District of Columbia Qualified Health Plan Bulletin

Insurance Subcommittee

October 29, 2012

District of Columbia QHP Bulletin
Insurance Subcommittee

The proceeding bulletin is meant to inform District of Columbia health insurance carriers and other interested stakeholders of the anticipated requirements for the submission and certification of qualified health plans (QHPs) to the District of Columbia Health Benefits Exchange (DC HBX) for the 2014 plan year.

Insurance Subcommittee staff utilized several resources in creation of this bulletin. This includes review of District carrier rate and form filings, anticipated SERFF plan management module data elements, and the work of other States in informing carriers and stakeholders of these anticipated requirements (most notably Arizona, Colorado, and New York).

We encourage comments regarding any aspect of the bulletin, but are looking for more specific guidance in the following areas:

- Anticipated data elements. Have we accurately captured the range of anticipated data elements needed for submission and certification of QHPs?
- Submission evidence. Is the documentation required for submission, such as certification of financial solvency and licensure, necessary or can it be collected in a more efficient manner?
- Overall design. Does this bulletin effectively illustrate requirements?
- Outstanding requirements. What additional guidance or policies are needed to address outstanding requirements such as network adequacy? Do the draft requirements in the bulletin adequately address these?

In addition to the questions above and at the direction of the DC HBX Executive Board, what additional QHP requirements would help improve plan certification? Insurance Subcommittee staff sees this as the beginning of a more robust discussion of additional requirements and would like to report any preliminary stakeholder comments on this issue at the next DC HBX Executive Board meeting.

The Public Comment period for this bulletin will conclude at COB on Tuesday, November 13, 2012. If you need additional time to comment, or have further questions, please contact Brendan Rose (Brendan.Rose@DC.gov) or Andre Beard (Andre.Beard@DC.gov) at the Department of Insurance, Securities, and Banking (DISB).

District of Columbia QHP Application Bulletin

Section 1: QHP Application Background and Guidance

Background:
This document presents the District's current thinking regarding what will be included in the Qualified Health Plan application. The Patient Protection and Affordable Care Act (ACA) requires that only Qualified Health Plans (QHPs) be allowed to offer coverage through a state or federally operated Health Benefits Exchange (Exchange). The act defines certain requirements to be certified as a QHP. At the federal level, the Center for Consumer Information and Insurance Oversight (CCIIO), within Health and Human Services (HHS), is responsible for Exchange regulations, monitoring and oversight. In 2011, CCIIO published a list of suggested QHP application elements for consideration by states.

Introduction:
The District utilized CCIIO's suggested list of QHP application elements as a starting point for research and discussion for the development of District of Columbia-specific QHP and stand-alone dental plan application elements/requirements. The District engaged a stakeholder group of health insurance carriers operating in the District and Compass, a consulting firm, to analyze plans offered within the District in order to determine a Benchmark Plan.

Process and Timing:
The Exchange Authority currently plans to contract out the QHP certification function to the Department of Insurance, Securities and Banking (DISB), who currently licenses commercial health insurance carriers in District of Columbia. In order to be reviewed and processed for the initial Exchange open enrollment period starting October 1, 2013, QHP applications will have to be submitted to DISB no later than April 1, 2013. DISB will begin accepting QHP applications no later than February 1, 2013. The same dates apply to dental plans to be offered through the Exchange.

The District plans to make a decision about the final QHP application in a timely manner to ensure sufficient time for carriers to plan for and develop their QHP offerings. This document and the QHP application elements/requirements are subject to change prior to the publication of a final QHP application and the publication of additional federal rules and/or guidance from CCIIO, as well as any District legislation or other policy guidance (e.g., adoption of new or amendment to existing administrative rules).

The District will use the information in this document, as well as public comments, to build the actual QHP application form(s). The application forms will include additional detail related to the application elements outlined here.

Overview:

The application will require information at both the carrier and the QHP-specific level.

Carrier Level:

Carriers will be asked to provide overall Issuer Information (**Additional information on pages 3-4).**

Carriers will also be required to provide an organizational chart and names and contact information for different key contacts (**Page 5**).

Carriers will need to provide licensure and financial condition attestations and supporting documentation (**Page 7**).

Carriers will be required to provide quality information related to:

- Accreditation (**Page 8**)
- Quality Reporting (**Page 9**)
- Quality Strategy (**Page 10**)
- Pharmacy Utilization Management Program (**Page 12**)
- Quality Rating Data (**Page 13**)

Plan Level:

Carriers will be required to submit basic QHP information. **(Additional information on page 14).**

Carriers will need to provide information on:

- Plan Benefit Design (**Pages 15-20**)
- Cost-sharing Characteristics (**Pages 20-21**)
- SBC Scenario Results (**Pages 21-23**)
- Out-of-pocket expenses (**Pages 24-25**)
- Pharmacy Benefit Plan Data (**Pages 25**)
- Drug Formulary Data (**Page 27**)

QHP-specific information will need to be provided on:

- Rates (**Page 28**)
- Performance Information (**Page 29**)
- Service Area (**Page 30**)
- Provider Data (**Page 31**)
- Attestations (**Page 32**)
- User Fees (**Page 34**)
- Risk Adjustment and Transitional Reinsurance (**Page 35**)

Decertification and Recertification:

The subject matter contained in this document is strictly related to the initial QHP and stand-alone dental plan applications. The District has not yet made specific, preliminary decisions about the process for decertification and any related, or periodic (such as annual) recertification requirements.

Requirements for recertification and decertification will be based on the certification requirements to be created at a later date.

Section 2: Potential Carrier-specific Application Requirements

1- Issuer General Information

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

This information is not specifically required by the ACA for Qualified Health Plan (QHP) certification.

DC QHP Requirements

The QHP issuer will need to be identified and included on the application. Required data elements may include the following:

Element Name
Company Legal Name
Name of Holding Company
Issuer Marketing Names/Underwriting Company
Non-Profit Indicator
Issuer Legal Name (State-level legal entity authorized to do business in DC)
Submitter First Name
Submitter Last Name
Submitter Email Address
Submitter Phone Number
Corporate Headquarters Address
Federal Employer Identification Number (EIN)/Federal Tax Identification Number
NAIC Company Code
NAIC Group Code
A.M. Best ID
Expected FFE State Participation
Consumer Operated and Oriented Plans (CO-OPs) Indicator
HIOS Issuer ID
Medicaid Managed Care Information
Medicaid Managed Care State ID
Stand-alone Dental Indicator
Current Market Coverage
Expected Exchange Market Coverage
All associated u/w companies

The following carrier information may also be required:

Element Name	Element Type
URL for Summary of Benefits & Coverage	Individual Market, Small Group Market, and Pharmacy Market
Consumer-Facing Web Site URL	Individual Market, Small Group Market, and Pharmacy Market
Customer Service Phone	Individual Market
Customer Service Phone Extension	Individual Market
Customer Service Toll Free Number	Individual Market
Customer Service TTY	Individual Market
Customer Service URL	Individual Market
Customer Service Phone	Small Group Market
Customer Service Phone Extension	Small Group Market
Customer Service Toll Free Number	Small Group Market
Customer Service TTY	Small Group Market
Customer Service URL	Small Group Market
Customer Service Phone	Pharmacy Benefit
Customer Service Phone Extension	Pharmacy Benefit
Customer Service Toll Free Phone Number	Pharmacy Benefit
Customer Service TTY	Pharmacy Benefit
Customer Service URL	Pharmacy Benefit

District of Columbia Dental Requirements

The same issuer general information requirements will apply to dental plans.

The information provided on the application must match the information on file with the DC Department of Insurance, Securities and Banking (DISB) and represent the legal entity that has the certificate of authority to offer health insurance policies in the District of Columbia.

2- Issuer Key Staff and Administrative Management

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

This information is not required by the ACA for QHP certification.

District of Columbia QHP Requirements

- Organizational Chart
- QHPs will be required to attest to language similar to, "We certify that we have an appropriate administrative structure, and will maintain appropriate staffing, qualified management, and all necessary administrative capacity to effectively administer this QHP, in addition to all other QHPs that we offer."
- The following Key Staff information may be required:

Element Name	Individual Exchange, SHOP or Both
Primary Company Contact – Name and Contact Information	Both
CEO – Name and Contact Information	Both
CFO – Name and Contact Information	Both
Primary Data Submitter – Name and Contact Information	Individual Exchange
Primary Data Submitter – Name and Contact Information	SHOP
Primary Data Validator – Name and Contact Information	Individual Exchange
Primary Data Validator – Name and Contact Information	SHOP
Primary Government Contact – Name and Contact Information	Individual Exchange
Primary Government Contact – Name and Contact Information	SHOP
Secondary Data Submitter – Name and Contact Information	Individual Exchange
Secondary Data Submitter – Name and Contact Information	SHOP
Secondary Data Validator – Name and Contact Information	Individual Exchange
Secondary Data Validator – Name and Contact Information	SHOP
Tertiary Data Submitter – Name and Contact Information	Individual Exchange
Tertiary Data Submitter – Name and Contact Information	SHOP
Tertiary Data Validator – Name and Contact Information	Individual Exchange
Tertiary Data Validator – Name and Contact Information	SHOP
Compliance Officer – Name and Contact Information	Both
Enrollment Contact – Name and Contact Information	Both
Online Enrollment Center Contact – Primary and Secondary Name and Contact Information	Both
System Contact – Name and Contact Information	Both
Company Appeals/Grievances Contact – Name and Contact Information	Both
Customer Services Operations Contact – Name and Contact Information	Both
User Access - Name and Contact Information	Both

Backup User Access Contact - Name and Contact Information	Both
Marketing Contact - Name and Contact Information	Both
Chief Medical Officer/Medical Director - Name and Contact Information	Both
Pharmacy/Formulary Contact - Name and Contact Information	Both
Payment Contact - Name and Contact Information	Both
Government Relations - Contact Name and Contact Information	Both
HIPAA Security Officer - Name and Contact Information	Both
HIPAA Privacy Officer - Name and Contact Information	Both
Financial Reporting Contact - Name and Contact Information	Both
Complaints Tracking Contact - Name and Contact Information	Both
Quality Contact - Name and Contact Information	Both
APTC/CSR Contact - Name and Contact Information	Both
Risk Corridors - Name and Contact Information	Both
Compliance Officer - Name and Contact Information	Both
Individual Market Contact - Name and Contact Information	Both
Small Group Contact - Name and Contact Information	Both
Rate and Benefit Contact - Name and Contact Information	Both
Risk Adjustment Contact - Name and Contact Information	Both
Reinsurance Contact - Name and Contact Information	Both
Quality Contact - Name and Contact Information	Both

District of Columbia Dental Requirements

Contact information and attestation language will also be required for the dental application.

The application or attached instructions will contain clear directions that the point of contact identified should be the person with primary responsibility for and authority over the carrier's QHP(s) in the DC Exchange.

3- Licensure and Financial Condition

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

A QHP issuer must be licensed and in good standing to offer health insurance coverage in each state in which the issuer offers health insurance coverage *(45 CFR Part 156.200(b)(4))*.

District of Columbia QHP Requirements

- The application will request licensure and financial condition information.
- QHPs will be required to attest to language similar to, "We certify that we are licensed to sell health insurance in the District of Columbia, and are in good standing, and will maintain good standing and appropriate solvency levels consistent with the addition of this new business."
- Necessary information may include:
    - Licensure Supporting Documentation: Supporting documentation to demonstrate current licensure and authority. May include license and/or certificate(s) of authority.
    - Seeking Licensure Narrative: Free text narrative describing additional licenses and/or authority needed to offer proposed plans described in application, if applicable.
    - Expected Date of Licensure/Authorization: Date by which the applicant expects to have obtained necessary licenses and/or authority, if applicable.
    - Solvency Supporting Documentation: Supporting documentation to demonstrate current compliance with State financial solvency requirements.
    - Solvency Justification Narrative: Free Text narrative providing justification for why the issuer does not meet State solvency requirements and/or does not project a positive net worth for the calendar year in which it is currently applying to offer QHPs, if applicable.
    - State Corrective Action Narrative: Free text narrative providing explanation related to current State corrective action, if applicable.
    - Financial Solvency Good Standing Documentation: Supporting documentation to demonstrate that applicant is not currently under corrective action by State related to non-compliance with financial solvency requirements.

District of Columbia Dental Requirements

The dental application will also require an attestation and licensure and financial condition information.

4- Quality Information (Accreditation)

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

To be certified, a plan shall at a minimum …(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria), or (ii) receive such accreditation within a period established by the Exchange for such accreditation that is applicable to all qualified health plans. *(Section 1311 (c)(1)(D) of the ACA)*

District of Columbia QHP Requirements

- The District of Columbia will accept all HHS accrediting entities (i.e., NCQA or URAC), as long as they cover the basic ACA requirements.
- Accreditation must cover the carrier's District of Columbia operations.
- There will be a **one-year** grace period for compliance for plans that are not accredited at the time of application. For QHPs within the grace period, an attestation that the plan has applied for accreditation and an updated application status will be required.
- Required data elements may include:
    - Accreditation Organization Identification Number (Org ID)/Application Number
    - Name of Accrediting Entity
    - Market Type (Commercial or Medicaid)
        - Health care coverage that a health care entity is already providing in the large, small or individual commercial markets or in the Medicaid market.
    - Accrediting Product (if applicable) (HMO/POS/PPO)
        - An organization may have accreditation at the product level
    - Accreditation Sub ID (if applicable)
        - A unique identifier that an accrediting entity assigns to each product within each existing line of business that is offered by a health care organization.
    - Authorized Release of Accreditation Survey
        - Indicator of whether applicant authorized release of accreditation survey by the accrediting entity to the Exchange and HHS. This authorization is required.

District of Columbia Dental Requirements

This information will **not** be required for the dental application.

Because of the reliance the D.C. HBX Authority will be placing on accreditation, additional quality information will be required of plans in the grace period that have not yet obtained their accreditation.

5- Quality Information (Quality Reporting)

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum,…
(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Services Act, as applicable, and (I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act. *(Section 1311(c)(1)(H)&(I))*

QHP issuers must disclose and report on:

- Health care quality and outcomes measures
- Implement and report on Quality Improvement Strategy(s) consistent with 1311(g)
- Enrollee satisfaction surveys consistent with section 1311(c)(4) (covered later in the Performance Information section) *(45 CFR Part 156.200(b)(5))*

Note: Specific measures related to health care quality and outcomes have not been further defined by HHS.

District of Columbia QHP Requirements

- Carriers will be required to report District of Columbia-specific quality information to satisfy DC quality reporting requirements. Specific guidance on District of Columbia quality reporting requirements will be provided in the future.

District of Columbia Dental Requirements

Quality reporting will **not** be required for the current dental application. Dental-specific quality measures may be promulgated by the District of Columbia for future plan years.

In an effort to ensure equal comparison of data between QHPs and to minimize administrative burden to the Exchange, health care quality and outcome measures should be reported in a consistent format as defined by HHS or the District of Columbia.

6- Quality Information (Quality Strategy)

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

QHP issuers must implement and report on quality improvement strategy or strategies consistent with 1311(g)(1) of the ACA *(45 CFR Part 156.200(b)(5). Note: This is the same citation as for the previous requirement, #1, as it is one of the three quality requirements listed.)*

(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES:
(1) STRATEGY DESCRIBED – A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for:

> (A) Improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage.
>
> (B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional.
>
> (C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
>
> (D) the implementation of wellness and health promotion activities; and
>
> (E) [as added by section 10104(g)] the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1). *(Section 1311 (g) of the ACA)*

District of Columbia QHP Requirements

- Quality improvement information will **not** be requested in the application from accredited carriers, but an attestation that addresses the required elements from this section will be included.
- Accreditation status for carriers will meet the quality strategy requirements if the accreditation adequately covers all required elements of the quality strategy requirements, including the guidelines to be developed by HHS.
- For carriers that have not been accredited, this requirement will apply and a written quality improvement strategy must be submitted.

District of Columbia Dental Requirements

The attestation of a quality strategy will **not** be required for the dental application.

7- Quality Information (Pharmacy Utilization Management Program)

This information will be Carrier-specific and will only need to be submitted once per carrier for all related initial QHP application submissions.

ACA Requirements

A QHP issuer must provide to HHS the following information:

- The percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type,… *(Section 156.295(a)(1))*
- The aggregate amount, and the type of rebates, discounts or price concessions…*(Section 156.295(a)(2))*
- The aggregate amount of the difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed *(Section 156.295(a)(3))*

District of Columbia QHP Requirements

The District of Columbia will have no requirements above and beyond ACA Pharmacy Utilization Management Program requirements.

District of Columbia Dental Requirements

Pharmacy utilization management program quality information will **not** be required for the dental application.

8- Quality Information (Quality Rating Data)

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4) *(Section 1311(c)(3) of the ACA).*

District of Columbia QHP Requirements

Quality rating information will be requested in the application.

District of Columbia Dental Requirements

Quality rating information will not be required for the dental application unless required by HHS or the District of Columbia.

DISB will request the quality rating data from the carriers that will be necessary to provide, implement and maintain the quality rating system developed by HHS. Reporting of quality data will be in a single form and format (to be determined).

Section 3: Potential QHP-specific Application Requirements

1- Basic QHP Data

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirements

This information is not required by the ACA for QHP certification.

District of Columbia QHP Requirements

Required data elements may include:

Element Name
Bank Account ID
Bank Name and Address
Bank Account Number
ABA Routing Number
HIOS Product ID
H.S.A.-Eligible?
Child-Only Offering
Plan Type (Network design)
Stand-Alone Dental Plan Type
Product ID
Product Name
Plan Effective Date
Plan Expiration Date
Administrative Fees (e.g., monthly fees)
Issuer Fee Conditions
Primary Care Physician Required
Network ID
Network Name
Network Provider List URL

District of Columbia Dental Requirements

The dental application will also require basic plan data.

2- Plan Benefit Design

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirements

A QHP issuer must submit rate and benefit information to the Exchange pursuant to 45 CFR Part 155.1020 *(45 CFR Part 156.210(b)).*

Benefit and rate information:

The Exchange must receive the following information, at least annually, from QHP issuers for each QHP in a form and manner to be specified by HHS:

- Rates
- Covered benefits
- Cost-sharing requirements *(45 CFR Part 155.1020(3)(c))*

District of Columbia QHP Requirements

- QHPs must complete an actuarial certification of benefit level (i.e., that the plan is actuarial equivalent to the metal level proposed) and include plan benefit design information.
- Under the approach described in the HHS Essential Health Benefits Bulletin, a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR 457.431, and provided that substitutions would not violate other statutory provisions.
- The detailed contract should also be included in the certification application.
- The plan must outline health benefit data and identify plan benefits which must meet or exceed the benefits of the benchmark plan.[1]
    - DC has selected the CareFirst BluePreferred Option 1 Plan as the Benchmark Plan.

[1] Pursuant to the District's EHB submission, further federal guidance may impact final benefit design and benefit limits.

CareFirst BluePreferred Option 1 Plan Benefits:

Benefit	Coverage Details	Source Plan
1. Ambulatory Patient Services		
a. Outpatient hospital facility services	Covered	Small Group- CareFirst BluePreferred Option 1
b. Ambulatory surgical facility services	Covered	Small Group- CareFirst BluePreferred Option 1
c. Professional medical services provided at care facility	Covered	Small Group- CareFirst BluePreferred Option 1
d. Professional surgical services provided at care facility	Covered	Small Group- CareFirst BluePreferred Option 1
e. Home health services	Limited to 90 visits up to 4 hours per episode of care	Small Group- CareFirst BluePreferred Option 1
2. Emergency Coverage		
a. Emergency room services (including voluntary HIV test performed while receiving emergency medical services at a hospital ER).	Covered	Small Group- CareFirst BluePreferred Option 1
b. Ambulance service	Covered	Small Group- CareFirst BluePreferred Option 1
3. Hospitalization		
a. Inpatient facility services (medical or surgical condition)	Covered	Small Group- CareFirst BluePreferred Option 1
b. Hospitalization for rehabilitation	Covered	Small Group- CareFirst BluePreferred Option 1
c. Inpatient professional medical services	Covered	Small Group- CareFirst BluePreferred Option 1
d. Inpatient professional surgical services	Covered	Small Group- CareFirst BluePreferred Option 1
e. Anesthesia services	Covered	Small Group- CareFirst BluePreferred Option 1
f. Hospice services	Limited to max 180 day hospice eligibility period	Small Group- CareFirst BluePreferred Option 1
4. Maternity/Newborn Care		
a. Pre-natal care	Covered	Small Group- CareFirst BluePreferred Option 1

Benefit	Coverage Details	Source Plan
b. Post-natal care	Covered	Small Group- CareFirst BluePreferred Option 1
c. Labor and Delivery	Covered	Small Group- CareFirst BluePreferred Option 1
d. Inpatient Facility Services	Covered (48 hours following a vaginal delivery, 96 hours following a Cesarean section).	Small Group- CareFirst BluePreferred Option 1
e. Routine newborn care	Covered	Small Group- CareFirst BluePreferred Option 1
f. Postpartum home visits	Covered	Small Group- CareFirst BluePreferred Option 1
5. Mental Health, Substance Use Disorders, Behavioral Health Treatment		
a. Mental health outpatient services	Visits 1-40: 25% of allowed benefit. Visits 40+: 40% of allowed benefit.	Small Group- CareFirst BluePreferred Option 1
b. Substance abuse outpatient services	Visits 1-40: 25% of allowed benefit. Visits 40+: 40% of allowed benefit.	Small Group- CareFirst BluePreferred Option 1
c. Medication management office visits	Covered	Small Group- CareFirst BluePreferred Option 1
d. Inpatient mental health facility services	Limited to 60 days per benefit period	Small Group- CareFirst BluePreferred Option 1
e. Inpatient substance abuse facility services	Limited to 60 days per benefit period	Small Group- CareFirst BluePreferred Option 1
f. Detoxification	Limited to 12 visits (inpatient or outpatient) per benefit period	Small Group- CareFirst BluePreferred Option 1
g. Partial hospitalization	Covered	Small Group- CareFirst BluePreferred Option 1
6. Prescription Drugs		
a. Preferred preventative drugs	Covered	Small Group- CareFirst BluePreferred Option 1
b. Generic Drug	Covered	Small Group- CareFirst BluePreferred Option 1
c. Preferred brand name drug	Covered	Small Group- CareFirst BluePreferred Option 1
d. Non-preferred brand name drug	Covered	Small Group- CareFirst BluePreferred Option 1
e. Diabetic supplies	Covered	Small Group- CareFirst BluePreferred Option 1

Benefit	Coverage Details	Source Plan
f. Oral chemotherapy drugs	Covered	Small Group- CareFirst BluePreferred Option 1
g. Injectable, self-administered medications	For each (34) day supply of covered injectable meds that are self-administered, except for insulin, the Member will be required to pay 50e% of Allowed Benefit up to a Member maximum Copay of $75 per covered injectable medication. For up to (90) day supply of self-administered, injectable Maintenance Drugs, except for insulin, the Member will be required to pay 50% of the Allowed Benefit up to a Member maximum payment of $150.	Small Group- CareFirst BluePreferred Option 1
h. Prescription drugs (general)	For Prescription Drugs purchased in a Pharmacy or purchased through the mail order program, there is one Copayment due for each thirty-four (34) day supply.	Small Group- CareFirst BluePreferred Option 1
i. Maintenance drugs (general)	For Maintenance Drugs, a Member may receive up to a ninety (90) day supply provided the Member pays one Copayment for the first thirty-four (34) day supply and a second Copayment for a supply of thirty-five (35) days or more.	Small Group- CareFirst BluePreferred Option 1
j. Contraception	Covered	Small Group- CareFirst BluePreferred Option 1
7. Rehabilitative & Habilitative Services and Devices		
a. Rehabilitation Services	Occupational therapy, physical therapy, speech therapy	Small Group- CareFirst BluePreferred Option 1
b. Spinal manipulation services	Limited to Members who are twelve years or age older	Small Group- CareFirst BluePreferred Option 1
c. Habilitative services for children	Limited to members under the age of 21	Small Group- CareFirst BluePreferred Option 1
d. Cardiac rehabilitation	Limited to members under the age of 21	Small Group- CareFirst BluePreferred Option 1
e. Pulmonary rehabilitation	Limited to 1 pulmonary rehabilitation program per lifetime	Small Group- CareFirst BluePreferred Option 1

Benefit	Coverage Details	Source Plan
f. Skilled nursing facility services	Limited to 60 days per benefit period	Small Group- CareFirst BluePreferred Option 1
g. Medical devices and supplies	Covered	Small Group- CareFirst BluePreferred Option 1
8. Laboratory Services		
a. Laboratory tests	Covered	Small Group- CareFirst BluePreferred Option 1
b. X-rays and other diagnostic procedures	Covered	Small Group- CareFirst BluePreferred Option 1
9. Preventative and Wellness Services		
a. Adult routine physical exam	Covered	Small Group- CareFirst BluePreferred Option 1
b. Routine gynecological exam	Covered	Small Group- CareFirst BluePreferred Option 1
c. Prostate cancer screening	Covered	Small Group- CareFirst BluePreferred Option 1
d. Pap smear	Covered	Small Group- CareFirst BluePreferred Option 1
e. Mammography	Covered	Small Group- CareFirst BluePreferred Option 1
f. Colorectal cancer screening	Covered	Small Group- CareFirst BluePreferred Option 1
g. Immunizations	Covered	Small Group- CareFirst BluePreferred Option 1
h. Medical nutrition therapy	Covered	Small Group- CareFirst BluePreferred Option 1
i. Professional nutritional counseling	Covered	Small Group- CareFirst BluePreferred Option 1
j. Allergy testing, treatment, and shots	Covered	Small Group- CareFirst BluePreferred Option 1
k. Diabetes treatment	Covered	Small Group- CareFirst BluePreferred Option 1
10. Pediatric Services, including Oral and Vision		
a. Well-child care	Covered	Small Group- CareFirst BluePreferred Option 1
b. Preventative services for obesity	Covered	Small Group- CareFirst BluePreferred Option 1
c. Vision- eye exam (separate visit)	1 per year	FEDVIP- BlueVision High Plan
d. Vision- lenses	1 pair per year	FEDVIP- BlueVision High Plan
e. Vision- frames	1 per year ($150 allowance)	FEDVIP- BlueVision High Plan
f. Vision- contact lenses	1 per year ($150 allowance, $600 for medical necessity)	FEDVIP- BlueVision High Plan

Benefit	Coverage Details	Source Plan
g. Dental class A- diagnostic and treatment services	1 oral evaluation per 6 months	FEDVIP-MetLife High Option
h. Dental class A- preventative services.	Sealants (1 per tooth every 36 months), prophylaxis (1 every 6 months), space maintainers (limited to children under 19).	FEDVIP-MetLife High Option
i. Dental class B-minor restorative service	Covered	FEDVIP-MetLife High Option
j. Dental class B- oral surgery	Covered	FEDVIP-MetLife High Option
k. Dental class C- major restorative services	Covered	FEDVIP-MetLife High Option
l. Dental class C- endodontic services	Covered	FEDVIP-MetLife High Option
m. Dental class C- periodontal services	Covered	FEDVIP- MetLife High Option
n. Dental class C- prosthodontics services	Covered	FEDVIP-MetLife High Option
o. Anesthesia services	Covered	FEDVIP-MetLife High Option
p. Intravenous sedation	Covered	FEDVIP-MetLife High Option

- Carriers must identify benefit cost sharing – cost-sharing tiers that permit different cost-sharing amounts for a set of providers or services (cost-sharing data are applicable to specific benefits, though not all cost-sharing factors are applicable to all benefits).
    - Plans will need to identify the applicability of cost-sharing characteristics that can potentially be applied to each of the specific health benefits that carriers will need to identify.
    - Possible cost-sharing characteristics are included in the below table:

Characteristic	Description of Characteristic
Covered?	Is this benefit covered, not covered, available as rider?
Tier (Y/N)?	Do you have cost-sharing tiers?
Number of tiers	Enter the number of cost-sharing tiers
Tier name	Enter the name of the cost-sharing tier
Coinsurance (in network)	If an in-network coinsurance is charged, enter the percentage here. If no coinsurance is charged, leave blank.
Coinsurance (out of network)	If an out of network coinsurance is charged, enter the percentage here. If no coinsurance is charged, leave blank.
Copayment (in network)	If an in-network copayment is charged, enter the amount here. If no copayment is charged, leave blank.
Copayment (out of network)	If an out of network copayment is charged, enter the amount here. If no copayment is charged, leave blank.

Out of Pocket Limit (in network)	This is defined as an annual cap on the amount of money individuals are required to pay out of pocket for health care costs, excluding the premium cost. Exclusions will be identified.
Out of Pocket Limit (out of network)	This is defined as an annual cap on the amount of money individuals are required to pay out of pocket for health care costs, excluding the premium cost. Exclusions will be identified.
Referral(s) Required	Referral(s) Required None, single, or multiple referral(s) required for this benefit
Prior Authorization(s) Required	None, one, or multiple prior authorization(s) required for this benefit
Quantitative Limit on Service (Y/N)?	If there are quantitative limits on this benefit, enter Y.
Limit Quantity	If there are limits on this benefit, enter the numerical limit. (e.g., day or visit limits for essential health benefits, dollar limits on services other than essential health benefits.)
Limit Unit	Is the limit the number of visits (e.g. 30 physical therapy visits in one year), number of days, etc.?
Non-Quantitative Limit on Service (Y/N)?	If there are limits on non-quantitative parameters of service, enter Y.
List Non-Quantitative Limits of Service	List the non-quantitative limits and exclusions applicable to this benefit. This includes non-quantitative treatment limits listed at 45 CFR 146.136.
Minimum Stay	If there is a minimum stay, list the minimum stay in hours for this benefit.
Explanation (text field)	Free text field to list any notes.
Exclusions	If particular services or diagnoses are excluded, please list those exclusions. Commonly excluded benefits include non-emergency transportation, elective cosmetic surgery, and therapy.

- Carriers will need to include the Summary of Benefits and Cost (SBC) scenario results in the application
    - The National Association of Insurance Commissioners (NAIC) released a sample SBC document that a plan would have to make available to the public. In this document, plans must submit three treatment scenarios (having a baby, treating breast cancer, and managing diabetes) and the cost for each one. For each treatment situation, the

Coverage Example helps show how deductibles, copayments, and coinsurance can add up.

- A table will be provided that requires carriers to enter the following data elements for each plan for three required and one other treatment scenario.

Reference ID	Data element name	Data element description
400	Having a Baby: Final Payment to Provider	SBC example, having a baby. What is the final payment to the provider?
401	Having a Baby: Deductible	SBC example, having a baby. What is the deductible?
402	Having a Baby: Copayment	SBC example, having a baby. What is the copayment due from the insured?
403	Having a Baby: Coinsurance	SBC example, having a baby. What is the coinsurance due from the insured?
404	Having a Baby: Customer Total Cost	SBC example, having a baby. What is the total cost to the customer?
405	Having a Baby: Limits	SBC example, having a baby. What is the total cost to the customer for limits and exclusions?
406	Treating Breast Cancer: Final Payment to Provider	SBC example, treating breast cancer. What is the final payment to the provider?
407	Treating Breast Cancer: Deductible	SBC example, treating breast cancer. What is the deductible?
408	Treating Breast Cancer: Copayment	SBC example, treating breast cancer. What is the copayment due from the insured?
409	Treating Breast Cancer: Coinsurance	SBC example, treating breast cancer. What is the coinsurance due from the insured?

Reference ID	Data element name	Data element description
410	Treating Breast Cancer: Customer Total Cost	SBC example, treating breast cancer. What is the total cost to the customer?
411	Treating Breast Cancer: Limits	SBC example, treating breast cancer. What is the total cost to the customer for limits and exclusions?
412	Managing Diabetes: Final Payment to Provider	SBC example, managing diabetes. What is the final payment to the provider?
413	Managing Diabetes: Deductible	SBC example, managing diabetes. What is the deductible?
414	Managing Diabetes: Copayment	SBC example, managing diabetes. What is the copayment due from the insured?
415	Managing Diabetes: Coinsurance	SBC example, managing diabetes. What is the coinsurance due from the insured?
416	Managing Diabetes: Customer Total Cost	SBC example, managing diabetes. What is the total cost to the customer?
417	Managing Diabetes: Limits	SBC example, managing diabetes. What is the total cost to the customer for limits and exclusions?
418	Other Example: Final Payment to Provider	SBC example, other example. What is the final payment to the provider?
419	Other Example: Deductible	SBC example, other example. What is the deductible?
420	Other Example: Copayment	SBC example, other example. What is the copayment due from the insured?
421	Other Example: Coinsurance	SBC example, other example. What is the coinsurance due from the insured?
422	Other Example: Customer Total Cost	SBC example, other example. What is the total cost to the customer?
423	Other Example: Limits	SBC example, other example. What is the total cost to the customer for limits and exclusions?
424	Are the following services covered (Y/N)?	Do you cover the following services: cosmetic surgery, long-term care, routine eye care (adult), dental care (adult), non-emergency care when traveling outside the United States, routine foot care, infertility treatment, private duty nursing, routine hearing test, acupuncture for rehabilitation purposes, chiropractic care, bariatric surgery, hearing aids or weight loss programs?

- Other plan data will also be required including:
  - Plan – plan-level identification information that does not vary by the individual health benefit and was not captured in the issuer application.
  - Plan cost sharing – the plan overall cost-sharing information, such as in-network, out-of-network, or deductible, including:
    - Medical Records coverage
    - Out-of-country coverage
    - Out-of-Service Area Coverage
    - National Network
  - The following include selected additional data elements that may be required:

Element Name	Element Description
Plan Level Combined Maximum Out of Pocket for Additional Benefits Above EHBs	Maximum out of pocket (MOOP) for additional benefits above EHBs combined for in and out of network and medical/drug. Combined MOOP may be a number smaller than the sum

	of the in-network MOOP plus the out-of network MOOP. Medical MOOP may be separate from Drug MOOP and may or may not be additive. Additional benefits above EHBs include state-mandated benefits and issuer-added benefits.
Limits for Plan Level Combined Maximum Out of Pocket for Additional Benefits Above EHBs	List all benefits that are excluded from plan level combined maximum out of pocket for additional benefits above EHBs.
Plan Level Maximum Out of Pocket In Network for Additional Benefits Above EHBs	Maximum out of pocket (in network) for additional benefits above EHBs. Combined for medical/drug.
Limits for Plan Level Maximum Out of Pocket In Network for Additional Benefits Above EHBs	List all benefits that are excluded from plan level maximum out of pocket in network for additional benefits above EHBs.
Plan Level Maximum Out of Pocket Out of Network for Additional Benefits Above EHBs	Maximum out of pocket (out of network) for additional benefits above EHBs. Combined for medical/drug.
Limits for Plan Level Maximum Out of Pocket Out of Network for Additional Benefits Above EHBs	List all benefits that are excluded from plan level maximum out of pocket out of network for additional benefits above EHBs.
Plan Level Combined Maximum Out of Pocket—Individual Additional Benefits Above EHBs	Individual maximum out of pocket for additional benefits above EHBs combined for in and out of network and medical/drug. Additional benefits above EHBs include state mandated benefits and issuer-added benefits.
Limits for Plan Level Combined Maximum Out of Pocket—Individual for Additional Benefits Above EHBs	List all benefits that are excluded from plan level combined maximum out of pocket—individual for additional benefits above EHBs.
Plan Level Combined Maximum Out of Pocket—Family for Additional Benefits Above EHBs	Family maximum out of pocket for additional benefits above EHBs combined for in and out of network and medical/drug. Additional benefits above EHBs include state-mandated benefits and issuer-added benefits.
Limits for Plan Level Combined Maximum Out of Pocket—Family for Additional Benefits Above EHBs	List all benefits that are excluded from plan level combined maximum out of pocket— family for additional benefits above EHBs.
Plan Level Combined Maximum Out of Pocket for EHBs	Maximum out of pocket for EHBs combined for in and out of network

	and medical/drug.
Limits for Plan Level Combined Maximum Out of Pocket for EHBs	List all benefits that are excluded from plan level combined maximum out of pocket for EHBs.
Plan Level Maximum Out of Pocket In Network for EHBs	Maximum out of pocket (in network) for EHBs. Combined for medical/drug.
Limits for Plan Level Maximum Out of Pocket In Network for EHBs	List all benefits that are excluded from plan level maximum out of pocket in network for EHBs.
Plan Level Maximum Out of Pocket Out of Network EHBs	Maximum out of pocket (out of network) for EHBs. Combined for medical/drug.
Limits for Plan Level Maximum Out of Pocket Out of Network for EHBs	List all benefits that are excluded from plan level maximum out of pocket out of network for EHBs.
Plan Level Combined Maximum Out of Pocket—Individual for EHBs	Individual maximum out of pocket for EHBs combined for in and out of network and medical/drug.
Limits for Plan Level Combined Maximum Out of Pocket—Individual for EHBs	List all benefits that are excluded from plan level combined maximum out of pocket—individual for EHBs.
Plan Level Combined Maximum Out of Pocket—Family for EHBs	Family maximum out of pocket for EHBs combined for in and out of network and medical/drug.
Limits for Plan Level Combined Maximum Out of Pocket—Family for EHBs	List all benefits that are excluded from plan level combined maximum out of pocket—family for EHBs.
Plan Level Combined Maximum Out of Pocket—Total	Combined maximum out of pocket—total.
Limits for Plan Level Combined Maximum Out of Pocket—Total	List all benefits that are excluded from plan level combined maximum out of pocket—total.
Plan Level Maximum Out of Pocket In Network—Total	Overall maximum out of pocket (in network)—total.
Limits for Plan Level Maximum Out of Pocket In Network—Total	List all benefits that are excluded from plan level maximum out of pocket in network—total.
Plan Level Maximum Out of Pocket Out of Network—Total	Overall maximum out of pocket (out of network)—total.
Limits for Plan Level Maximum Out of Pocket Out of Network—Total	List all benefits that are excluded from plan level maximum out of pocket out of network—total.
Plan Level Combined Maximum Out of	Individual combined maximum out of

Pocket—Individual—Total	pocket—individual —total.
Limits for Plan Level Combined Maximum Out of Pocket—Individual—Total	List all benefits that are excluded from plan level combined maximum out of pocket—individual—total.
Plan Level Combined Maximum Out of Pocket—Family—Total	Family combined maximum out of pocket—family —total.
Limits for Plan Level Combined Maximum Out of Pocket—Family—Total	List all benefits that are excluded from plan level combined maximum out of pocket—family—total.
Wellness Program Offered	List wellness programs offered according to Section 2705 of the Public Health Service Act.

The application will also require the following drug benefit data elements:

Pharmacy Benefit Plan Data – overall drug benefit data:

Element Name	Element Description
Drug Plan ID	Unique identifier for drug plan to link tables.
Drug Deductible Amount	What is the dollar value of the drug deductible?
Drugs Exempted From Drug Deductible	Does the benefit design exempt categories of drugs from the drug deductible? For which categories of drugs (e.g., “preventive” drugs)?
Drug MOOP	Amount of drug maximum out of pocket (MOOP).
Network Retail Pharmacy Limitation	If beneficiary must obtain maintenance supplies (60–90 day quantity) after some number of 30-day fills at a retail pharmacy, what is the number of retail pharmacy fills allowed before prescription must go to mail order?
Network Retail Pharmacy (60-90 Day Supply) Covered	Is retail pharmacy fill of maintenance supplies (60–90 day quantity) permitted, or must beneficiary go to plan’s designated mail order pharmacy?
Network Mail Order Pharmacy (60-90 Day Supply)	Does plan designate one or more mail order pharmacies?
Network Specialty Pharmacy	Does plan designate one or more specialty pharmacies?

Drug Tier Data - further definitions of drug benefits based on drug tiers and cost sharing:

Element Name	Element Description
Drug Tier ID	Tier ID
Cost-Sharing Type	Indicate the type of cost-sharing structure for this tier. Type options are copay or coinsurance.
Drug Tier Type	Tier drug types (select all that apply).

	Provide drug tier number (1 through 7) for each, then describe: Only select brands. All generics. All preferred generics. All non-preferred generics. Only select generics. All brands. All preferred brands. All non-preferred brands.
Up to 1 Month In Network Coinsurance Pharmacy	Indicate coinsurance percentage for in-network pharmacy up to 1-month supply.
2 Month In Network Coinsurance Pharmacy	Indicate coinsurance percentage for in-network pharmacy 2-month supply.
3 Month In Network Coinsurance Pharmacy	Indicate coinsurance percentage for in-network pharmacy 3-month supply.
Up to 1 Month In Network Copayment Pharmacy	Indicate copayment amount for in-network pharmacy up to 1-month supply.
2 Month In Network Copayment Pharmacy	Indicate copayment amount for in-network pharmacy 2-month supply.
3 Month In Network Copayment Pharmacy	Indicate copayment amount for in-network pharmacy 3-month supply.
2 Month Coinsurance Mail Order Pharmacy	Indicate coinsurance percentage for mail order pharmacy 2-month supply.
3 Month Coinsurance Mail Order Pharmacy	Indicate coinsurance percentage for mail order pharmacy 3-month supply.
2 Month Copayment Mal Order Pharmacy	Indicate copayment amount for mail order pharmacy 2-month supply.
3 Month Copayment Mail Order Pharmacy	Indicate copayment amount for mail order pharmacy 3-month supply.

The District of Columbia is awaiting future guidance on drug formulary data from HHS and will alert carriers when guidance is received.

District of Columbia Dental Requirements
The same information will be requested separately in the dental application; however actuarial certification will **not** apply unless required by HHS.

3- Rates

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirements

- General rate requirement: A QHP issuer must set rates for an entire benefit year, or for the SHOP plan year. *(45 CFR Part 156.210(a))*
- Rate and benefit submission: A QHP issuer must submit rate and benefit information to the Exchange pursuant to 45 CFR Part 155.1010. *(45 CFR Part 156.210(b))*
- Rate justification: A QHP issuer must submit a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site. *(45 CFR Part 156.210(c))*

District of Columbia QHP Requirements

Rate and rate justification will be required in the form and manner to be specified by HHS and the District.

District of Columbia Dental Requirements

Rate and rate justification will be required for the dental application.

4- Performance Information

This information will be Carrier-specific and will only need to be submitted once, per carrier, for all related initial QHP application submissions.

ACA Requirements

- The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include the enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans. *(Section 1311(c)(4) of the ACA)*
- A QHP issuer must provide the following information in accordance with the standards in paragraph (b) of this section:
    - Claims payment policies and practices
    - Periodic financial disclosures
    - Data on enrollment
    - Data on disenrollment
    - Data on the number of claims that are denied
    - Data on rating practices
    - Information on cost-sharing and payments with respect to any out-of-network coverage and
    - Information on enrollee rights under Title I of the Affordable Care Act *(45 CFR Part 156.220(a))*

District of Columbia QHP Requirements

- QHPs will be required to use the enrollee satisfaction survey system developed by the HHS Secretary and report results to the Exchange.
- The Exchange will require reporting only on the information that is required in 45 CFR Part 156.220.

District of Columbia Dental Requirements

It has not been decided whether performance information will be required for the dental application.

QHPs will be asked to include any additional performance information reporting that surfaces as a requirement.

5- Service Area

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirements

- The Exchange must have a process to establish or evaluate the service areas of QHPs to determine whether the following minimum criteria are met:
    - The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.
    - The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations. *(45 CFR Part 156.1055)*

District of Columbia QHP Requirements

- Guidance regarding specific service areas within the District of Columbia will be issued at a future point in time.

District of Columbia Dental Requirements

Service area information will also be included in the dental application.

6- Provider Data

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirement

- Ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers. *(ACA Section 1311(c)(1)(B))*
- Include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure. *(ACA Section 1311(c)(1)(C))*

District of Columbia QHP Requirements

- For HCSOs and PPOs, the District of Columbia Exchange will enforce the network adequacy and essential provider requirements under the ACA.
- Provider network reporting requirements will be developed based on a standardized format to be developed, or adopted, by the D.C. HBX Authority.
- Carriers will be required to attest that their network is sufficient and that they have essential community providers.
- Data required to document network adequacy may include:
    - Provider-enrollee ratios and time/distance measures for each QHP network that the applicant will include in the rate and benefit submission.
    - Essential Community Provider Name (Name of ECP as recognized/identified by HHS)
    - Essential Community Provider in Network Indicator (Specifies whether or not an Essential Community Provider is in a given network)
    - Essential Community Provider Alternative Standard Documentation (Documentation required to demonstrate compliance with alternative essential community provider standard defined in 45 CFR 156.235(b))

District of Columbia Dental Requirements

Provider network information will also be required for the dental application.

7- Attestations

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirements

- Comply with the minimum certification standards set forth in 45 CFR Subpart C of Part 156, with respect to each QHP on an ongoing basis:
    - Comply with Exchange processes, procedures, and requirements set forth pursuant to 45 CFR Subpart K of Part 155 and, in the small group market, Part 155.705 of Subpart H.
    - Ensure that each QHP complies with benefit design standards, as defined in 45 CFR Part 156.20.
    - Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage.
    - Implement and report on a quality improvement strategy or strategies consistent with the standards of Section 1311(g) of the ACA, disclose and report information on health care quality and outcomes described in Sections 1311(c)(1)(H) and (I) of the ACA, and implement appropriate enrollee satisfaction surveys consistent with Section 1311(c)(4) of the ACA.
    - Pay any applicable user fees assessed under 45 CFR Part 156.50.
    - Comply with the standards related to the risk adjustment program under 45 CFR Part 153.

District of Columbia QHP Attestation Requirements

- Attestations will be included on the application.
- The attestation language will cover the ACA requirements listed above, and will include specific attestations where agreed to in the other sections of this document.
- Attestations will cover QHPs existing operations as well as the contractual commitment to meet Exchange requirements on an on-going basis.
- Attestation that the plan falls within an accredited product as referenced in Section 2 Part 4 of this bulletin.

Other District of Columbia Required Attestations

- QHPs will be required to attest to language similar to, "We have no corrective action plans in the District of Columbia that have not or will not be addressed by December 31, 2013." QHPs with corrective action plans will be required to provide copies and necessary explanation.
  QHPs will be required to attest to language similar to, "We will comply with all applicable District laws governing marketing of insurance plans and will not discourage enrollment of individuals with significant health needs. Our communications will be simple and understandable, and will use Plain Language and language that is accessible to people with Limited English Proficiency."

District of Columbia Dental Requirements

Some of the same attestation language will apply to dental plans, but there may also be attestations that are unique to medical or dental.

The District of Columbia will require issuer experience attestations for the dental application.

8- User Fees

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirements
Pay any applicable user fees assessed under 45 CFR Part 156.50 *(45 CFR Part 156.200(b)(6)).*

District of Columbia QHP Requirements
Pay any applicable user fees assessed by the District of Columbia. Guidance on exact user fees will be issued at a future point in time.

District of Columbia Dental Requirements
User fee requirements will also apply to dental plans.

9- Risk Adjustment and Transitional Reinsurance

This information will be QHP-specific and will need to be included for each QHP in the carrier's submission.

ACA Requirements

Comply with the standards related to the risk adjustment program under 45 CFR Part 153 *(45 CFR Part 156.200(b)(7))*

District of Columbia QHP Requirement

QHPs will be required to attest that they will comply with ACA risk adjustment and transitional reinsurance requirements.

District of Columbia Dental Requirements

Risk adjustment and transitional reinsurance requirements will **not** apply to dental plans.