Carrier Reference Manual

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I. Summary of Changes from 2016 Carrier Manual

The significant updates in this 2017 Carrier Manual are as follows:

- 2017 Essential Health Benefit (EHB) benchmark plan information and expanded resources.
- Additional information on Dental Specific Rating Rules and requirements for embedded pediatric dental benefits.
- The section on Nondiscrimination has been revised to reflect new certification standards adopted by HBX. Carriers must submit to the HBX a copy of the insurance contract also known as a certificate of coverage/evidence of coverage for each certified qualified health plan. Further, DISB Guidance on Nondiscrimination in Benefit Design is attached as new Appendix D.
- Language has been added to the Rating Rules and Rate Review section clarifying issues around the index rate and merged risk pool.
- Enhanced guidance on Rate Review requirements provided by DISB.
- A section on Summary of Benefits and Coverage (SBCs) has been modified, giving guidance on format and file name conventions, and deadlines.
- The Carrier Submission process section has been updated with new filing deadlines for 2017 and CCIIO templates for 2017 that must be submitted.

II. Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. A key provision of the law requires all states to participate in an American Health Benefit Exchange beginning January 1, 2014. The District of Columbia declared its intention to establish a state -based health benefit exchange in 2011 with the introduction and enactment of the *Health Benefit Exchange Authority Establishment Act of 2011*, effective March 3, 2012 (D.C. Law 19-0094).

The *Health Benefit Exchange Authority Establishment Act of 2011* establishes the following core responsibilities for the Exchange:

(1) Enable individuals and small employers to find affordable and easier-to-understand health insurance;
(2) Facilitate the purchase and sale of qualified health plans;
(3) Assist small employers in facilitating the enrollment of their employees in qualified health plans;
(4) Reduce the number of uninsured;
(5) Provide a transparent marketplace for health benefit plans;
(6) Educate consumers; and

(7) Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions. [1]

The DC Health Benefit Exchange Authority is responsible for the development and operation of all core Exchange functions including the following:

- Certification of Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs)
- Operation of a Small Business Health Options Program (SHOP)
- Consumer support for making coverage decisions
- Eligibility determinations for individuals and families
- Enrollment in QHPs
- Contracting with certified carriers
- Determination for exemptions from the individual mandate

The *Health Benefit Exchange Authority Establishment Act of 2011* allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. This manual and appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. Health and dental carriers offering coverage in the individual and/or small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in this manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

III. Carrier Participation

The DC Health Link is open to all health and dental carriers and qualified health and dental plans that meet the requirements set forth in Section 1301 of the ACA and by the DC Health Benefit Exchange Authority (the "Authority"). The Authority intends to contract with any licensed health carrier ("Carrier") that offers a health insurance plan that meets minimum requirements for certification as a qualified health plan (QHP) under federal and District law and Exchange requirements. Licensed health carriers include an accident and sickness insurance company, a health maintenance organization (HMO), a hospital and medical services corporation, a non-profit health service plan, a dental plan organization, a multistate plan, or any other entity providing a qualified health benefit plan.

HBX will also contract with any licensed dental carrier that offers a stand-alone dental plan for the individual market that meets minimum requirements for certification as a qualified dental

[1] Sec.3, Health Benefit Exchange Authority Establishment Act of 2011

plan (QDP) under federal and District law and exchange requirements. Stand-alone dental plans will be added to SHOP when the functionality becomes available.

IV. Essential Health Benefits

Pursuant to HHS rules requiring the adoption of a new benchmark for plan year 2017, the District designated the Group Hospitalization and Medical Services, Inc. (CareFirst) BluePreferred PPO $1,000-100%/80% as the base-benchmark plan. The selection is consistent with the District's previous benchmark selection for plans sold from 2014-2016. The GHMSI BluePreferred PPO plan was the largest small group health plan sold in the District during the first quarter of the 2014 plan year.

Pediatric vision and dental benefits in the Federal Employees Dental and Vision Insurance Program (FEDVIP) with the largest national enrollment have been defined as the pediatric vision and pediatric dental essential health benefits.

Habilitative services have been defined as services that help a person keep, learn, or improve skills, and functioning for daily living, including, but not limited to, Applied Behavioral Analysis for the treatment of autism spectrum disorder.

The following resources provide more detail on the District's benchmark plan:

1. 2014-2016 Summary of EHB Benchmark Plan Benefits
2. District-required Benefits
3. 2017 EHB Benchmark Plan Information

The drug formulary of each Carrier offering a QHP must include the greater of:

1. One drug in each category and class of the United States Pharmacopieal Convention (USP), or
2. The number of drugs in each USP class and category in the Essential Health Benefits package.[2]

Further guidance on the EHB benchmark package, including an itemized list of required benefits, can be found on DISB's website (http://disb.dc.gov) or by clicking here.

[2] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule." 78 Federal Register 37 (25 February 2013). pp. 12834 – 12872.

V. Network Adequacy

A carrier is required to submit the CCIIO Federal Network Template and the CCIIO Network Adequacy Template to DISB when the carrier files QHPs for approval.

A carrier must submit provider data at regular intervals and in agreed to format for use to populate DC Health Link's single provider directory search tool.

Pursuant to federal requirements,each carrier must make its provider directory for a QHP available on its website. It must also make the directory available to DC Health Link for publication online and to enrollees or potential enrollees in hard copy upon request. The QHP provider directory must provide an up- to-date listing of providers and clearly designate providers that are not accepting new patients.

As of October 1, 2015, carriers must prominently post a phone number or email address on their on-line and print provider directories (not necessarily a dedicated phone number or email address) for consumers to report inaccurate provider directory information. Carriers must will be required, within 30 days, validate reports that directories are inaccurate or incomplete and, when appropriate, to correct the provider information. The carrier will be required to maintain a log of consumer reported provider directory complaints that would be accessible to DISB or HBX upon request.

Carriers are required to take steps to maintain a high level of accuracy in their provider directories. Annually, a carrier is required to take at least one of the following steps and report such steps to DISB:

1. Perform regular audits reviewing provider directory information.
2. Validate provider information where a provider has not filed a claim with a carrier in 2 years (or a shorter period of time).
3. Take other innovative and effective actions approved by DISB to maintain accurate provider directories. For example, an innovative and effective action is validating provider information based on provider demographic factors such as an age where retirement is likely.

Carriers must submit an Access Plan to HBX upon request. The template for the Access Plan will be developed by the Plan Management Advisory Committee.

VI. Nondiscrimination

Carriers must submit to HBX a copy of the insurance contract also known as a certificate of coverage/evidence of coverage for each certified qualified health plan. Submission to HBX must be consistent with the timing requirements under federal law for required disclosure.

VII. Standard Plans

In the individual marketplace, carriers are required to offer one standard QHP plan for each metal level of QHPs it offers. Standard plan information for 2016 can be found here. A stakeholder working group is revising standards and plans to complete its work in April. Additional guidance for 2017 standard plans will be provided in April or May and in a future version of this manual.

If a benefit is not listed on the standard plan template, carriers must follow the DC Benchmark Plan for non-listed benefits. In this context, "Carrier" means each licensed entity with its own NAIC Company Code.

VIII. Rating Rules and Rate Review

A. Merged Risk Pool

The individual and small group market shall be merged into a single risk pool for rating purposes in the District.[3] The index rate must be developed by pooling individual and small group market experience at the licensed entity level. The merged risk pool does not change how Carriers may choose to offer plans in the individual or small group markets. For federal reporting purposes, Carriers shall use unmerged market standards.[4] Limited exceptions to the merged risk pool include student health plans, and grandfathered health plans.[5] Catastrophic plans must be developed by making plan level adjustments to the index rate. [6]

The index rate for federal reporting must be the same for individual and small group markets. Carriers should merge claims experience for the individual and small group markets into a single risk pool in order to calculate this single index rate prior to applying separate modifiers for risk adjustment, reinsurance, and risk corridors. Carriers

[3] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule." 78 Federal Register 39 (27 February 2013). pp. 13406 – 13442.
[4] Id.
[5] Id.
[6] 45 CFR 156.80(d)(2)

should then apply the separate modifiers and, therefore, create separate "market-adjusted index rates" for individual and small group markets, i.e. , the market-level adjustments made to the Index Rate to produce the Market Adjusted Index Rate, and the plan-level adjustments that are applied to produce the Plan Adjusted Index Rates .

The District has been approved to use a hybrid approach to the merging of its markets which requires issuers to utilize a single risk pool of individual and small group claims in the development of the index rate; however, all other aspects of rate development are separate for each market. All assumptions used in producing the Index Rate, Market Adjusted Index Rate, Plan Adjusted Index Rates, and consumer level premiums are reviewed by DISB for reasonableness and consistency with federal and District law.

For federal reporting purposes, medical loss ratios should also be calculated separately for each market.[7]

In addition, filing for the small group can include a quarterly adjustment to the index rate as authorized by federal regulations. Due to limitations with federal systems, rates may only be submitted once per year for both markets.[8]

Carriers should follow the approach below to rate setting for QHPs in the merged risk pool:

Step 1. Determine the base period allowed cost PMPM by combining the small group and individual experience.

Step 2. Develop the Index Rate by projecting PMPM from the result of Step 1 and adjusting for the following items:
- (a) Trend (including cost, utilization, changes in provider mix, etc.)
- (b) Future population morbidity changes for the combined individual and small group markets (due to the impact of items such as guarantee issue, premium subsidies, impact of adjusted community rating, etc.)
- (c) Adding or removing benefits to arrive at the projected Essential Health Benefits (EHB) benchmark.

Step 3. Apply modifiers to the Index Rate separately for individual and small group:
- (a) Apply projected transitional reinsurance receipts and subtract/add expected individual risk adjustment receipts/payments to the Index Rate to use for individual insurance.
- (b) Subtract/add expected small group risk adjustment receipts/payments to the Index Rate to use for small group insurance.

Step 4. Develop plan-specific rates from the results of Step 3 by adjusting for plan-specific modifiers.

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[7] "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule." U.S. Department of Health and Human Services (December 1. 2010)

[8] "Rate Changes for Small Group Market Plans and System Processing of Rates." Centers for Medicare and Medicaid Services Memorandum (April 8, 2013).

Please note that transitional reinsurance receipts should be applied only to the individual market to be consistent with federal regulations.

B. Permissible Rating Factors

Rates may be adjusted for age and family composition. All other rate factors – including but not limited to gender, tobacco use, group size (small businesses), industry, health, and geographic rating within the District – are prohibited.

Before separating the experience into two separate lines of business (individual and small group lines of business), the following adjustment factors are allowed to arrive at the ACA EHB single risk pool of "allowed costs" (i.e. the index rate);

- An adjustment to remove non-EHB benefits that are included in the base period and/or manual experience
- An adjustment to include additional EHB's (including Pediatric Dental) which are not reflected in the base period experience
- A utilization adjustment (i.e. induced demand) to reflect differences between the average benefit utilization underlying the base period experience and the average benefit utilization underlying the projection period
- A demographic adjustment to reflect the average demographics anticipated in the projection period
- A product/network to reflect the average product/network mix in the projection period
- A morbidity adjustment to reflect the average morbidity anticipated in the projection period
- Trend to account for anticipated changes in provider contracts and utilization
- Pent up demand adjustment
- Other applicable carrier-specific adjustments

Please note that result after application of the above adjustment factors is the combined/merged single risk pool (projected period) index rate prior to applying the separate modifiers for each separate (individual and small group) lines of business.

Then after separating into two separate lines of business for individual and small group, the following market level adjustment factors are allowed and must be applied equally to all plans:

- An adjustment for risk adjustment including anticipated risk transfer payments and the risk adjustment user fee
- An adjustment for transitional reinsurance, including a reinsurance recovery adjustment factor and an amount for the reinsurance fee
- Exchange fee fixed cost adjustment

Five plan level adjustments are then allowed by regulation and may vary for each plan, as actuarially supported:

- The impact of benefits and actuarial value, including an induced demand adjustment to account for differences between the average induced demand underlying the index rate and the anticipated induced demand of each plan
- Product/network adjustment
- Non-EHB items adjustment
- Administrative retention expenses
- Catastrophic adjustment factor (applied only to Catastrophic plans)

The following calibration factors must then be applied:

- Average age calibration factor (based on the average age underlying the index rate)
- A calibration adjustment to account for a billable member limit of no more than three children under the age of 21

Carriers must use standardized age bands comprised of a single age band for children aged 0 to 20, one year age bands for adults 21 to 64, and a single age band for adults 64 and older. Age rating cannot vary by more than 3:1 between adults that are 21 and adults that are 64[9]. The Exchange will use an age curve developed by the Department of Insurance Securities and Banking (DISB). See Appendix A for more information about the age rating curve.

C. Plans Using the AVC

The Plans & Benefits Template uses the AVC to calculate AVs for all standard, non-catastrophic plans, all silver plan CSR variations, and all limited cost sharing plan variations. If AVs cannot be calculated, the *AV Calculator Output Number* remains blank. If *Unique Plan Design?* equals "Yes" on the Benefits Package worksheet of the Plans & Benefits Template, the AV from the AVC is not used during validation; instead, the *Issuer Actuarial Value* entered by the issuer into the Cost Share Variances worksheet is used to validate that the plan's AV falls within the relevant de minimis range.

If the Cost Share Variance worksheet contains both unique plan designs and non-unique plan designs, the Check AV Calculator procedure attempts to calculate an AV for the unique as well as the non-unique plan designs. If the stand-alone AVC returns an error for a unique plan design, resulting in a blank *AV Calculator Output Number*, the issuer does not need to address the error to validate the template; so long as the *Issuer Actuarial Value* falls within the relevant de minimis range for unique plan designs, the

[9] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule." 78 Federal Register 39 (27 February 2013). pp. 13406 – 13442.

template validates. While not required, the Centers for Medicare & Medicaid Services (CMS) recommends that issuers run the Check AV Calculator procedure on Cost Share Variance worksheets that contain only unique plan designs so that the issuer's submission includes the *AV Calculator Output Number* for plans that do not generate an error in the stand-alone AVC.

A de minimis variation of ±2 percentage points is used for standard metal-level plans, while ±1 percentage point is used for CSR silver plan variations.

Calculation of Employer Contribution for Health Reimbursement Arrangement (HRA) and Health Savings Account (HSA) Plans Offered in SHOP

The employer contribution is not allowed to be included in determining the Actuarial Value (AV) of a QHP.

D. Rate Development and Review

The Department of Insurance Securities and Banking will review all rates including rates for DC Health Link products. DISB evaluates rates based on recent and future costs of medical care and prescription drugs, the company's financial strength, underwriting gains, and administrative costs. DISB also considers the company's overall profitability, investment income, surplus, and public comments. Companies must show that the requested rate is reasonable considering the plan's benefits, and overall rates must be projected to meet minimum medical loss ratio requirements. Health insurance rates must not be excessive, inadequate or unfairly discriminatory. In addition, proposed rates must reflect risk adjustment, reinsurance, and risk corridors. If the company's data does not fully support a requested rate, DISB will ask for more information, approve a lesser rate, or reject the requested rate increase.

HBX will have a carrier's rate and form filings as filed with DISB. Carriers are required to respond to requests for additional information from consulting actuaries for HBX. Consulting actuarial review of the assumptions in carrier rate filings and the actuarial reports will be published on an HBX webpage and submitted to DISB for consideration. Published reports will not contain confidential information provided by carriers.

The Authority will not negotiate rates with Carriers. Each QHP offered through DC Health Link must have a prior approved rate by DISB.

If a carrier voluntarily provides its rate filing to HBX and works with the HBX's consulting actuaries, HBX will provide a special on-line designation to the carrier's QHPs. HBX will also provide a written recommendation to DISB for approval of the rate by DISB. Additional information on the rate submission process and timeline is included below.

DISB shall, after the May 2, 2016 due date, make all rate filings, including all supporting documentation, amended filings, and reports available for public inspection on its website. DISB will consider comments received on any rate filings during the review of the rates.

Any new entrants to DC Health Link will be afforded some flexibility in HBX submission deadlines.

E. Dental-Specific Rating Rules

Dental carriers are required to follow QHP rating rules, including the filing of age based rates utilizing the Federal Rate Data Table template.

QHPs with an embedded EHB pediatric dental benefit must have a separate deductible for that pediatric dental benefit.[10] The maximum deductible in embedded pediatric dental plans shall be $50/$100 (individual in & out-of-network) and $100/$200 (family in & out-of-network).[11]

IX. Summary of Benefits and Coverage (SBC) Guidelines

HBX requires carriers to use the standard Federal format for SBCs submitted for **BOTH** QHPs and QDPs where applicable.

A. Format and File Name Conventions

SBCs, prior to submission to HBX, must be created and saved as PDF file formats (.pdf). Failure to use this format (and the associated file extension) will result in delays in processing.

SBC plan names must be identical to the QHP marketing name, and SBC (.pdf) file name must be identical to the QHP or QDP marketing name.

Examples of Correct Naming Conventions

1. <u>SHOP</u>

Marketing name: Carrier PPO Bronze 6500
SBC Title name: Carrier PPO Bronze 6500
SBC File name (inbound to HBX): Carrier PPO Bronze 6500_SHOP

[10] Resolution to Determine a Separate Deductible for Pediatric Dental Benefits (5/14/2014)
[11] Resolution to Adopt a Recommendation Regarding Separate Deductible for Pediatric Dental Benefits Offered in QHPs (11/12/2014)

2. **Individual Marketplace**
Marketing name: Carrier POS Silver 2500
SBC Title name: Carrier POS Silver 2500
SBC File name (inbound to HBX): Carrier_POSSilver2500_50CSR_IVL, carrier_POSSilver2500_75CSR_IVL, Carrier_POSSilver2500_0CSR_IVL

Note: Please **DO NOT** use special characters (e.g. *, #) in the SBC file extension. The only acceptable special character is an underscore (_).

B. Deadlines for Submission

The deadline for SBCs is **September 1, 2016**, and will be loaded into DC Health Link by HBX plan management staff in advance of scheduled carrier testing and carrier review.

The deadline for corrected SBC is **September 30, 2016**. In response to issues identified by customers, HBX staff and carrier staff, HBX Plan Management team will focus its resources to review the accuracy of SBCs.

X. Carrier Submission Process for Qualified Health Plans (QHPs)

The Authority, in coordination with DISB, has set forth the following timeline for QHP certification and re-certification for 2017:

There are two categories of forms that Carriers must complete: Plan Rate & Form Filings and Carrier Certification. DISB will review and approve/disapprove forms and rates to ensure that QHPs meet District and federal exchange standards for rates and benefits. DISB will also review and approve/disapprove Carrier Certification submissions on behalf of DC Health Link.

All federal templates referenced below can be found at: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

Currently CCIIO has several "draft" templates available, and that is reflected in the hyperlinks below. This manual will be updated with final template hyperlinks once they are made available. For certification DC HBX will not accept templates in draft form unless CCIIO fails to provide final templates prior to the template filing deadline.

For plan year 2017, Federal Template submissions (with the exception of the Uniform Rate Review Template) will not be required until the conclusion of the plan form and rate review by DISB. All required Federal Templates- including the Federal Plan & Benefits template and the Federal Rate Table template- will be submitted through SERFF and passed to the DC Health Link insurance marketplace.

Plan Form and Rate Filing Deadline May 2, 2016

Federal Templates Filing Deadline August 1, 2016

QHP Benefit Summary/SBC Submission Deadline September 1, 2016

Final SBC Revision Deadline September 30, 2016[12]

DISB will publish initial rate filings on their website no later than May 30, 2016 and will make final rate approval determinations by July 15, 2016.

A. QHP Rate, Form Filings, and Carrier Certification

Form Filings: All Carriers must submit the following information to DISB via SERFF:

1. DISB Required Form Submissions – See Appendix B

Carrier Certification: All Carriers must submit the following information in SERFF:

1. Federal Attestation Form - Federally required Program Attestations for State Based Exchanges.
2. Quality Improvement Plan- Existing Carrier Quality Improvement Plan

Rate Filings: All Carriers must submit the following information to DISB via SERFF:

1. Federal Uniform Rate Review Template – Data for market-wide review.
2. DISB Actuarial Value Input Template – Collects plan actuarial value data (Available on SERFF).
3. DISB Rate Requirements – See Appendix B

DISB will notify carriers of form and rate approval no later than July 15, 2016.

B. QHP Data for DC Health Link

Each carrier must submit the following Federal QHP Templates through SERFF for certification to offer QHPs through DC Health Link:

1. Essential Community Providers (ECP) / Network Adequacy Template- Collects identifying information for Essential Community Providers and detailed provider network information.

[12] No SBC corrections, unless previously authorized by DC HBX will be accepted beyond this date.

2. Plan/Benefit Template- Collects plan and benefit data for medical and dental; basis of plan display in DC Health Link insurance marketplace.
3. Plan/Benefit Add-In- To be utilized in conjunction with submission of the Plan/Benefit Template.
4. Prescription Drug Template- Collects formulary data for plans.
5. Network ID Template- Information identifying a provider's network.
6. Rate Data Template- Rating tables; basis of premium display in DC Health Link insurance marketplace.
7. Business Rules Template- Supporting carrier business rules.
8. Accreditation Template- Collects information related to a carrier's NCQA , URAC, or AAAHC accreditation status.
9. Plan Crosswalk Template
10. Service Area Template

All Federal Templates listed above must be submitted to DC Health Link via SERFF no later than **August 1, 2016**. Failure to meet this deadline can impact the time allotted to carriers to test plan, benefit, and rate display in DC Health Link.

C. Contracting

The ACA requires exchanges to have contracts with Carriers offering QHPs. Consequently, Carriers that offer coverage through the DC Health Link will be required to enter into a contract with the DC Health Benefit Exchange Authority. A standard contract will be used. The DC Health Benefit Exchange Authority does not intend to negotiate contract terms with each Carrier individually. A draft standard contract will be provided. There will be a 15 day period for feedback from Carriers. The terms and conditions of the contract will include requirements for health carriers to comply with federal and District laws and regulations, and DC Health Link rules and policies.

XI. Carrier Submission Process for Qualified Dental Plans (QDPs)

The process for QDP submissions is similar to the process for QHPs.

The Authority, in coordination with DISB has set forth the following timeline for QDP renewal, recertification, and any new plan offerings for 2017:

Plan Form and Rate Filing Deadline May 2, 2016

Federal Template Filing Deadline August 1, 2016

QDP Benefit Summary/SBC Submission Deadline September 1, 2016

Final QDP Benefit Summary/SBC Revision Deadline September 30, 2016

A. QDP Rate, Form Filings, and Carrier Certification

Form and Rate Filings: All carriers must submit the following information to DISB via SERFF:

DISB Required dental plan form and rate submissions

Carrier Certification : All carriers must submit the following information in SERFF:

Federal Attestation Form: Federally Required Program Attestation for State Based Exchanges.

B. QDP Data for DC Health Link

All dental carriers must submit the following Federal Templates through SERFF for certification to offer QDPs on the DC Health Link insurance marketplace:

1. Network ID Template- Information identifying a provider's network.
2. Essential Community Providers (ECP) / Network Adequacy Template- Collects identifying information for Essential Community Providers and detailed provider network information.
3. Plan/Benefit Template- Collects plan and benefit data for medical and dental; basis of plan display in DC Health Link insurance marketplace.
4. Plan/Benefit Add-In- To be utilized in conjunction with submission of the Plan/Benefit Template.
5. Rate Data Template- Rating tables; basis of premium display in DC Health Link insurance marketplace.
6. Business Rules Template- Supporting carrier business rules
7. Plan Crosswalk Template

Like QHPs, all Federal and District templates listed above must be submitted to DC Health Link via SERFF no later than **August 1, 2016**. Failure to meet this deadline can impact the time allotted to carriers to test plan, benefit, and rate display in DC Health Link.

C. Contracting

The ACA requires exchanges to have contracts with Carriers offering QDPs. Consequently, Carriers that offer coverage through the DC Health Link will be required to enter into a contract with the DC Health Benefit Exchange Authority. A standard contract will be used. The DC Health Benefit Exchange Authority does not intend to negotiate contract terms with each Carrier individually. A draft standard contract will be provided. There will be a 15 day period for feedback from Carriers. The terms and conditions of the contract will include requirements for health carriers to comply with federal and District laws and regulations, and DC Health Link rules and policies.

D. Trading Partner Agreement

Any dental carrier that has not offered plans/products on DC Health Link prior to plan year 2017 must sign and submit the DCHBX Trading Partner Agreement (TPA) in order to begin technical onboarding and EDI connectivity and scenario testing.

XII. Additional Information and Requirements

A. Transparency

The ACA requires that all health plans and health insurance policies provide enrollees and applicants with a uniform summary of benefits and coverage (SBC). The SBC provides consumers consistent information about what health plans cover and what limits, exclusions, and cost-sharing apply. It must be written in plain language. At the outset, the final rule requires two illustrations of typical patient out-of-pocket costs for common medical events (routine maternity care and management of diabetes). Carriers must provide the SBC as part of the qualified plan certification process for participation in DC Health Link. A SBC template and sample completed SBC are posted at http://cciio.cms.gov .

Federal regulations implementing the ACA (45 CFR §156.220(d)) require Carriers to make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through a web site and through other convenient means for individuals without access to the Internet.

ACA implementing regulations (45 CFR §156.220) require Carriers to also disclose other information that would help consumers understand how reliably each QHP reimburses claims for covered services, whether the provider network is adequate to assure access to covered services, and other practical information. The required information must be provided to DC Health Link, HHS and DISB in plain language that the intended audience, including individuals with limited English proficiency, can readily understand and use. DC Health Link will make accurate and timely disclosure to the public of the following information:

- Claims payment policies and practices
- Financial disclosures
- Information on enrollee rights
- Data on rating practices
- Data on enrollment/disenrollment
- Data on number of claims that are denied

- Information on cost-sharing and payments with respect to out-of-network coverage
- Upon request of an individual, information on cost-sharing with respect to a specific item/service

B. Quality Data

The ACA requires carriers to implement quality improvement strategies, enhance patient safety, case management, chronic disease management, readmission prevention, wellness and health promotion activities, activities to reduce health care disparities and publicly report quality data for each of their QHPs. Presently, HHS is working on measuring quality of qualified health plans by:

(1) Developing and testing a quality reporting system;
(2) Developing a quality improvement strategy;
(3) Implementing a consumer experience survey; and
(4) Requiring carriers to work with patient safety organizations.

It is expected that QHP issuers will have reported data in mid- 2016 for care provided in 2015. This rating system is expected to be functional in time for the open enrollment period for the 2017 coverage year.

In accordance with 45 CFR §156.275, DC Health Link will accept Carrier accreditation based on local performance of its QHPs by the three accrediting agencies currently recognized by HHS: the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC) and URAC. Carriers that are not accredited at this time will be provided a grace period for accreditation, pursuant to 45 CFR § 155.1045 (Accreditation timeline for federally facilitated exchanges).

For DC Health Link in 2016, Carriers will be required to attest to meeting the federal quality standards. During 2015 and 2016, HBX will continue to collect information from Carriers on their existing quality improvement plans (QIPs). Carrier submitted QIPs are posted for public review on DC Health Link (https://dchealthlink.com/carriers). Going forward, the HBX will work to coordinate with public and private payers and other stakeholders to update QIP requirements and public reporting thereof based on stakeholder input, continuing federal guidance and the District's public health priorities.

C. Marketing Guidelines

Carriers must comply with all applicable federal and District laws and regulations governing marketing of health benefit plans. Carriers must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

D. Enrollment

Carriers must abide by enrollment periods established by HBX and coverage effective dates consistent with District and federal laws and regulations. Carriers shall process enrollment in accordance with standards set forth in 45 CFR §156.265, applicable District laws and regulations and eligibility information supplied by HBX. Carrier shall be responsible for notifying Enrollees of their coverage effective dates in accordance with 45 CFR §156.260. Carriers must provide each new enrollee with an enrollment information package that is written in plain language, accessible, and in compliance with the requirements of 45 CFR 155.220.

As required by 45 CFR §155.400, HBX will accept QHP selections from applicants eligible for enrollment, notify Carriers of QHP selections, and transmit necessary eligibility and enrollment information promptly to Carriers and to HHS. Accordingly, on a monthly basis, Carriers are required to acknowledge the receipt of enrollment information and to reconcile such information with HBX and HHS. Carriers must assist HBX in its obligation to produce timely and accurate annual federal tax forms and to report IRS-related data on a monthly basis.

Carriers and HBX will observe the federal requirements for initial, annual, and special open enrollment periods established by HHS in 45 CFR §155.420. For the 2017 plan year, the open enrollment period for individuals will run from **November 1, 2016** through **January 31, 2017**. Special enrollment periods must be provided for qualified individuals experiencing certain triggering events.

Individuals generally will have 60 days from the triggering event to modify their QHP selection.

E. QHP Certification

Pursuant to 45 CFR §1080, HBX may decertify any QHP that fails to meet the required certification standards or the requirements for recertification. Carriers will have the right to appeal decertification decisions through DISB.

The standards for decertification will be developed through the Plan Management Standing Advisory Committee.

Appendix A

District of Columbia Age Factors and Rating Curve

District of Columbia Age Factors and Rating Curve

Age	DC Age Factors		DISB Age Curve- 3:1 Ratio Required		Premium Ratio
0-20	0.654				
21	0.727		1.000		1.000
22	0.727		1.000		1.000
23	0.727		1.000		1.000
24	0.727		1.000		1.000
25	0.727		1.000		1.000
26	0.727		1.000		1.000
27	0.727		1.000		1.000
28	0.744		1.023		1.023
29	0.760		1.045		1.022
30	0.779		1.072		1.025
31	0.799		1.099		1.026
32	0.817		1.124		1.023
33	0.836		1.150		1.023
34	0.856		1.177		1.024
35	0.876		1.205		1.023
36	0.896		1.232		1.023
37	0.916		1.260		1.022
38	0.927		1.275		1.012
39	0.938		1.290		1.012
40	0.975		1.341		1.039
41	1.013		1.393		1.040
42	1.053		1.448		1.039
43	1.094		1.505		1.039
44	1.137		1.564		1.039
45	1.181		1.624		1.039
46	1.227		1.688		1.039
47	1.275		1.754		1.039
48	1.325		1.823		1.039
49	1.377		1.894		1.039
50	1.431		1.968		1.039
51	1.487		2.045		1.039
52	1.545		2.125		1.039
53	1.605		2.208		1.039
54	1.668		2.294		1.039
55	1.733		2.384		1.039
56	1.801		2.477		1.039

57	1.871		2.574		1.039
58	1.944		2.674		1.039
59	2.020		2.779		1.039
60	2.099		2.887		1.039
61	2.181		3.000		1.000
62	2.181		3.000		1.000
63	2.181		3.000		1.000
64+	2.181		3.000		1.000

Appendix B

DISB Health Insurance Rate & Form Filing Requirements

Health Insurance Rate Filing Requirements – ACA-Compliant Plans

The Government of the District of Columbia Department of Insurance, Securities and Banking (DISB), Actuarial Analysis Division, only accepts Health rate filings via the National Association of Insurance Commissioner's (NAIC) System for Electronic Rate and For Filings (SERFF).

Health insurance FORM filings should be filed in SERFF separately from Health Insurance RATE filings.

Health insurance rate filings for ACA-compliant plans should include the following information as pertinent to the nature of the purpose of the filing:

1. Fill out all requested information for the rate filing in SERFF under the tabs labeled "General Information" and "Rate/Rule Schedule"

2. Create a cover letter on Company Letterhead that includes the following:
    a. Company Name
    b. NAIC Company Code
    c. Unique Company Filing Number (assigned by Company)
    d. Date Submitted
    e. Proposed Effective Date
    f. Type of Product
    g. Individual or Group
        i. Group Size
    h. Scope and Purpose of Filing
    i. Indication Whether Initial Filing or Change
    j. Indication if no DC Policyholders
    k. Overall Premium Impact of Filing on DC Policyholders
    l. Contact Information, Name, Telephone, Fax, E-mail
    m. Signature and Date

3. If someone other than the insurer is submitting a filing on the insurer's behalf, then the filing must include a letter of authorization from the insurer. This letter must be on the insurer's Letterhead, dated, and signed by a person with authority. Submit this letter in the tab labeled "Supporting Documentation" in the scheduled item called **Certificate of Authority to File**.

4. Effective March 28, 2013, the Uniform Rate Review Template (URRT) replaced the Rate Summary Worksheet (Preliminary justification Part I). The URRT, a market-wide reform, is required to be completed and submitted in SERFF and in HIOS for ALL individual and small group health insurance rate filings that are not grandfathered health plan coverage or excepted benefits under the Rate Review Regulation, regardless of whether the rate action meets or exceeds the "subject to review" threshold of the Rate Review Regulation. Additionally, the Actuarial Memorandum Part III, is also required to be submitted whenever the URRT is submitted. This applies to both SERFF and HIOS.

    Please download the URRT from the HIX web page, complete the document and attach the Excel version to the URRT Requirement under the "Supporting Documentation" tab within applicable

SERFF filings. If you are submitting a rate increase that meets or exceeds the "subject to review" threshold under the Rate Review Regulation, you should attach the same version of the URRT that you prepared for upload into the HIOS system.

The completed URRT must be downloaded from the HIX page, completed, and included on every applicable health insurance rate filing beginning March 28, 2013.

Please bypass this requirement on large group filings and/or filings that have grandfathered plans or excepted benefits.

Please refer to the documentation in SERFF's Online Help for instruction on completing the required PPACA fields.

The elements of the URRT are as follows:

A. **Part I (Unified Rate Review Template)**
    a. Historical and projected claims experience
    b. Trend projections related to utilization, and service or unit cost
    c. Any claims assumptions related to benefit changes
    d. Allocation of the overall rate increase to claims and non-claims costs
    e. Per enrollee per month allocation of current and projected premium
    f. Three year history of rate increases for the product associated with the rate increase

B. **Part II (Preliminary Justification) (ONLY REQUIRED WHEN A RATE INCREASE IS GREATER THAN THE THRESHOLD FOR RATE REVIEW)** - The written description of the rate increase must include a simple and brief narrative describing the data and assumptions used to develop the rate increase, including the following:
    a. Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary
    b. Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios

C. **Part III (Actuarial Memorandum)** – Two versions are required; an unredacted version for regulators and a redacted version for public disclosure. The Actuarial Memorandum should include the following elements:
    a. Company Identifying Information
        i. Company Legal Name
        ii. State
        iii. HIOS Product ID
    b. Effective date
    c. Company contact information
    d. Market
    e. Average rate increase requested
    f. Reason for rate increase
    g. Risk Adjustment
    h. Risk Score
    i. Reinsurance

j. Non-Benefit Expenses
    i. Administrative Costs of Programs that Improve Health Care Quality
    ii. Taxes and Licensing or Regulatory Fees
k. Projected Loss Ratio
l. Index Rate
m. Market Adjusted Index Rate
n. AV Value
o. Benefit/Metal level(s)
p. Calibration
q. Consumer Adjusted Premium Rate Development
r. Past experience
s. Rating Factors
t. Credibility assumption
u. Trend assumption
v. Cost-sharing changes
w. Benefit changes
x. Claim reserve needs
y. Reliance
z. Actuarial Certification

5. Download and complete the **DISB Actuarial Memorandum Dataset** template from SERFF (located on the "Supporting Documents" tab) and upload the completed version.

6. Download and complete the **District of Columbia Plain Language Summary** template from SERFF (located on the "Supporting Documents" tab) and upload the completed version.

7. Complete the **Rate Filing Checklist** (see *Appendix C*)

8. The filing (and all applicable elements) should also be submitted in the Health Insurance Oversight System (HIOS) portal. Refer to the HIOS Portal User Manual published on the CMS website for detailed instructions on using the portal. Note that the HIOS Product ID must be included in the Actuarial Memorandum submitted with the SERFF filing.

9. The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% (85% in the large group market) of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. If they fail to meet these standards, the insurance companies are required to provide a rebate to their customers starting in 2012.

   Insurers must submit a report each year to the Department of Health and Human Services (HHS) showing how much the insurer spent on health care and activities that improve care in the past year. Each year's report is due by July 31 of the following year.

Each insurer's Medical Loss Ratio information is provided separately for each state and, within each state, by market (individual, small group and large group markets). It is not provided by a particular plan, product, or policy.

Complete the **MLR Report** and submit the report to CMS by the required due date. Also send either the Excel version, or a PDF version, of the completed MLR Report for the District of Columbia to DISB via email to **Efren Tanhehco, Supervisory Health Actuary** (efren.tanhehco@dc.gov).

Appendix C

DISB Rate Filing Checklist

RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP
PLANS SOLD ON DC HEALTH LINK
CHECK-LIST

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	**Location of the Data Element**
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.		
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.		
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.		
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2017 and later, follow filing due date requirements.		
5	Market	Indicate whether the products are sold in the individual or small employer group market.		
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non-grandfathered, or a mixture of both.		
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.		
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. **In the small group market, please also provide weighted average rate increase requested for 2016Q1 over 2015Q1; etc.**		
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)		
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)		
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.		
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.		
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for Maryland and the nationwide average rate history.		
14	Exposure	Current number of policies, certificates and covered lives.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	**Location of the Data Element**
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.		
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.		
17	Index Rate	Provide the index rate.		
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.		
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.		
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.		
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.		
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders. For initial filings, provide the derivation of any new plan factors.		
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.		
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.		
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.		
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.		
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation . Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.		

Number	Data Element	Requirement Description	Individual/and Small Group	
			Has the Data Element Been Included?	**Location of the Data Element**
27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.		
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in Maryland, the loss ratio meets the minimum.		
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative support for the amount.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
29.1	Reinsurance	Provide information on the Reinsurance contribution assumption, consistent with the national contribution rate for the projection period. In individual filings, provide information on the Reinsurance recovery assumption, consistent with the company's continuation table used in pricing. Provide previous year-end estimated reinsurance payable amount and quantitative support for the amount.		
29.2	Risk Corridor	Does the company assume Risk Corridor charges or payments? If so, provide support. Provide previous year-end estimated risk corridor payable or receivable amount and quantitative support for the amount.		
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.		
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	**Location of the Data Element**
32	Past and Prospective Expenses	Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change. Provide the assumed administrative costs in the following categories: • Salaries, wages, employment taxes, and other employee benefits • Commissions • Taxes, licenses, and other regulatory fees • Cost containment programs / quality improvement activities • All other administrative expenses • Total		
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.		
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.		
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of the District of Columbia and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet --- Provide this document with all Grandfathered plan filings. **Provide in Excel and PDF format.**		
36.1	Unified Rate Review Template (Non-Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. **Provide in Excel and PDF format.**		
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for *all* individual and small employer group filings (whether or not they are "subject to review" as defined by HHS).		
38	DISB Actuarial Memorandum Dataset	Summarizes data elements contained in Actuarial Memorandum. Provide this document with all Non-Grandfathered plan filings. **Provide in Excel format only**.		
39	District of Columbia Plain Language Summary	Similar to the Part II Preliminary Justification, this is a written description of the rate increase as specified by 45 CFR § 154.215, but as a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. Provide this document for all individual and small employer group filings.		

40	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: • Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule; • Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and • Demonstration that the plan has a reasonable annual limitation on cost-sharing.		

Certifying Signature

The undersigned representative of the organization submitting this rate filing attests that all items contained in the above checklist have been included in the filing to the best of the company's ability.

______________________________	____
(Print Name)	**(Signature)**

Appendix D

CCIIO Program Attestations for State Based Exchanges

State-based Marketplace Issuer Attestations:
Statement of Detailed Attestation Responses

Instructions: Please review and respond Yes or No to each of the attestations below and sign the Statement of Detailed Attestation Responses document. CMS may accept a No response, along with a justification for any of these No responses, to any of the individual attestations identified with an '*' below. Please be sure to reference the specific attestation in your justification discussion. If the applicant is submitting the signed attestation document indicating Yes to all attestations, the justification document is not required.

Program Attestations

General Issuer Attestations

1. By the first resubmission period during the QHP certification process, applicant is in good standing and as such is licensed, by all applicable states, to offer the specific type of health insurance or health plans that the issuer is submitting to the State Based Marketplace for certification; is in compliance with all applicable state solvency requirements; and is in compliance with all other applicable state laws and regulations.

   Yes No

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

   Yes No

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

   Yes No

State-based Marketplace Issuer Attestations:
Statement of Detailed Attestation Responses

Benefit Design Attestation

1. Applicant attests that it will follow all Actuarial Value requirements, including 45 CFR 156.135 and 156.140, or 156.150 for stand-alone dental plans.

Yes No

Stand-Alone Dental Attestations

1. Applicant attests that all stand-alone dental plans that it offers will comply with all benefit design standards and federal regulations and laws for stand-alone dental plans in 45 CFR 155.1065 and 156.150, as applicable, including that:

   a. the out-of-pocket maximum for its stand-alone dental plan complies with the regulatory standard in 45 CFR 156.150, including for the coverage of pediatric dental;

   b. it offers the pediatric dental EHB;

   c. it does not include annual and lifetime dollar limits on the pediatric dental EHB.

Yes No

2. Applicant attests that any stand-alone dental plans it offers are limited scope dental plans.

Yes No

3. Applicant attests that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit, including 45 CFR 155.340(e) and (f).

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

Yes No

Financial Management Attestations

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

Yes No

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

   a. risk corridor data standards and annual HHS notice of benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 CFR 153.500-530);*

b. remit charges to HHS under the circumstances described in 45 CFR 153.510(c)*.

Yes No

3. Applicant attests that it will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit and cost sharing reductions, including the provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, 156.460, and 156.470.

   Yes No

4. Applicant attests that it will reduce premiums on behalf of eligible individuals if the Marketplace notifies the QHP Issuer that it will receive an APTC on behalf of that individual pursuant to 45 CFR 156.460.

   Yes No

5. Applicant attests that it will adhere to the data standards and reporting requirements for the CSR reconciliation process pursuant to 45 CFR 156.430(c) for QHPs.

   Yes No

6. The following applies to applicants participating in the risk adjustment and reinsurance programs inside and/or outside of the Marketplace. Applicant attests that it will:

   a. adhere to the risk adjustment standards and requirements set forth by HHS in the annual HHS notice of benefit and payment parameters (45 CFR Part 153 Subparts G and H);

   b. remit charges to HHS under the circumstances described in 45 CFR 153.610;

   c. adhere to the reinsurance standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR 153.400, 153.405, 153.410, 153.420);*

   d. remit contributions to HHS under the circumstances described in 45 CFR 153.400;*

   e. establish dedicated and secure server environments to host enrollee claims, encounter, and enrollment information for the purpose of performing risk adjustment and reinsurance operations for all plans offered;*

   f. allow proper interface between the dedicated server environment and special, dedicated CMS resources that execute the risk adjustment and reinsurance operations;*

   g. ensure the transfer of timely, routine, and uniform data from local systems to the dedicated server environment using CMS-defined standards, including

file formats and processing schedules;*

h. comply with all information collection and reporting requirements approved through the Paperwork Reduction Act of 1995 and having a valid OMB control number for approved collections. The Issuer will submit all required information in a CMS-established manner and common data format;*

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

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

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

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

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

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

Yes No

7. The following attestation applies to applicants participating in the Marketplaces and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. 18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device, a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines up to $500,000.

18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute. Applicant acknowledges the False Claims Act, 31 U.S.C., §§ 3729-3733.*

Yes No

8. The following applies to applicants participating in the Marketplaces and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Applicant attests to provide and promptly update when applicable changes occur in its Tax Identification Number (TIN) and associated legal entity name as registered with the Internal Revenue Service, financial institution account information, and any other information needed by CMS in order for the applicant to receive invoices, demand letters, and payments under the APTC, CSR, user fees, reinsurance, risk adjustment, and risk corridors programs, as well as, any reconciliations of the aforementioned programs.*

Yes No

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

Yes No

______________________________ ________________________
Signature Date

______________________________ ________________________
Printed Name Title/Position

Attestation Justification

Provide a justification for any attestation for which you indicated **No**. Be sure to reference the specific attestation in your justification.

Appendix E

DISB Guidance on Nondiscrimination in Benefit Design

Government of the District of Columbia
Department of Insurance, Securities and Banking

Stephen C. Taylor
Commissioner

NON-DISCRIMINATORY BENEFIT DESIGN

The intent of this guidance is to clarify non-discrimination standards and provide examples of benefit design for Qualified Health Plans (QHP) that are potentially discriminatory under the Affordable Care Act (ACA)[1]. The ACA enacted standards that protect consumers from discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or health condition and prohibit issuers from designing benefits or marketing QHPs in a manner that would discourage individuals with significant health care needs from enrolling in QHPs. In addition, The Public Health Service Act (PHS) Section 2711 generally prohibits group health plans and health insurance issuers offering group insurance coverage from imposing lifetime or annual limits on the dollar value of essential health benefits offered under the plan or coverage. Furthermore, with respect to plans that must provide coverage of the essential health benefit package, issuers may not impose benefit-specific waiting periods, except in covering pediatric orthodontia, in which case any waiting periods must be reasonable pursuant to 45 CFR §156.125[2] and providing EHB. It is also important to note that benefit designs must meet the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements. These standards do not apply to stand-alone dental plans (SDP).

Ultimately, the Department of Insurance, Securities and Banking (DISB) and the DC Health Benefit Exchange Authority (HBX) will determine if a plan design is a discriminatory practice after a review of the plan forms, rates, and the Center for Consumer Information and Insurance Oversight (CCIIO) templates as submitted through SERFF, in addition to any other materials that may be requested by these agencies. In particular, the DISB will conduct an in depth review of the Prescription Drug Template, the Plans and Benefits Template and the data captured by the CCIIO review tools in particular (namely the Non-discrimination Tool, the Non-discrimination Formulary Outlier Tool and the Non-discrimination Clinical Appropriateness Tool).

A number of benefit design features are utilized in the context of medical management, including but not limited to: exclusions; benefit substitution; utilization management; cost-sharing; medical necessity definitions; drug formularies; and/or visit limits. Each of these features has the

[1] For additional guidance please see the 2016 Letter to Issuers in the Federally-facilitated Marketplaces and the 2016 Notice on Benefit and Payment parameters released by the Department of Health and Human Services (HHS).

[2] 45 CFR §156.125 – Prohibition on discrimination – "(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. (b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and (c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques." §156.200(e) QHP issuer participation standards states that "A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation."

potential to be either discriminatory or an important element in a QHP's quality and affordability, depending on how the feature is designed and administered. CMS has identified examples of potentially discriminatory benefit design within each of these domains, as well as best practices for minimizing the discriminatory potential of these features. These examples[3] are not definitively discriminatory. As potential discrimination is assessed, issuers should consider the design of singular benefits in the context of the plan as a whole, taking into account all plan features, including maximum out of pocket (MOOP) limits.

<u>Drug Formularies</u>

In the event that a QHP imposes overly restrictive utilization management which unduly limits access to commonly used medications for any chronic disease, including HIV/AIDS, the regulators may find this to be a discriminatory practice and de-certify a plan. Moreover, by placing all medications for a single chronic disease, including generics, on the highest cost-sharing tier, and/or requiring all such medications be accessed through a mail-order pharmacy, health plans discourage people living with those chronic diseases from enrolling in those health plans – a practice which unlawfully discriminates on the basis of disability. A QHP formulary drug list URL must be easily accessible, and its information up-to-date, accurate, and inclusive of a complete list of all covered drugs. The information should also provide a clear description of any tiering structure that the plan has adopted and any restrictions on the manner in which a drug can be obtained.

<u>Behavioral Health Care</u>

All QHP's are required to comply with the Mental Health Parity and Addiction Equity Act (45 CFR 156.115). The DISB will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. The DISB will use CCIIO tools for outlier analysis on specific QHP benefits, including: inpatient mental/behavioral health stays, specialist visits, specific conditions including behavioral health conditions such as mental health disorders and substance abuse, and prescription drugs. Moreover, the DISB and HBX will review provider networks to ensure sufficient access to behavioral health and substance use and recovery providers[4].

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[3] The table below is based on the Ohio Department of Insurance Plan Management Toolkit guidance on Non-discrimination in Benefit Design document posted at https://www.insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf .

[4] Pursuant to 45 C.F.R. Section 156.230 (a)(2) which requires a QHP issuer to maintain a network that has sufficient numbers and types of health care providers, including providers specializing in the delivery of mental health and substance use disorder services.

Government of the District of Columbia

Department of Insurance, Securities and Banking

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Exclusions	Transplant	Bone marrow transplants are excluded from transplant coverage, regardless of medical necessity	Excluding bone marrow transplants regardless of medical necessity may discriminate against individuals with specific conditions, including certain cancers and immune deficiency disorders, for which this procedure is a medically necessary treatment	Transplant coverage is dictated by medical evidence and consideration of patient history
Cost-Sharing	Emergency Room Services	Emergency room services with significantly increasing cost-sharing burden as the number of visits increases	Increasing the cost-sharing burden with increasing emergency room visits may discriminate against individuals with certain medical conditions that reasonably necessitate more frequent emergency room usage (for example, but not limited to, asthma, sickle cell anemia, heart failure)	Emergency room services cost-sharing design that is not contingent on the frequency of service utilization
Medical Necessity Definitions	Speech Therapy	Medical necessity for rehabilitative speech therapy services that is defined with the use of restrictive phrases such as “recovery of lost function” or “restoration to previous levels of functioning” when habilitative speech therapy is not covered	Defining medical necessity for rehabilitative speech therapy with restrictive phrases may discriminate against individuals with health conditions that would benefit from this therapy in order to improve functionality that may have never been present (e.g. individuals with cerebral palsy) and/or to prevent further deterioration of function (e.g. multiple sclerosis)	Medical necessity for rehabilitative speech therapy services includes coverage for all conditions in which medical evidence supports the use of speech therapy services, regardless of whether this service is used to recover lost function, improve functionality that was never present, or to prevent further deterioration of function

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Drug Formularies	Non-Preferred Brand/Specialty Drugs	Requiring consumers to receive specialty medications particularly for certain medical conditions from mail-order pharmacies and not allowing the use of retail pharmacies	Eliminating access to certain specialty medications through retail pharmacies may discriminate against individuals with significant health care needs or with certain conditions, such as rheumatoid arthritis, who are eligible to receive discounts on those drugs through retail pharmacies	Permitting consumers to use retail pharmacies when discounts are available and the cost-sharing is lower than the mail-order pharmacy option
	Non-Preferred Brand/Specialty Drugs	Placing expensive life-saving or life-prolonging drugs, for which there is no generic and/or less expensive comparable alternative treatment, in tiers with high consumer cost-sharing	Placing high consumer cost-sharing on life-saving or life-prolonging drugs may discriminate against individuals with conditions such as HIV/AIDS for which these drugs are a necessary treatment	Structuring prescription drug cost-sharing design in manner that does not place disproportionate burden on individuals with specific conditions
Visit Limits	Outpatient Rehabilitation Services	The number of covered outpatient rehabilitation visits is limited without regard to best medical practices for a given condition	Limiting the number of covered outpatient rehabilitation visits without regard to medical necessity may discriminate against individuals conditions that require more rehabilitation services than are covered in order to fully regain function after certain conditions, such as stroke	The number of covered outpatient rehabilitation visits is determined by medical necessity and best medical practices

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Utilization Management	Non-Preferred Brand/ Specialty Drugs	Requiring prior authorization and/or step therapy for most or all drugs in drug classes such as anti-HIV protease inhibitors, and/or immune suppressants regardless of medical evidence	Requiring prior authorization and/or step therapy for most or all medications in a specific drug class may discriminate against individuals with conditions for which those drug classes are applicable, such as HIV or rheumatoid arthritis, and cause undue burden to receive necessary therapies	Using current medical evidence to establish clinically appropriate prior authorization, step therapy, or unrestricted coverage for drugs in a given drug class
	Imaging (CT/PET Scans, MRIs)	Covering mammography alone and not covering breast MRIs in combination with mammography, for individuals who would benefit from breast cancer evaluation that incorporates an MRI	Denying coverage of diagnostic imaging without regard to medical evidence and necessity may discriminate against individuals who have either been previously diagnosed with or are more susceptible to developing breast cancer	Determining cancer diagnostic testing and treatment coverage based on current medical evidence and medical necessity

Appendix F

Standardized Plan Benefit Design Guidance

Standard Plans Advisory Working Group
Platinum Plan 2017

Actuarial Value		90.99%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
Medical		$0	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$2,000	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$20	
	Specialist visit	$40	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$20	
	X-rays and diagnostic imaging	$40	
	Imaging (CT/PET scans, MRIs)	$150	
Drugs to treat Illness or Condition	Generic	$5	
	Preferred brand	$15	
	Non-preferred Brand	$25	
	Specialty	$100	
Outpatient Surgery	Facility fee (e.g. hospital room)	$250	
	Physician/Surgeon fee		
Outpatient Non-surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	$75	
Need Immediate Attention	Emergency room services (waived if admitted)	$150	
	Emergency medical transportation	$150	
	Urgent Care	$40	
Hospital Stay	Facility fee (e.g. hospital room)	$250 per day up to 5 days	
	Physician/surgeon fee		
Mental/Behavioral Health	M/B office visits	$20	
	M/B outpatient services	$20	
	M/B inpatient services	$250 per day up to 5 days	
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$20	
	Substance abuse disorder inpatient services	$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	$250 per day up to 5 days	
	Delivery and all inpatient services — Professional		

*Copay may not apply in a staff model HMO setting.

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Help recovering or other special health needs	Home health care	$20	
	Outpatient rehabilitation services	$20	
	Outpatient habilitation services	$20	
	Skilled nursing care	$150 per day up to 5 days	
	Durable medical equipment	10%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

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D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Gold Plan 2017

Actuarial Value		81.89%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
Medical		$500	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$3,500	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$25	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$30	
	X-rays and diagnostic imaging	$50	
	Imaging (CT/PET scans, MRIs)	$250	
Drugs to treat Illness or Condition	Generic	$15	
	Preferred brand	$50	
	Non-preferred Brand	$70	
	Specialty	20%	
Outpatient Surgery	Facility fee (e.g. hospital room)	$600	
	Physician/Surgeon fee		
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	$75	
Need Immediate Attention	Emergency room services (waived if admitted)	$250	
	Emergency medical transportation	$250	
	Urgent Care	$60	
Hospital Stay	Facility fee (e.g. hospital room)	$600 per day up to 5 days	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B office visits	$25	
	M/B outpatient services	$25	
	M/B inpatient services	$600 per day up to 5 days	X
Substance Abuse needs	Substance abuse disorder outpatient services	$25	
	Substance abuse disorder inpatient services	$600 per day up to 5 days	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	$600 per day up to 5 days	X
	Delivery and all inpatient services — Professional		X

*Copay may not apply in staff model HMO setting.

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Help recovering or other special health needs	Home health care	$30	
	Outpatient rehabilitation services	$30	
	Outpatient habilitation services	$30	
	Skilled nursing care	$300 per day up to 5 days	
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

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Standard Plans Advisory Working Group
Silver Plan 2017

Actuarial Value		71.72%	
Individual Overall Deductible		N/A	
Other individual deductibles for specific services			
Medical		$2,000	
Prescription Drugs		$250	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$25	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$45	
	X-rays and diagnostic imaging	$65	
	Imaging (CT/PET scans, MRIs)	$250	
Drugs to treat Illness or Condition	Generic	$15	
	Preferred brand	$50	X
	Non-preferred Brand	$70	X
	Specialty	20%	X
Outpatient Surgery	Facility fee (e.g. hospital room)	20%	X
	Physician/Surgeon fee	20%	X
Outpatient Non-surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X
Need Immediate Attention	Emergency room services (waived if admitted)	$250	X
	Emergency medical transportation	$250	X
	Urgent Care	$90	
Hospital Stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B office visits	$25	
	M/B outpatient services	5%	
	M/B inpatient services	20%	X
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$25	
	Substance abuse disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	20%	x
	Delivery and all inpatient services — Professional		x

*Coinsurance may not apply in staff model HMO setting.

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Help recovering or other special health needs	Home health care	$45	
	Outpatient rehabilitation services	$45	
	Outpatient habilitation services	$45	
	Skilled nursing care	20%	x
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

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Standard Plans Advisory Working Group
Bronze Plan 2017

Actuarial Value	61.96%
Individual Overall Deductible	$5,300
Other individual deductibles for specific services	
Medical	$5,000
Prescription Drugs	$300
Dental	$0
Individual Out-of-Pocket Maximum	$7,150

Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$50	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$50	x
	X-rays and diagnostic imaging	$50	x
	Imaging (CT/PET scans, MRIs)	$500	x
Drugs to treat Illness or Condition	Generic	$25	
	Preferred brand	50%	x
	Non-preferred Brand	50%	x
	Specialty	50%	x
Outpatient Surgery	Facility fee (e.g. hospital room)	20%	x
	Physician/Surgeon fee	20%	x
Outpatient Non-surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	x
Need Immediate Attention	Emergency room services	20%	x
	Emergency medical transportation	0	
	Urgent Care	$50	
Hospital Stay	Facility fee (e.g. hospital room)	20%	x
	Physician/surgeon fee	20%	x
Mental/Behavioral Health	M/B office visits	$50	
	M/B outpatient services	10%	
	M/B inpatient services	20%	x
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$50	
	Substance abuse disorder inpatient services	20%	x
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services: Hospital	20%	x
	Delivery and all inpatient services: Professional		x

*Coinsurance may not apply in a staff model HMO setting.

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Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	$0	x
	Outpatient rehabilitation services	$50	x
	Outpatient habilitation services	$50	x
	Skilled nursing care	20%	x
	Durable medical equipment	20%	x
	Hospice services	20%	x
Child eye care	Eye exam (OD)	$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$41	
Child Dental Major Services	Root canal - molar	$512	
	Gingivectomy per Quad	$279	
	Extraction – single tooth exposed root or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	

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Appendix G

DCHBX Authority Executive Board Resolutions

DC HBX Authority Board QHP & QDP Certification Resolutions

The following resolutions enacted by the DC HBX Authority Executive Board are required for QHP and QDP carriers offering plans on the DC Health Link insurance market place. This memo provides a short summary of the resolution and hyperlink to the full text and additional materials (if applicable). For access to all resolutions enacted by the Board, please visit http://hbx.dc.gov/page/adopted-resolutions

Resolution to Approve an Essential Health Benefit (EHB) Benchmark Plan for 2017 (6/24/2015)

- Pursuant to Department of Insurance, Securities and Banking statute §31-3311.03(a), the HBX Executive Board approves GHMSI Blue Preferred PPO $1,000 – 100%/80% as the EHB benchmark for plan year 2017.
- Plan Contract and SBC
- DISB announcement (6/30/2015)

Resolution- To Update the Qualified Health Plan (QHP) Certification Requirements (2/9/2015)

Updated QHP Certification Requirements Working Group Report (1/21/2015)

- Network Adequacy
  - For plan year 2016 and beyond, in addition to submitting the CCIIO Federal Network Template, carriers must also submit the CCIIO Network Adequacy Template for QHP certification
  - DISB will track complaints related to network adequacy and will update their tracking mechanism as necessary

- Provider Directory
  - For plan year 2016 and beyond, carriers must submit provider data at intervals and in formats as determined by HBX for use to populate DC Health Link's provider directory search tool. Carriers participating in the individual market have already begun providing provider information to populate a DC Health Link individual market provider directory search tool, which is scheduled to "go live" in Spring 2015. Timing of developing and implementing a DC Health Link provider directory for the small group marketplace will be determined based on experience and consumer use of individual marketplace provider directory tool.
  - In time for the 2016 plan year open enrollment (beginning October 1, 2015), Carriers will be required to prominently post a phone number or email address on their on-line and print provider directories (not necessarily a dedicated phone number or email address) for consumers to report inaccurate provider directory information. Carriers will be required, within 30 days, to validate reports that directories are inaccurate or

incomplete and, when appropriate, to correct the provider information. The carrier will be required to maintain a log of consumer reported provider directory complaints that would be accessible to DISB or HBX upon request.
  - Carriers will be required to take steps to maintain a high level of accuracy in their provider directories. Beginning in calendar year 2015 and annually, a carrier is required to take at least one of the following steps and report such steps to DISB;
    - Perform regular provider directory information
    - Validate provider information where a provider has not filed a claim with a carrier in 2 years (or a shorter period of time).
    - Take other innovative and effective actions approved by DISB to maintain accurate provider directories.

- Review of Rates
  - For plan year 2016 and beyond, similar to reviews that occurred in 2013 and 2014, HBX is clarifying that for 2015 (plan year 2016 rates): 1) HBX will have a carrier's rate and form filings as filed with DISB, 2) Carriers are required to respond to requests for additional information from consulting actuaries for HBX, and 3) Consulting actuarial review of the assumptions in carrier rate filings and the actuarial reports will be published on HBX webpage and submitted to DISB for consideration. Published reports will not contain confidential information provided by carriers.
  - In this work, HBX will coordinate with DISB to minimize duplication of effort and maintain confidentiality of submissions consistent with current practice.
  - In addition to these steps, HBX will develop an enhanced process under its legal authority. HBX will coordinate with DISB and will work with carriers, consumers, and other stakeholders to develop an enhanced process.

- Quality of Health Plans
  - For plan year 2016 DCHBX will use the federal standards and approach to make data on plan quality available to consumers and the DCHBX will establish on dchealthlink.com a link to the NCQA public report cards for health plans

- Non-Discrimination
  - Carriers must submit to DCHBX a copy of the insurance contract- also known as the certificate of coverage/evidence of coverage- for each certified QHP. Submission to HBX shall be at the health plan level and shall be made at the same time federal law requires disclosure to consumers.

Resolution - To Adopt Recommendations Establishing Standard Qualified Health Plans at Each of the Four Metal Level Tiers to Promote Easier Comparison Shopping Through DC Health Link (11/12/2014)

Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefits Exchange Authority (10/6/2014)

Addendum to Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority (11/5/2014)

Metal tier by metal tier Benefit Design example

- Beginning in plan year 2016, the Executive Board has adopted standard plans for DCHL at all four metal tiers in the Individual health insurance marketplace and carriers are required to offer one standardized plan at each metal level.

Resolution - To Adopt a Recommendation Regarding a Separate Deductible for Pediatric Dental Benefits Offered in QHPs (11/12/2014)

- The maximum deductible in embedded pediatric dental plans shall be $50/$100 (individual in and out-of-network) and $100/$200 (family in and out-of-network).

Resolution to Establish Employer Choice of Qualified Dental Plans (5/14/2014)

- Enables employers, purchasing coverage through DC Health Link, to offer their employees any number of qualified dental plans available through the DCHL insurance marketplace.
- Employers are not required to have a minimum contribution amount toward standalone qualified dental plan coverage.
- If an employer chooses to offer a contribution for stand-alone qualified dental plan coverage, the employer contribution methodology shall be the employer contribution methodology shall be the employer contributing a percentage of the member-level age rate within a reference plan selected by the employer; this is the same methodology used for contributions for a qualified health plan.
- DC Health Link shall provide greater transparency (more information) about pediatric dental benefits.

Resolution to Allow Health Carriers in DC Health Link to Determine Whether a Pediatric Essential Dental Benefit is Included in a Qualified Health Plan (5/14/2014)

- QHP carriers offering coverage on DC Health Link have the choice to embed, or not embed, the pediatric essential health benefits in the qualified health plans being offered.

Resolution to Determine a Separate Deductible for Pediatric Dental Benefits Offered in QHPs (5/14/2014)

- QHP's with an embedded essential pediatric dental benefit being offered in DC Health Link must have a separate deductible beginning in plan year 2016 for its pediatric dental benefit.
- There shall be maximum amounts for the deductible to be informed by the Dental Working Group, or other group to which the Executive Board may assign the issue. A QHP carrier can choose to have lower or zero deductibles for pediatric dental benefit.

Resolution to Require Qualified Health Plan (QHP) Carriers to Establish Policies that Address Transition of Care for Enrollees in the Midst of Active Treatment in the Time of Transition into a QHP (5/9/2013)

- QHPs in the District of Columbia Health Benefit Exchange shall implement policies that address transition care for enrollees in the midst of active treatment. Such policies must require that QHPs, upon request by the enrollee, allow non-participating providers to continue to provide health care services for the lesser of the remaining course of treatment or 90 days (except that such time limit is not applicable to maternity care). The transition policy shall be similar to that which was adopted by the Maryland Health Progress Act of 2013, as appropriate.

Resolution to Establish an Automatic Enrollment Policy for the Individual Exchange Marketplace and to Define "Exceptional Circumstances" Permitting a Special Enrollment Period (5/9/2013)

- The District of Columbia Health Benefit Exchange (DCHBX) will enable an individual to be automatically enrolled if he or she does not select a new plan, and does not terminate such coverage when their existing plan is no longer offered in a subsequent plan year, into a similar plan, if available. A similar plan is defined as same carrier, metal tier, and provider network.
- Additionally, a new 60-day SEP is established. The triggering date is the effective date for the plan in which the individual has been automatically enrolled. This provides the individual an additional opportunity to change plans.
- There is no automatic enrollment if there is no similar plan available.

Resolution - To Establish Outreach Strategies to Promote Tobacco Cessation Programs and Other Preventive Benefits That Are Covered Without Cost Sharing (5/9/2013)

1. As part of the general information on the DC HBX website, provide descriptive information on the ACA covered preventive services including tobacco cessation and, when feasible, link to carrier websites which describe the availability of their tobacco cessation/preventive benefits.
2. Recognizing that carriers now communicate with new enrollees, ensure that carriers include information about tobacco cessation and other preventive services in their new member communication. Note: this recommendation is not intended to duplicate existing communication or add to costs.
3. Recognizing that carriers now communicate with providers, ensure that carrier communications to their providers include up to date information on the preventive benefits and tobacco cessation programs to be provided with no cost sharing. Note: this recommendation is not intended to duplicate existing communication or add to costs.
4. As part of training for navigators, in-person assistors (IPAs), and certified application counselors (CACs), the DC HBX should provide descriptive materials on the availability of no cost preventive services including tobacco cessation for use in enrollment counseling sessions. These counselors should stress the importance of enrollees speaking directly with their carrier to obtain more information on these benefits.
5. Utilize alternative vehicles for communication, other than carriers, including providing educational materials to small business owners and benefit administrators on the availability of preventive services including tobacco cessation
6. Maintain ongoing discussions with key stakeholder groups to identify additional opportunities to increase the use of preventive services including tobacco cessation. Stakeholder groups should include at least carriers, providers, and community organizations.

Appendix H

DCHBX Plan Management Policy Bulletins

MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: June 3, 2015

SUBJECT: QHP Terminations (Carrier Reference Manual Update: 2015.0001)

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately.

QHP Terminations

DCHBX QHP and QDP carriers offering plans on either the Individual market, the small group/SHOP market, or both, must adhere to 45 CFR 156.270, Termination of Coverage for Qualified Individuals, and 45 CFR 155.430, Termination of Coverage.

77 Federal Register 18394 (March 27, 2012) states that a "request for termination may be received through either the Exchange or the QHP (carrier)," and that "regardless of which entity the enrollee contacts to terminate coverage, the Exchange and QHP carriers will need to notify the other entity of the enrollee's coverage status to keep updated enrollment records."

These regulations allow for an individual to terminate coverage directly with their carrier OR the Exchange. Up to this point, DCHBX has been the sole entity processing terminations of coverage for individuals, with those wishing to terminate coverage needing to contact the DCHBX directly or through referral by their carrier.

The DCHBX recognizes that customers must provide "reasonable notice" to either DCHBX or the carrier to terminate coverage. Fourteen (14) days is considered reasonable notice in advance of a termination request.

1225 I Street, 4th Floor, NW, Washington, DC 20005

However, carriers are free to terminate, on the date the consumer requests, with less than 14 days' notice. This creates multiple scenarios depending on when a customer makes the request and for what date the termination is requested. See examples below:

Date of Request	Termination Request Date	Latest Date Term Can Occur	Earliest Date Term Can Occur	Explanation
1/17/2016	1/31/2016	1/31/2016	1/31/2016	Customer Provided Reasonable Notice (14 days) prior to requested date.
1/17/2016	2/8/2016	2/8/2016	2/8/2016	Customer Provided Reasonable Notice (22 days) prior to requested date.
1/24/2016	1/31/2016	2/7/2016	1/31/2016	Customer DID NOT provide reasonable notice, so cannot get date requested UNLESS carrier agrees.

DCHBX has established a **voluntary, manual** process to allow carriers to directly accept terminations by customers over the phone, via e-mail, or through other methods the customer is made aware of (i.e. secure consumer portal). This is based on our current procedures for terminations of individuals who reach out to the DCHBX as well as our experience with carriers in receiving timely and accurate EDI termination transactions.

Customer initiates Termination with Carrier:

1. Customer calls carrier call center and/or provides electronic communication indicating that they would like to terminate their coverage.
2. Carrier CSR takes down the following information:
    a. Date of desired termination (following the chart above)
    b. Enrollee full name
    c. Any dependents to be included in termination
    d. Enrollee DOB
    e. Enrollee plan selection

3. Carrier CSR informs customer that termination will be processed within 3 business days
4. Carrier representative provides information on termination to assigned HBX liaison, including whether they will exercise discretion and terminate in less than the required 14 days.
5. No less than every other day, carrier HBX liaison provides matrix to HBX Plan Management team for EDI processing.
6. DCHBX proceeds with termination transaction- providing an outbound 834 file to appropriate carrier.
7. Carrier provides acknowledgement of receipt of termination file and processes in a timely manner (3 business days).

In the event a carrier fails to adhere to these procedures, and a customer subsequently calls DCHBX requesting termination, the DCHBX will accept customer self-attestation of 1) the date they called the carrier to request termination and 2) whether the carrier agreed to terminate in less than 14 days from the date of that request. The carrier may submit contrary evidence within 7 days of a voluntary termination transmission.

Payment Grace Periods and QHP Terminations

For those DCHBX enrollees receiving APTC, federal regulations allow for a 3-month grace period in premium payments prior to termination for non-payment (by a carrier). Those enrollees who do not receive APTC are extended a 31-day grace period in premium payments prior to termination.

If a DCHBX enrollee can demonstrate that their carrier did not generate an invoice at least 7 days prior to the premium due date, that enrollee will be made eligible for a special enrollment period (SEP).

Mid-Month Terminations

DCHBX will accept mid-month terminations both directly and from carriers following the process laid out above. DCHBX follows the guidance of 77 Federal Register 18394 (March 27, 2012) that states "We want to ensure that individuals who have access to other coverage sources do not need to maintain Exchange coverage longer than necessary." No matter the origin of the mid-month termination, DCHBX requires that the following information is provided by the individual's carrier:

- Prorated premium amount (including refunding any amounts already paid)
- Prorated APTC amount (if applicable)

Timing of HBX receipts of prorated premium amount to be determined after initial analysis of carrier process (pending responses).

For mid-month terminations, whether originating with DCHBX or the carrier, carriers are expected to prorate both the premium amount and APTC according to Federal proration methodology (155.240(e)) as follows:

> *Premium/APTC/advance CSR/user fee for full month of coverage * (# daysof coverage/# days in month) = partial month premium/APTC/advance CSR/user fee 2*

Termination Grace Periods

Pursuant to federal regulations imposed on both carriers and the federally facilitated marketplace, DCHBX recognizes a grace period of no less than one-month for individual market enrollees who are late in their payments to be terminated (this period is expanded to three-months for individual market enrollees who receive financial assistance).

DCHBX expects that any termination for non-payment, an 834 termination file MUST be delivered to DCHBX with the appropriate termination date (not the date of file transfer) and any relevant premium or APTC proration information. DCHBX is not, however, waiving its right to terminate people for non-payment in those cases where we learn that a customer has not paid and the carrier has been delinquent in acting.

DCHBX reserves the right to initiate 834 termination files for of customers' QHP coverage, retroactively, when it learns that those customers have not paid for coverage for a period of time and the carrier has been delinquent in initiating or transmitting a termination file. This action is necessary to ensure accuracy of our enrollment records.

Retroactive SHOP Employee Terminations

DCHBX allows retroactive terminations of up to 60 days for SHOP employees. For example, if an employee is terminated on 1/1/2015, we allow until 3/1/2015 to be informed and process the termination with the respective carrier(s).

Until approximately March 2015, this rule was stretched by certain Congressional terminations due to internal operations within both the House and Senate that often prevented the timely transmission of terminations. Recognizing that the adverse impact this had on carriers we enforced the small group termination policy of 60 days on Congress. So far this has proven to be a success.

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. Health and dental carriers offering coverage in the individual and/or small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy, and Operations

DATE: June 22, 2015

SUBJECT: Religious Accommodations (Carrier Reference Manual Update: 2015.0004)

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately .

Religious Accommodations

DCHBX QHP and QDP carriers offering plans on either the Individual market, the small group/SHOP market, or both, must adhere to 45 C.F.R. 147.131, Preventinve Health Services Exemption and Accomodations.

The federal regulations provide that a group health plan seeking to take advantage of the exemption for certain religious employers are required to complete a self-certification and provide it to the health insurance carrier or carriers providing coverage in connection with the plan. Alternatively, the group health plan can provide a notice to the Secretary of Health and Human Services that it is an eligible organization. If the group health plan provides the self-certification directly to the issuer, the issuer is solely responsible for providing the coverage the employer has self-certified it has a religious objection to providing in accordance with the preventive health services requirements set forth a 45 C.F.R. 147.130. If the group health plan elects to provide notice to the Secretary of HHS, HHS will then contact each carrier to inform them of their obligations with respect to that group health plan.

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier

Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. Health and dental carriers offering coverage in the individual and/or small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: July 22, 2015

SUBJECT: Carrier Reference Manual Update: 2015.0005

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately.

SHOP Conversion

The DC Health Benefit Exchange Authority (HBX) is extending the phase-in period to complete the conversion of the District's small group marketplace to DC Health Link. Carriers will have an additional six months to provide the necessary data and set up their renewing groups with DC Health Link. **Carriers must set up groups with up to 50 employees who are renewing coverage effective July 1, 2016**, or later to enable the renewal through DC Health Link. An updated schedule for completion of the phased approach will be distributed to all carriers.

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. Health and dental carriers offering coverage in the individual and/or small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: August 6, 2015

SUBJECT: SHOP Conversion #2 (Carrier Reference Manual Update: 2015.0006)

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately.

SHOP Conversion #2

In response to several questions received by DCHBX in relation to the SHOP Conversion and groups with 51-100 full-time equivalent employees (FTEs), the following is the framework for small group medical insurance purchases and renewals through July 1, 2016:

Present through 6/30/2016 plan years (GROUPS WITH 1-50 FTEs)

Must purchase through DC Health Link

- New groups of 1-50 FTEs (not currently offering coverage)
- Groups if 1-50 FTEs who already offer coverage through DC Health Link (upon their plan year renewal)
- Groups of 1-50 FTEs currently offering coverage, not through DC Health Link, that want to change carrier (upon their plan year renewal)

Choice to purchase directly through carrier or through DC Health Link

- Groups of 1-50 FTEs currently offering coverage, not through DC Health Link, that want to renew with the same carrier, but may change products within that carrier (upon their plan year renewal)

Beginning 7/1/2016 plan years (GROUPS WITH 1-50 FTEs)

Must purchase coverage through DC Health Link

- All groups with 1-50 FTEs, whether currently offering coverage through DC Health Link or through the carrier directly (upon their plan year renewal)
    - Groups currently offering coverage directly through the carrier will be pre-setup by DC Health Link and the carrier to expedite the renewal process which will be the first time these groups will be on DC Health Link

Beginning 1/1/2016 plan years (GROUPS WITH 51-100 FTEs)

Choice to purchase directly through carrier or through DC Health Link

- Groups with 51-100 FTEs purchasing small group products

Only purchase coverage directly through carrier (1/1/2016 – 10/1/2016 plan year **renewals only**)

- Groups with 51-100 FTEs who wish to purchase large group products, in accordance with DISB Bulletin 15-IB-05-04/28

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

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Carrier Reference Manual

UPDATE

July 6, 2016 | 2016.0008

Adult Dependents Aging Off a Policy

Following consultation with each carrier, we are updating our policy regarding adult dependents who age off of a policy. Going forward, the policy is that carriers shall terminate coverage for adult dependent children at the end of the calendar year (December 31st) during which the dependent turns 26 years of age. This applies in both the small group and individual markets. In connection with this policy, we are implementing two customer service enhancements:

1. Our system will automatically initiate a special enrollment period on the dependent's behalf in the individual market due to the life event.
2. We will also reach out to these members regarding this change in their coverage status and available options.

For any carriers not currently complying with this guidance, please note this is effective September 1, 2016 going forward.

KEY DATES for Plan Year 2017

Activity		Dates
Release of 2017 Carrier Reference Manual v. 1		4/1/2016
Rate & Form Filing Deadline		5/2/2016
QHP Application Submission & Review	**Submission of Templates and Supporting Documents in SERFF**	**8/1/2016**
	SBCs Due	9/1/2016
	Deadline to submit all plan corrections	10/1/2016

ANNOUCEMENTS & CARRIER WORKING GROUP CALENDER

All one-on-one conference calls have been scheduled with each carrier. These calls occur every other week. The scope of these calls is intended to be more policy focused. The Plan Management team sincerely appreciates your kindly submitting agenda items via email to

carrier.hbxinquiries@dc.gov

the day before your scheduled conference call so we may compile the agenda and distribute it to all meeting participants.

This update has been issued to keep all issuers of qualified health and qualified dental plans current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2017 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. Health and dental carriers offering coverage in the individual and/or small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

Carrier Reference Manual

UPDATE

July 1, 2016 | 2016.0009

Eligibility of District Residence Temporarily Absent from DC Health Link Service Area

Individuals who are temporarily absent from the District of Columbia but otherwise meet the requirements for eligibility for enrollment in a qualified health plan (QHP) offered through DC Health Link may not be denied or terminated from coverage if they intend to return to the District of Columbia when the purpose of the absence has been accomplished.

The impact of this policy is that, effective now, DCHBX may on occasion generate 834 files containing home addresses that are not within the DCHBX service area. Carriers offering plans through DC Health Link must be able to accept data files on behalf of these individuals and facilitate enrollment.

DCHBX will consult with each carrier on a process for operationalizing this requirement.

KEY DATES for Plan Year 2017

Activity		Dates
Release of 2017 Carrier Reference Manual v. 1		4/1/2016
Rate & Form Filing Deadline		5/2/2016
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	8/1/2016
	SBCs Due	9/1/2016
	Deadline to submit all plan corrections	10/1/2016

ANNOUNCEMENTS & CARRIER WORKING GROUP CALENDER

This update has been issued to keep all issuers of qualified health and qualified dental plans current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2017 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. Health and dental carriers offering coverage in the individual and/or small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

Appendix I

CCIIO Quality Improvement Strategy (QIS) Implementation Plan and Progress Form

Please retain a copy of the completed Quality Improvement Strategy (QIS) Implementation Plan form so that it is available for future use for reporting on activities conducted to implement the QIS. For detailed instructions, please refer to the QIS Technical Guidance and User Guide for the 2017 Coverage Year.

QIS Submission Type

Part A. New or Continuing QIS Submission

This field is required, but will not be scored as part of the QIS evaluation.

1. Type of QIS Submission

Select the option that describes the type of QIS submission, and follow the instructions to complete the submission.

Type of QIS	Instructions
New QIS[1] with No Previous QIS Submission	Complete the Background Information Section (Parts B and C) and the Implementation Plan Section (Parts D and E).
New QIS after Discontinuing a QIS Submitted during the Qualified Health Plan (QHP) Application Period[2]	**Must complete two forms:** 1. Complete a form to close out the discontinued QIS, including the Background Information Section (Parts B and C); Implementation Plan Section (Parts D and E), with the discontinued QIS information; and Progress Report Section (Part F); AND 2. Complete a new/separate form to submit the new QIS, including the Background Information Section (Parts B and C) and the Implementation Plan Section (Parts D and E).
Continuing a QIS with No Modifications	Complete the Background Information Section (Parts B and C), Implementation Plan Section (Parts D and E), and the Progress Report Section (Part F).
Continuing a QIS with Modifications[3]	Complete the Background Information Section (Parts B and C); Implementation Plan Section (Parts D and E); and the Progress Report Section (Part F).

[1] A "new QIS" is defined as a QIS that has not been previously submitted to a Marketplace, or is a QIS that is based upon a different market-based incentive(s) and/or topic area(s) than the issuer's previous QIS.
[2] A new QIS is required if an issuer: changes its QIS market-based incentive type or sub-type, changes its QIS topic area, reaches one or more of its QIS performance targets, the QIS is not having the expected impact, or the QIS results in negative outcomes or unintended consequences.
[3] An issuer may continue with an existing QIS even if it changes the following: QIS activities, QIS goals, and/or QIS measures.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Background Information

Part B. Issuer Information

These fields are required, but will not be scored as part of the QIS evaluation.

2. Issuer Legal Name

3. Company Legal Name

4. HIOS Issuer ID

5. Issuer State

6. QIS Primary Contact's First Name

QIS Primary Contact's Last Name

7. QIS Primary Contact's Title

8. QIS Primary Contact's Phone **Ext.**

9. QIS Primary Contact's Email

10. QIS Secondary Contact's First Name

QIS Secondary Contact's Last Name

11. QIS Secondary Contact's Title

12. QIS Secondary Contact's Phone **Ext.**

13. QIS Secondary Contact's Email

14. Date Issuer Began Offering Coverage Through the Marketplace

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

15. Current Payment Model(s) Description

Select the category(ies)[4] of payment models that are used by the issuer across its Marketplace product line. If "Fee for Service – Linked to Quality or Value" AND/OR "Alternative Payment Models Built upon Fee for Service Architecture" is checked, provide the percentage of payments tied to quality or value.

Payment Model Type	Payment Model Description
Fee for Service – No Link to Quality or Value	Payments are based on volume of services and not linked to quality or efficiency.
Fee for Service – Linked to Quality or Value	At least a portion of payments vary based on the quality or efficiency of health care delivery.
Alternative Payment Models Built upon Fee for Service Architecture	Some payment is linked to the effective management of a population or an episode of care. Payments still are triggered by delivery of services, but there are opportunities for shared savings or two-sided risk.
Population-based Payment	Payment is not directly triggered by service delivery, so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., more than one year).

Provide percentage of payments:

Percentage of Fee for Service payments linked to quality or value: %

Percentage of payments tied to quality or value through alternative payment models: %

[4] Categories of payment models are defined in Rajkumar R, Conway PH, and Tavenner M. CMS— Engaging Multiple Payers in Payment Reform. JAMA. 311:19. See the *QIS Technical Guidance and User Guide for the 2017 Coverage Year* for examples of payment models within each category.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part C. Data Sources Used for Goal Identification and Monitoring Progress

These fields are required, but will not be scored as part of the QIS evaluation.

16. Data Sources

Indicate the data sources used for identifying QHP enrollee population needs and supporting the QIS rationale (Element 22). Check all that apply.

Data Sources
Internal issuer enrollee data
Medical records
Claim files
Surveys (enrollee, beneficiary satisfaction, other)
Plan data (complaints, appeals, customer service, other)
Registries
Census data Specify Type [e.g., block, tract, ZIP Code]:
Area Health Resource File (AHRF)
All-payer claims data
State health department population data
Regional collaborative health data
Other

If you checked “Other,” please describe. Do not include company identifying information in your data source description.

(100 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

QIS Implementation Plan Section

Part D. QIS Summary

These fields are required, but will not be scored as part of the QIS evaluation.

17. QIS Title

Provide a short title for the QIS.

(200 character limit)

18. QIS Description

Provide a brief summary description of the QIS. The description must include the market-based incentive type and topic area.

(1,000 character limit)

Is the QIS described above part of a mandatory state initiative?

Yes No

Is the QIS submission[5] a strategy that the issuer currently has in place for its Marketplace product line and/or for other product lines?

Yes No

[5] Issuers may use existing strategies employed in non-Marketplace product lines (e.g., Medicaid, commercial) if the existing strategies are relevant to their QHP enrollee populations and meet the QIS requirements and criteria.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

If “yes” was checked for either/both of the above, please describe the state initiative and/or current issuer strategy.

(1,000 character limit)

Describe the overall goal(s) of the QIS (no more than two).

Note: *Measures described in Element 24 should be linked to these goals.*

QIS Goal 1:

(500 character limit)

QIS Goal 2:

(500 character limit)

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Part E. QIS Requirements

The Elements in Part E will be scored as part of the QIS evaluation. All elements must receive a “meets” score during the QIS evaluation. If any elements are scored as “does not meet” in the QIS evaluation, the issuer must revise those elements and resubmit its Implementation Plan for re-review.

19. Market-based Incentive Type(s) (Must Pass)

Select the type and sub-type of market-based incentive(s) the QIS includes. Check all that apply. If either “In-kind incentives” or “Other provider market-based incentives” is selected, provide a brief description in the space provided.

Provider Market-based Incentives:

Increased reimbursement

Bonus payment

In-kind incentives (Provide a description in the space below.) *(500 character limit)*

Other provider market-based incentives (Provide a description in the space below.) *(500 character limit)*

Enrollee Market-based Incentives:

Premium credit

Co-payment reduction or waiver

Co-insurance reduction

Cash or cash equivalents

Other enrollee market-based incentives (Provide a description in the space below.) *(500 character limit)*

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20. Topic Area Selection (Must Pass)

Select the topic area(s) this QIS addresses, as defined in the Affordable Care Act.[6] Check each topic area that applies.

QIS Topic Area	Example Activities Cited in the Affordable Care Act
Improve health outcomes	▪ Quality reporting ▪ Effective case management ▪ Care coordination ▪ Chronic disease management ▪ Medication and care compliance initiatives
Prevent hospital readmissions	▪ Comprehensive program for hospital discharge that includes: – Patient-centered education and counseling – Comprehensive discharge planning – Post-discharge reinforcement by an appropriate health care professional
Improve patient safety and reduce medical errors	▪ Appropriate use of best clinical practices ▪ Evidence-based medicine ▪ Health information technology
Implement wellness and health promotion activities	▪ Smoking cessation ▪ Weight management ▪ Stress management ▪ Healthy lifestyle support ▪ Diabetes prevention
Reduce health and health care disparities	▪ Language services ▪ Community outreach ▪ Cultural competency trainings

[6] Implementation of wellness and health promotion activities are cited in Section 2717(b) of the Affordable Care Act. All other activities are cited in Section 1311(g)(1) of the Affordable Care Act.

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21. Targets All Health Plans Offered Through a Marketplace (Must Pass)

21a. Indicate if this QIS is applicable to all QHPs you offer or are applying to offer through the Marketplaces, or to a subset of QHPs.

All QHPs

Subset of QHPs*

* If "Subset of QHPs" was selected above, an additional QIS Implementation Plan(s) (Parts D and E of this form) must be submitted for QHPs not covered by this QIS.

If "Subset of QHPs" was selected above, please indicate the number of forms that will be submitted: This is form of .

21b. In the space provided, specify all QHPs covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]). Indicate if each one is a new or existing QHP. Note: Please list additional health plans covered by the QIS on page 25.

HIOS Plan ID (SCID)	New Health Plan	Existing Health Plan
HIOS Plan ID (SCID)	New Health Plan	Existing Health Plan
HIOS Plan ID (SCID)	New Health Plan	Existing Health Plan

21c. Select the relevant product types to which the QIS applies. Check all that apply.

Health Maintenance Organization (HMO)

Point of Service (POS)

Preferred Provider Organization (PPO)

Exclusive Provider Organization (EPO)

Indemnity

22. Rationale for QIS (Must Pass)

Provide a rationale for the QIS that describes how the QIS will address the needs of the current QHP enrollee population(s).

(1,000 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

23. Activity(ies) that Will Be Conducted to Implement the QIS (Must Pass)

23a. List the activities that will be implemented to achieve the identified goals.

(1,000 character limit)

23b. Describe how the activities relate to the selected market-based incentive (see Element 19).

(1,000 character limit)

23c. Describe how the activities relate to the topic area(s) selected (see Element 20).

(1,000 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

23d. If health and health care disparities was not chosen as a selected topic area in Element 20, does the QIS include any activities related to addressing health and health care disparities? If yes, describe the activities below. If (1) health and health care disparities is one of the topic areas selected in Element 20; OR (2) health and health care disparities are not addressed in this QIS, check Not Applicable.

(1,000 character limit)

24. Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress (Must Pass)

Restate the goal(s) identified in the QIS description (see Element 18).

QIS Goal 1:

(500 character limit)

For this goal, identify at least one (but no more than two) primary measure(s) used to track progress against the goal.

24a. **Measure 1a**

Measure 1a Name:

Provide a narrative description of the measure numerator and denominator.
(500 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Is this a National Quality Forum (NQF)-endorsed measure? Yes No

If yes, provide 4-digit ID number: If no, check Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

Yes No Not Applicable

24b. Describe how [Measure 1a] supports the tracking of performance related to [Goal 1].

(1,000 character limit)

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

24e. Provide numerical value performance target for this measure:

24a. **Measure 1b**

Measure 1b Name:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Provide a narrative description of the measure numerator and denominator.
(500 character limit)

Is this a National Quality Forum (NQF)-endorsed measure? Yes No

If yes, provide 4-digit ID number: If no, check Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

Yes No Not Applicable

24b. Describe how [Measure 1b] supports the tracking of performance related to [Goal 1].

(1,000 character limit)

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter “1” in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

24e. Provide numerical value performance target for this measure:

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QIS Goal 2:

(500 character limit)

For this goal, identify at least one (but no more than two) primary measure(s) used to track progress against the goal.

24a. **Measure 2a**

Measure 2a Name:

Provide a narrative description of the measure numerator and denominator.
(500 character limit)

Is this a National Quality Forum (NQF)-endorsed measure? Yes No

If yes, provide 4-digit ID number: If no, check Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

Yes No Not Applicable

24b. Describe how [Measure 2a] supports the tracking of performance related to [Goal 2].

(1,000 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter “1” in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

24e. Provide numerical value performance target for this measure:

24a. **Measure 2b**

Measure 2b Name:

Provide a narrative description of the measure numerator and denominator.
(500 character limit)

Is this a National Quality Forum (NQF)-endorsed measure? Yes No

If yes, provide 4-digit ID number: If no, check Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

Yes No Not Applicable

24b. Describe how [Measure 2b] supports the tracking of performance related to [Goal 2].

(1,000 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

24e. Provide numerical value performance target for this measure:

25. Timeline for Implementing the QIS

25a. QIS Initiation/Start Date:

25b. Describe the milestone(s) and provide the date(s) for each milestone (e.g., when activities described in Element 23 will be implemented). At least one milestone is required. *(100 character limit per milestone)*

	Milestone(s)	Date for Milestone(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

8.

9.

10.

26. Risk Assessment

26a. List any known or anticipated barriers to implementing QIS activities.

(1,500 character limit)

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26b. Describe the mitigation activities that will be incorporated to address each barrier identified in Criterion 26a.

(1,500 character limit)

QIS Progress Report Section

Part F. Progress Report Summary

***The elements in Part F will be scored as part of the QIS evaluation**. All elements must receive a "meets" during the QIS evaluation. If any elements are scored as "does not meet" in the QIS evaluation, the issuer must revise its Progress Report and submit it for re-review.*

27. Addition of QHPs to the Issuer's QIS

27a. Indicate if the issuer is adding any QHPs to the QIS originally listed in 21b.

Add QHP(s)

No additional QHP(s)

27b. If "Add QHP(s)" was selected, list all new QHPs and provide each plan's unique 14-digit HIOS Plan ID (SCID). If no additional QHPs were included, check Not Applicable.

Note: Please list additional health plans covered by the QIS on page 26.

HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

28. QIS Modifications

28a. If "**Continuing a QIS with Modifications**" was selected in Part A, Element 1, please indicate what type of modification the issuer is making to its QIS. Check all that apply. Note that modifications only apply to elements in Part D (Implementation Plan). If no modifications are being made, check Not Applicable.

Element Being Modified
Goals
Performance measure(s)
Activities

28b. Provide a justification and brief description of the modification(s) selected in Criterion 28a. If "Continuing a QIS with Modifications" was **NOT** checked in Part A, Element 1, check Not Applicable.

(500 character limit)

29. Analyze Progress Using Baseline Data, as Documented in the Implementation Plan (Must Pass)

Restate the goals identified in the Implementation Plan (see Elements 18 and 24). For each goal, restate the measure(s) information identified in Element 24, and complete the tables below.

QIS Goal 1:

(500 character limit)

Measure 1a:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

-

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

29c. Measure 1a Name:

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter “1” in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter “1” in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

Was the performance target (Criterion 24e) achieved?

Yes No

Measure 1b:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

-

29c. Measure 1b Name:

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter “1” in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

Was the performance target (Criterion 24e) achieved?

Yes No

QIS Goal 2:

(500 character limit)

Measure 2a:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

-

29c. Measure 2a Name:

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

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Denominator:

Was the performance target (Criterion 24e) achieved?

Yes No

Measure 2b:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

-

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

-

29c. Measure 2b Name:

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

Was the performance target (Criterion 24e) achieved?

Yes No

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

30. Summary of Progress (Must Pass)

Indicate why progress was or was not made toward the performance target(s) documented in Element 24. Include a description of activities that led to the outcome.

If modifications were checked in Criterion 28a, indicate whether the information provided here affects the decision to modify or change the QIS:

(1,500 character limit)

31. Barriers

31a. Were barriers encountered in implementing the QIS?

Yes No

If "Yes," describe the barriers.

(1,500 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

31b. Were there problems meeting timelines as indicated in Element 25?

Yes No

If “Yes,” describe the problems in meeting timelines.

(1,500 character limit)

32. Mitigation Activities

If “Yes” was selected in 31a or 31b, describe the mitigation activities implemented to address each barrier or problem in meeting the timeline. Also, describe the result(s) of the mitigation activities.

If “No” was selected in 31a and 31b, check Not Applicable.

(1,500 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Criterion 21b continued

In the space provided, place specify any additional health plans (outside of those already listed in Criterion 21b) covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]). Indicate if each one is a new or existing health plan.

HIOS Plan ID (SCID) New Health Plan Existing Health Plan

HIOS Plan ID (SCID) New Health Plan Existing Health Plan

HIOS Plan ID (SCID) New Health Plan Existing Health Plan

HIOS Plan ID (SCID) New Health Plan Existing Health Plan

HIOS Plan ID (SCID) New Health Plan Existing Health Plan

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HIOS Plan ID (SCID) New Health Plan Existing Health Plan

HIOS Plan ID (SCID) New Health Plan Existing Health Plan

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Criterion 27b continued

In the space provided, place specify any additional health plans (outside of those already listed in Criterion 27b) covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]).

HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
HIOS Plan ID (SCID)	HIOS Plan ID (SCID)
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