changes to the organizational chart provided within 30 days of that change after the  
42 submission of this application.

43 Applicant will upload a copy of the applicant's organizational chart.

### 44 **Operational Attestations**

45 1.) Applicant attests that it will notify HHS of any pending change in ownership of the QHP  
46 issuer or that issuer's parent entities and will obtain approval for transfer of responsibility for its  
47 QHPs prior to making any change in ownership.

48 2.) Applicant attests that it will comply with all QHP requirements, including technical  
49 requirements related to the use of FFE Plan Management system, on an ongoing basis and  
50 comply with Exchange systems, tools, processes, procedures, and requirements.

51 3.) Applicant attests that it has in place an effective internal claims, grievance, and appeals  
52 process that complies with 45 CFR 147.136 as applicable, and agrees to act in accordance with  
53 all requirements for an external review process with respect to QHP enrollees in an applicable  
54 State or Federal external review process in compliance with 45 CFR 147.136 as applicable.

### 55 **Benefit Design Attestations**

56 1.) Applicant attests that it will not employ benefit designs that have the effect of discouraging  
57 the enrollment of individuals with significant health needs or pre-existing conditions in QHPs in  
58 accordance with 45 CFR 156.225.

59 2.) Applicant attests that it will comply with all benefit design standards, federal regulations and  
60 laws, and state mandated benefits for all services including: preventive services, emergency  
61 services, and formulary drug list.

62 3.) Applicant attests that it will abide by all cost-sharing limits:

63 a.) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) for  
64 emergency department services is the same regardless of provider network status, as applicable;

65 b.) it will make available enrollee cost sharing under an individual's plan or coverage for a  
66 specific item or service, consistent with 45 CFR 156.220.

67 4.) Applicant attests that it will follow all Actuarial Value requirements.

- 68 5.) Applicant attests that it will offer through the Exchange a minimum of one QHP at the silver  
69 coverage level and one QHP at the gold coverage level in accordance with 45 CFR 156.200(c),  
70 or a minimum of one plan at either a high or low coverage level for issuers of stand-alone dental  
71 plans.
- 72 6.) Applicant attests that it will offer a child-only QHP(s) at the same level of coverage(s) as any  
73 QHP or stand-alone dental plans offered through the Exchange in accordance with 45 CFR  
74 156.200(c).
- 75 7.) Applicant attests that its catastrophic QHPs will only enroll individuals under the age of 30 or  
76 individuals deemed exempt from the individual mandate.
- 77 8.) Applicant attests that its QHPs provide coverage for each of the 10 statutory categories of  
78 EHB in accordance with the applicable EHB benchmark plan and federal law:
- 79 a.) its QHPs provide benefits and limitation on coverage that are substantially equal to those  
80 covered by the EHB-benchmark plan;
- 81 b.) it complies with the requirements of 45 CFR 146.136 with regard to mental health and  
82 substance use disorder services, including behavioral services;
- 83 c.) it provides coverage for preventive services described in 45 CFR 147.130;
- 84 d.) it complies with EHB requirements with respect to prescription drug coverage;
- 85 e.) any benefits substituted in designing QHP plan benefits are actuarially equivalent to those  
86 offered by the EHB benchmark plan;
- 87 f.) it complies with the prohibition on discrimination with regard to EHB;
- 88 g.) its QHPs' benefits reflect an appropriate balance among the EHB categories, so that benefits  
89 are not unduly weighted toward any category;
- 90 h.) its QHPs include all applicable state required benefits.

91 **Stand-Alone Dental Attestations**

- 92 1.) Applicant attests that all stand-alone dental plans that it offers it will comply with all benefit  
93 design standards and federal regulations and laws for stand-alone dental plans, as applicable,  
94 including that:
- 95 a.) the out-of-pocket maximum for its stand-alone dental plan is reasonable for the coverage of  
96 pediatric dental EHB;
- 97 b.) it offers the pediatric dental EHB;
- 98 c.) it does not include annual and lifetime dollar limits on the pediatric dental EHB.
- 99 2.) Applicant attests that any stand-alone dental plans it offers are limited scope dental plans.

100 3.) Applicant attests that any stand-alone dental plans it offers will adhere to the standards set  
101 forth by HHS for the administration of advance payments of the premium tax credit.

102 Applicant attests that it either offers no stand-alone dental plans, or attests to all of the above.

103 **Rate Attestations**

104 Applicant attests that it will comply with all rate requirements as applicable, including that it  
105 will:

106 a.) charge the same rates for each qualified health plan, or stand-alone dental plan, of the issuer  
107 without regard to whether the plan is offered through an Exchange or whether the plan is offered  
108 directly from the issuer or through an agent;

109 b.) set rates for an entire benefit year, or for the SHOP, plan year and submit the rate and benefit  
110 information to the Exchange as required in 45 CFR 156.210;

111 c.) submit to the Exchange a justification for a rate increase prior to the implementation of an  
112 increase;

113 d.) prominently post rate increase justifications on its Web site;

114 e.) adhere to all rating area variation requirements pursuant to 45 CFR 156.255 for QHPs;

115 f.) comply with federal rating requirements or the state's Affordable Care Act compliant rating  
116 requirements, as applicable.

117 **Enrollment**

118 1.) Applicant attests that it will meet the individual market requirement to:

119 a.) enroll a qualified individual during the initial and subsequent annual open enrollment periods  
120 and abide by the effective dates of coverage;

121 b.) make available, at a minimum, special enrollment periods (SEPs) established by the  
122 Exchange and abide by the effective dates of coverage determined by the Exchange.

123 2.) Applicant attests that it will enable enrollees to make enrollment changes during open and  
124 special enrollment periods for which they are eligible.

125 3.) Applicant attests that it will only terminate coverage as permitted by the Exchange and  
126 applicable State or federal law:

127 a.) the applicant will abide by the termination of coverage effective dates requirements;

128 b.) the applicant will maintain termination records in accordance with Exchange standards;

- 129 c.) the applicant will provide the enrollee with a notice of termination of coverage, consistent  
130 with the effective date required by applicable regulations, if terminating an enrollee's coverage  
131 for any reason. Notices must include an explanation of the reason for the termination. When  
132 applicable, the applicant will include in the notice an explanation of the enrollee's right to  
133 appeal;
- 134 d.) the applicant will establish a standard policy for the termination of coverage of enrollees due  
135 to non-payment of premium, provision of fraudulent application information or abuse of his or  
136 her benefit cards.
- 137 4.) Applicant attests that it will provide enrollees with required documentation including: an  
138 enrollment information package, effective dates of coverage, summary of benefits and coverage,  
139 evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials,  
140 ID cards, and any notices as required by State or federal law.
- 141 5.) Applicant attests that it will adhere to enrollment information collection and transmission  
142 requirements and will:
- 143 a.) accept enrollment information in an electronic format from the Exchange that is consistent  
144 with requirements;
- 145 b.) reconcile enrollment files with the Exchange no less than once a month;
- 146 c.) acknowledge receipt of enrollment information in accordance with Exchange standards and;
- 147 d.) timely, accurately and thoroughly process enrollment transactions and submit electronic 834  
148 confirmation files to the Exchange to confirm the enrollees portion of the premium has been paid  
149 and coverage has been effectuated.
- 150 6.) Applicant attests that if applicant utilizes Application Programming Interface (API) provided  
151 by the Exchange, the applicant will:
- 152 a.) direct individuals to the Exchange in order to initiate the eligibility process;
- 153 b.) enroll an individual only after receiving confirmation from the Exchange that the eligibility  
154 process is complete and the individual has been determined eligible for enrollment in a QHP, in  
155 accordance with the standards.
- 156 7.) Applicant attests that the Issuer will follow the premium payment process requirements  
157 established by the Exchange in accordance with §156.265(d) and future guidance.
- 158 8.) Applicant attests that it will provide a grace period of at least three consecutive months if an  
159 enrollee receiving advance payments of the premium tax credit has previously paid-in-full at  
160 least one month's premium. If an enrollee exhausts the grace period without submitting payment

161 in full of outstanding premium due, the applicant will terminate the enrollee's coverage effective  
162 at the end of first month of the payment grace period.

163 9.) Applicant attests that it will provide the enrollee with notice of payment delinquency if an  
164 enrollee is delinquent on premium payment.

165 10.) Applicant attests that it will develop, operate and maintain viable systems, processes,  
166 procedures, and communication protocols for:

167 a.) the timely, accurate and valid enrollment and termination of enrollees' coverage within the  
168 exchange;

169 b.) the prompt resolution of urgent issues affecting enrollees, such as changes in enrollment and  
170 discrepancies identified during reconciliation.

171 11.) Applicant attests that it will accept the total premium breakdown as determined by the  
172 Exchange and as specified in the electronic enrollment transmission. This includes:

173 a.) the total premium amount which is based on rate attestations submitted by the applicant;

174 b.) the APTC amount;

175 c.) any other payment amounts as depicted on the enrollment transmission.

176 12.) Applicant attests that it will accept the advance CSR amount as determined by the Exchange  
177 and as specified in the electronic enrollment transmission.

178 13.) Applicant attests that it will approve of the use of the following information for display on  
179 the FFE Web site for consumer education purposes: information on rates and premiums,  
180 information on benefits, the provider network URL(s) provided in this application, the URL(s)  
181 for the Summary of Benefits and Coverage provided in this application, the URL(s) for payment  
182 provided by this application, information on whether the issuer is a Medicaid managed care  
183 organization, and quality information, as applicable, derived from the accreditation survey,  
184 including accreditation status and CAHPS data.

## 185 **Financial Management**

186 1.) Applicant attests that it will acknowledge and agree to be bound by Federal statutes and  
187 requirements that govern Federal funds. Federal funds include, but are not limited to, advance  
188 payments of the premium tax credit, cost-sharing reductions, and Federal payments related to the  
189 risk adjustment, reinsurance, and risk corridor programs.

190 2.) Applicant attests that it will adhere to the risk corridor standards and requirements set by  
191 HHS as applicable for:

- 192 a.) risk corridor data standards and annual HHS notice of benefit and payment parameters for the  
193 calendar years 2014, 2015, and 2016 (45 CFR 153.510);
- 194 b.) remit charges to HHS under the circumstances described in 45 CFR 153.510( c).
- 195 3.) Applicant attests that it will adhere to the standards set forth by HHS for the administration of  
196 advance payments of the premium tax credit and cost sharing reductions, including the  
197 provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, 156.460, and 156.470.
- 198 4.) Applicant attests that it will submit to HHS the applicable plan variations that adhere to the  
199 standards set forth by HHS at 45 CFR 156.420.
- 200 5.) Applicant attests that it will pay all user fees in accordance with 45 CFR 156.200(b)(6).
- 201 6.) Applicant attests that it will reduce premiums on behalf of eligible individuals if the  
202 Exchange notifies the QHP Issuer that it will receive an APTC on behalf of that individual  
203 pursuant to §156.460.
- 204 7.) Applicant attests that it will adhere to the data standards and reporting for the CSR  
205 reconciliation process pursuant to 45 CFR 156.430(c) for QHPs.
- 206 8.) The following applies to applicants participating in the risk adjustment and reinsurance  
207 programs inside and/or outside of the Exchange. Applicant attests that it will:
- 208 a.) adhere to the risk adjustment standards and requirements set by HHS in the annual HHS  
209 notice of benefit and payment parameters (45 CFR Subparts G and H);
- 210 b.) remit charges to HHS under the circumstances described in 45 CFR 153.610;
- 211 c.) adhere to the reinsurance standards and requirements set by HHS in the annual HHS notice of  
212 benefit and payment parameters (45 CFR 153.400, 153.405, 153.410, 153.420);
- 213 d.) remit contributions to HHS under the circumstances described in 45 CFR 153.405;
- 214 e.) establish dedicated and secure server environments to host enrollee claims, encounter, and  
215 enrollment information for the purpose of performing risk adjustment and reinsurance operations  
216 for all plans offered;
- 217 f.) allow proper interface between the dedicated server environment and special, dedicated CMS  
218 resources that execute the risk adjustment and reinsurance operations;
- 219 g.) ensure the transfer of timely, routine, and uniform data from local systems to the dedicated  
220 server environment using CMS-defined standards, including file formats and processing  
221 schedules;
- 222 h.) comply with all information collection and reporting requirements approved through the  
223 Paperwork Reduction Act of 1995 and having a valid OMB control number for approved

224 collections. The Issuer will submit all required information in a CMS-established manner and  
225 common data format;

226 i.) cooperate with CMS, or its designee, through a process for establishing the server  
227 environment to implement these functions, including systems testing and operational readiness;

228 j.) use sufficient security procedures to ensure that all data available electronically are authorized  
229 and protect all data from improper access, and ensure that the operations environment is  
230 restricted to only authorized users;

231 k.) provide access to all original source documents and medical records related to the eligible  
232 organization's submissions, including the beneficiary's authorization and signature to CMS or  
233 CMS' designee, if requested, for audit;

234 l.) retain all original source documentation and medical records pertaining to any such particular  
235 claims data for a period of at least 10 years;

236 m.) be responsible for all data submitted to CMS by itself, its employees, or its agents and based  
237 on best knowledge, information, and belief, submit data that are accurate, complete, and truthful;

238 n.) all information, in any form whatsoever, exchanged for risk adjustment shall be employed  
239 solely for the purposes of operating the premium stabilization programs and financial programs  
240 associated with state markets, including but not limited to, the calculation of user fees to fund  
241 such programs, oversight, and any validation and analysis that CMS determines necessary.

242 9.) The following attestation applies to applicants participating in the Exchanges and premium  
243 stabilization programs as defined in the Affordable Care Act and applicable regulations. Under  
244 the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another  
245 person or entity to submit, false claims for payment of government funds are liable for three  
246 times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim. 18  
247 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the  
248 jurisdiction of any department or agency of the United States knowingly and willfully falsifies,  
249 conceals, or covers up by any trick, scheme, or device, a material fact, or makes any false,  
250 fictitious or fraudulent statements or representations, or makes any false writing or document  
251 knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual  
252 offenders are subject to fines of up to \$250,000 and imprisonment for up to 5 years. Offenders  
253 that are organizations are subject to fines up to \$500,000. 18 U.S.C. 3571(d) also authorizes  
254 fines of up to twice the gross gain derived by the offender if it is greater than the amount  
255 specifically authorized by the sentencing statute. Applicant acknowledges the False Claims Act,  
256 31 U.S.C., §§ 3729-3733.

257 10.) The following applies to applicants participating in the Exchanges and premium  
258 stabilization programs as defined in the Affordable Care Act and applicable regulations.  
259 Applicant attests to provide and promptly update when applicable changes occur in its Tax  
260 Identification Number (TIN) and associated legal entity name as registered with the Internal  
261 Revenue Service, financial institution account information, and any other information needed by  
262 CMS in order for the applicant to receive invoices, demand letters, and payments under the



263 APTC, CSR, user fees, reinsurance, risk adjustment, and risk corridors programs, as well as, any  
264 reconciliations of the aforementioned programs.

265 11.) The following applies to applicants participating in the Exchanges and premium  
266 stabilization programs as defined in the Affordable Care Act and applicable regulations.  
267 Applicant attests that it will develop, operate and maintain viable systems, processes, procedures  
268 and communication protocols to accept payment-related information submitted by CMS.

## 269 **SHOP**

270 1.) Applicant attests that it will adhere to the SHOP issuer requirements set by HHS in 45 CFR  
271 156.285.

272 2.) Applicant attests that it will not vary premiums based on whether or not the employer offers  
273 employees a choice among QHPs.

274 3.) Applicant attests that it will issue SHOP QHP policies naming the qualified employer rather  
275 than the SHOP as the policyholder.

276 4.) Applicant attests that it waives the application of any minimum participation rates calculated  
277 at the issuer level that may be allowed under state law.

278 Applicant attests that it either offers no SHOP plans, or attests to all of the above.

## 279 **Reporting Requirements**

280 1.) Applicant attests that it will provide to the Exchange the following information in the manner  
281 identified by HHS, as applicable: claims payment policies and practices; periodic financial  
282 disclosures; data on enrollment; data on disenrollment; data on the number of claims that are  
283 denied; data on rating practices; information on cost-sharing and payments with respect to any  
284 out-of-network coverage; and information on enrollee rights under title I of the Affordable Care  
285 Act.

286 2.) Applicant attests that it will report required data on prescription drug distribution and costs  
287 consistent with 45 CFR 156.295 and all applicable guidance.

288 3.) Applicant attests that it will comply with the specific quality disclosure, reporting and  
289 implementation requirements of 45 CFR §156.200(b)(5) as will be detailed in future guidance.