

## 2021 Plan Year QIS Participation Criteria Fact Sheet

This fact sheet is intended to help issuers understand the quality improvement strategy (QIS) participation criteria as they review the draft 2021 Plan Year QIS Issuer List. The draft Issuer List includes issuers that offer plans in states on the Federally-facilitated Exchange (FFE) (Exchange) or in a state performing plan management activities.

Issuers should refer to this fact sheet if they have questions about how to determine whether they meet the QIS participation criteria and, therefore, are included in the draft 2021 Plan Year QIS Issuer List.

**NOTE: In response to the coronavirus pandemic, CMS has suspended activities related to the collection and reporting of data for the QIS for the 2021 Plan Year.**

If the issuer:	
✓	Offered coverage through an Exchange in Plan Years 2018 and 2019. <sup>1</sup>
✓	Provides family and/or adult-only medical coverage. <sup>2</sup>
✓	Had at least 500 enrollees as of July 1, 2019. <sup>3 4</sup>
<b>Then the issuer should implement a new QIS and submit Sections A-E of the QIS Implementation Plan and Progress Report.</b>	

If the issuer also:	
✓	Submitted an Implementation Plan or Progress Report for the 2020 Plan Year. <sup>5 6 7</sup>
✓	Is applying for QHP Certification in the FFEs for the 2021 Plan Year.
<b>Then the issuer should report on progress by submitting Sections A-G of the QIS Implementation Plan and Progress Report</b>	

If the issuer:	
✓	Wants to discontinue its existing QIS and still meets the QIS participation criteria.
<b>Then the issuer should complete and submit two QIS forms: one to report progress and discontinue its current QIS (Sections A-G), and one to implement its new QIS (Sections A-E).</b>	

<sup>1</sup> The QIS reporting requirements apply to issuers that have been operating in an Exchange for two consecutive years and will continue operating in the Exchange in 2020, regardless of whether their qualified health plans (QHPs) have changed during that time. If the issuer offered coverage in the 2019 and 2020 Plan Years, but not in the 2018 Plan Year OR if the issuer is not continuing coverage in the 2021 Plan Year, it would NOT meet the participation criteria for QIS.

<sup>2</sup> Eligible QHPs are QHPs offered through the Exchange at all levels of coverage for the following product types: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS) plans, exclusive provider organizations (EPOs), and indemnity plans. These eligibility criteria apply to QHPs that are compatible with Health Savings Accounts (HSAs), also known as HSA-eligible plans. These eligibility criteria does not apply to child-only plans or stand-alone dental plans (SADPs).

<sup>3</sup> The QIS minimum enrollment threshold is defined as 500 enrollees within a product type per state on July 1, 2019. Enrollees who purchased insurance outside the Exchange (off-Exchange) should not be included in the minimum enrollment calculation.

<sup>4</sup> An issuer that changes a product type will continue to meet the minimum enrollment threshold when the issuer: (a) crosswalks enrollees from the old product type to a different one, and (b) still has at least 500 enrollees in the new product type.

<sup>5</sup> An issuer should submit two consecutive years of QIS Progress Reports if it is continuing a QIS, regardless of whether the issuer's product type(s) continues to meet the minimum enrollment threshold.

<sup>6</sup> An issuer may discontinue its QIS Progress Report submissions if a QIS for its product type(s) no longer meets the minimum enrollment threshold prior to the third consecutive year of submitting a QIS Progress Report.

<sup>7</sup> If the issuer's product type(s) meets the minimum enrollment threshold for the third consecutive year of submitting a QIS Progress Report, the issuer should submit the Progress Report for an additional two consecutive years.