DC Health Benefit Exchange Authority

February 28, 2013

Recommendations of the Qualified Health Plan (QHP) Issuer Certification Process Working Group

This report is submitted by the QHP Issuer Certification Working Group Chair (Kevin Lucia) and Vice Chair (Katherine Stocks). The purpose of this report is to outline the recommendations of the QHP Issuer Certification Working Group regarding what issuers will be required to submit the DC Health Benefit Exchange Authority (HBX) with respect to becoming certified to sell health insurance through the HBX.

Background

For health insurance coverage beginning in 2014, individuals and small groups will be able to purchase coverage through exchanges, the purpose of which is to provide a competitive marketplace and facilitate comparison of health plans based on quality, price, coverage and other factors. Health insurance issuers must be certified as meeting minimum standards in order to participate in the exchange and issue qualified health plans. In March of 2012, the U.S. Department of Health and Human Services issued a final (some parts interim final) rule on "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers." (45 CFR Parts 155, 156 and 157). The preamble to the rule and the rule itself provide detailed guidance to exchange operators on the federal standards with which the exchange and the issuers must comply, such as state licensure; benefit and product standards; rating, rate filing and rating disclosures; marketing; quality, network adequacy and accreditation; and other required processes, procedures and disclosures.

To assist the working group in its discussions and deliberations, the working group used a document developed by the Georgetown University Health Policy Institute outlining the certification requirements, as adapted by the working group's facilitator after she thoroughly reviewed the federal rule. That document is attached. (Attachment A)

One of the ways departments of insurance (DOIs) across the nation operate is to use attestations (also known as certifications) of issuers that they are in compliance with the law. For example, company actuaries routinely certify that their rates are reasonable in relation to the premium charged and that they are not unfairly discriminatory. State DOIs, including DC's Department of Insurance Securities and Banking (DISB), accept these actuarial certifications. Similarly, issuers file annual financial statements and certify that they are correct. Again, state DOIs, including DISB, routinely accept these certifications.

DISB retains regulatory authority by acceptance of attestations, since it has full authority to enforce correction of an issuer error and impose any sanction, such as a fine, commensurate with the gravity of the error.

A significant portion of the working group's discussion recognized the fact that the DC HBX is in start-up mode, and time is of the essence in getting processes underway in order for plans to have qualified products and the HBX to be ready for the initial open enrollment period, which starts on October 1, 2013. Due to this very real time crunch, the bulk of the working group's recommendations are to accept issuer certifications of compliance with the various standards for first plan year. However, the working group also recognizes that operation of the HBX will be an evolving experience and in fact the HBX will have more data as the HBX grows and adds more enrollees. The working group recommends that the HBX Board revisit these standards prior to QHP certification in the second plan year, since the HBX will have additional data and experience to evaluate whether regulator verifications based on prospective evidence or means of accreditation other than issuer certifications should be required for certain standards.

It is also important to note that under the federal regulation, exchanges have an obligation to monitor compliance with federal standards for QHP and issuer certification. As HBX gains experience, becomes fully staffed and gains enrollees, actions such as spot checks of issuer websites and other monitoring activities should increase.

Working Group Members

The QHP Certification Process Working Group is comprised of representatives from health plans, benefit advisors and consumer advocates. Two meetings were held, on February 20 and 21, 2013, the first in-person and conference call participation, and the second by conference call.

Kevin Lucia	Georgetown University Health Policy Institute
Katherine Stocks	The Goldblatt Group
Dave Chandra	Center on Budget Policy and Priorities
Laurie Kuiper	Kaiser Permanente
Stacy Mills	Adventurous Consulting
Louisa Tavakoli	Care First
Colleen Cohan	UnitedHealthcare
James McSpadden	AARP DC
Kim Ruggiero	Aetna
Keith MacCannon	Chartered Health

Recommendations

The discussion and recommendations below follow the categories of Attachment A in order.

I – Licensed and in good standing

Consensus Recommendation:

- The regulator will verify that the issuer has a certificate of authority to conduct insurance business in DC for health (or dental) insurance

- Attestations for the following will be accepted:
  - Service area
  - General attestation that issuer has appropriate structure, staffing, management, etc. to administer QHP effectively and in conformance with federal requirements now and in the future
  - General attestation that issuer is in good standing – faces no outstanding licensing sanctions imposed by the Division of Insurance, Securities and Banking (DISB) and is not under a corrective action plan related to solvency

II – Benefit Standards and Product Offerings

The working group noted that DISB presently reviews and approves all forms before the products are allowed on the market. DISB will, in the future, review the forms to ensure compliance with the Affordable Care Act standards for benefits, including the determination of the actuarial value of the products, and whether they meet the requirements to be a QHP, or to be designated a Bronze, Gold, Silver or Platinum plan as proffered by the issuer. In fact, the federal government has developed, and made publicly available, an actuarial value calculator that is available to DISB staff to verify the metal level standard.

Consensus Recommendation:

- Attestations for the following will be accepted:
  - Product compliance for QHP and child-only policies
  - Compliance with nondiscrimination standards

III, IV and V – Rating Issues

The working group noted that DC has an "approved rate review program" (Center for Consumer Information and Insurance Oversight (CCIIO) determination) across all aspects of the individual and small group markets. The working group noted that DISB presently reviews and approves all rates before the products are allowed on the market.

Consensus Recommendation:
Attestations for all the standards will be accepted.

VI – Marketing

Due to the approaching enrollment start date, there will not be time for a front-end review of marketing materials. The working group noted that in most jurisdictions, with respect to major medical health insurance, Departments of Insurances tend to regulate marketing on the back end – through market conduct reviews or in response to consumer complaints. The working group also noted that generally speaking, on a national basis, major medical insurance has not seen problems with marketing issues. DC should be cautious, though, because there are no local standards for marketing and other lines of health insurance have been problematic in the past, such as Medicare Advantage when it was first introduced.

Consensus Recommendation:
Attestations for the standard will be accepted.

VII – Network Adequacy

The working group noted that both network adequacy and quality assurance are scrutinized thoroughly in the accreditation process. Presently, all issuers licensed to do business in DC are accredited.*

Consensus Recommendation:

- If an issuer is accredited, attestation for all the standards will be accepted.
- If an issuer is not accredited, it will be required to submit an access plan.

*Policy currently being reviewed by DC HBX network adequacy working group.

VIII – Applications and Notices
IX – Transparency Requirements

The working group noted the transparency standards will be self-regulating as the HBX will know if the issuer has reported to it as required.

Consensus Recommendation:
Attestations for all the standards will be accepted.

X – Enrollment Periods
XI – Enrollment Process for Qualified Individuals
XII- Termination of Qualified Individuals

The working group noted that if there were issues with any of these three groups of standards, the HBX would discover it very quickly as aggrieved individuals would likely file complaints about the alleged misconduct. State DOIs, including DISB, have a variety of data collection systems in place and track complaints very closely.

Consensus Recommendation:
Attestations for all the standards will be accepted.

XIII – Accreditation Standards

The working group noted that it would be imprudent for an issuer to attest to being accredited if that were not the case, since accreditation status can be easily verified through the accreditation bodies. The accreditation bodies perform a thorough review of issuer operations and processes before awarding accreditation.

Consensus Recommendation:

- If an issuer is accredited, attestation for all the standards will be accepted.
- If an issuer is not accredited, it will be required to attest that it is in the process of becoming accredited prior to whatever standard (e.g. one year) is set by the HBX Board.

XIV – Quality Assurance Program

The working group noted that both network adequacy and quality assurance are scrutinized thoroughly in the accreditation process. Presently, all issuers licensed to do business in DC are accredited.

Consensus Recommendation:

- If an issuer is accredited, attestation for all the standards will be accepted.
- If an issuer is not accredited, it will be required to submit a written quality improvement strategy.

XV – Segregation of Funds

The working group noted that DISB performs periodic financial examinations of all issuers, and this standard can be checked within that process.

Consensus Recommendation:
Attestations for the standard will be accepted.

XVI – Other Substantive Requirements

Consensus Recommendation:
Attestations for the remaining standards will be accepted.

XVII – Other Reporting Requirements

The working group noted that HHS would notify the HBX if an issuer was not complying with this standard on Rx drug reporting data.

Consensus Recommendation:

Attestation for the standard will be accepted.

Company Name (Name in DC Company is Licensed under):	
NAIC Company Number:	
Company Address:	
Contact Person for Filing:	
Contact Person for filing address:	
Contact Person for filing telephone number:	
Contact Person for filing email:	
☐Individual ☐SHOP ☐CO-OP ☐Multistate plan (under contract with OPM) ☐Dental only	

		Requirements	Federal Source	SERFF-supported function*	SERFF could be used for data collection**	Notes
☐	I	Licensed and in good standing	45 CFR § 156.200(b)(4)		X	1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	1.1	☐ Is licensed or authorized in {State} as: ☐ Domestic ☐ Foreign ☐ Stock ☐ Reciprocal ☐ Mutual ☐ Fraternal Benefit Society ☐ HMO ☐ Non Profit Health Care Plan ☐ {additional licenses available in DC}			X	
	1.2	☐ Authorized by DISB to offer **health** insurance ☐ Authorized by DISB to offer **dental** insurance			X	

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	1.3	☐ Is in good standing			X	
	1.4	☐ Service area				
	1.5	☐ General attestation regarding ability to participate in and abide by requirements of HBX, comply with the risk adjustment program, and that the products are in the interest of qualified individuals	45 CFR § 156.200(b); 45 CFR § 155.1000(c)(2)			
☐	II	Benefit Standards and Product Offerings				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	2.1	☐ Covers the Essential Health Benefit Package	42 USC §18022	X		
	2.2	☐ Complies with Annual Limitation on Cost Sharing. ☐ Cost-sharing shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage. FOR SHOP ONLY: ☐ Complies with Annual Limitations on Deductibles for Employer-Sponsored Plans.	42 USC §18022	X		
	2.3	☐ Offers through the Exchange: ☐ one silver level plan (AV 70%), **AND** ☐ one gold level plan (AV 80%).	45 CFR §156.200 (c)(1)	X		
	2.4	☐ Offers a child-only plan at the same level of coverage—bronze, silver, gold, or platinum—as	45 CFR §156.200(c)	X		

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		any other plan offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained age 21.				
	2.5	☐ Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.	45 CFR §156.200(e)		X	
	2.6	☐ Does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	X		
	2.7	☐ Submits a description of covered benefits and cost-sharing provisions to the Exchange at least annually.	45 CFR §156.210(b)		X	
☐	III	Rate Filings and other Rate Disclosure Requirements				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	3.1	☐ Files rates for prior approval.	{State law cite}	X		
	3.2	☐ Submits rate information to the Exchange at least annually.	45 CFR §155.1020 45 CFR §156.210(b)	X		
	3.3	☐ Submits to the Exchange a justification for a rate increase prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR §156.210(c)	X		
	3.4	☐ Prominently posts the rate increase justification on issuer Web site prior to the implementation of the increase.	45 CFR §155.1020; 45 CFR		X	

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			§156.210(c)			
☐	IV	Rating Standards—General				
	4.1	☐ Sets rates for an entire benefit year, or for the SHOP, plan year.	45 CFR §156.210(a)	X		
	4.2	☐ Rates must be the same for products inside and outside Exchange.	45 CFR §156.255(b)	X		
☐	V	Allowable Rating Variations	42 U.S.C. 300gg §2701; 45 CFR §156.255			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	5.1	☐ Varies rates only based on: ☐ geographic area ☐ age (3 to 1) ☐ tobacco use (1.5 to 1) ☐ family composition: ☐ Individual; ☐ Two-adult families; ☐ One-adult family with child(ren) ☐ All other families.	42 U.S.C. 300gg §2701; 45 CFR §156.255	X		
☐	VI	Marketing				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is

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						taking steps to meet the requirements prior to [DATE]
	6.1	☐ Marketing practices do not discourage the enrollment of individuals with significant health needs.	45 CFR §156.225(b)	X		
☐	VII	Network Adequacy Requirements	45 CFR §155.1050; 45 CFR §156.230			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	7.1	☐ Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay. ☐ Network must include providers that specialize in mental health and substance abuse services.	45 CFR §156.230(a)(2)		X	
	7.2	☐ Has a network with sufficient geographic distribution of providers for each plan.	45 CFR §156.230(a)(2)		X	
	7.3	☐ Has sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area.	45 CFR §156.230(a)(1); 45 CFR §156.235		X	
	7.4	Alternate standard for QHP issuers that provide major services through employed physicians or a single medical group	45 CFR §156.235(b)			
☐	7.5	☐ Makes its provider directory available: ☐ to the Exchange for publication online in accordance with guidance from the Exchange;	45 CFR §156.230(b)		X	

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		and ☐ to potential enrollees in hard copy upon request. ☐ Provider directory identifies providers that are not accepting new patients.				
☐	VIII	Applications and Notices				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	8.1	☐ Provides to applicants and enrollees all applications and other material: ☐ in plain language; and ☐ in a manner that is accessible and timely to: ☐ individuals living with disabilities, and ☐ to individuals with limited English proficiency through the provision of language services at no cost to the individual.	45 CFR §155.230(b)		X	
	8.2	☐ Complies with DC minimum language simplification standards.	{State law cite}		X	.
☐	IX	Transparency Requirements	45 CFR §155.1040; 45 CFR §156.220			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements

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						prior to [DATE]
	9.1	☐ Makes available to the public in an accurate and timely manner, and in plain language: ☐ 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 for out-of network coverage; ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	
	9.2	☐ Makes available to the Exchange in an accurate and timely manner, and in plain language: ☐ 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 for out-of network coverage; ☐ Information on enrollee rights under Title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	
	9.3	☐ Makes available to Commissioner of Insurance in an accurate and timely manner, and in plain language: ☐ Claims payment policies and practices; ☐ Periodic financial disclosures;	45 CFR §156.220		X	

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		☐ 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 for out-of network coverage; ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).				
	9.4	☐ Makes available to the U.S. DHHS in an accurate and timely manner, and in plain language: ☐ 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 for out-of network coverage; ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §156.220		X	
	9.5	☐ Makes available the amount of enrollee cost sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual. ☐ Makes available such information through: ☐ Internet Web site; and ☐ Other means for individuals without access to the Internet.	45 CFR § 156.220(d)		X	
	9.6	☐ Provides required notices on internal and	45 CFR		X	

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		external appeals in a culturally and linguistically appropriate manner.	§147.136(e)			
☐	X	Enrollment Periods				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	10.1	☐ Provides an **initial open enrollment** period October 1, 2013 to March 31, 2014.	45 CFR §155.410(b)		X	
	10.2	☐ Provides an **annual open enrollment** period October 15 to December 7.	45 CFR §155.410(e)		X	
	10.3	☐ Enrolls qualified individuals under 10.1 and 10.2 with the proper effective coverage date	45 CFR §155.410(c		X	
	10.4	☐ Provides **special enrollment** periods for qualified enrollees with proper effective coverage date	45 CFR §155.420		X	
☐	XI	Enrollment Process for Qualified Individuals				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	11.1	☐ Enrolls a qualified individual when Exchange	45 CFR §156.265		X	

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		notifies the issuer that the individual is a qualified individual and transmits information to the issuer.	(b)(1)			
	11.2	☐ If an applicant initiates enrollment directly with the issuer for enrollment through the Exchange, the issuer either: ☐ Directs the individual to file an application with the Exchange; or ☐ Ensures that the individual received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.	45 CFR §156.265 (b)(2)		X	
	11.3	☐ Accepts enrollment information consistent with the privacy and security requirements established by the Exchange.	45 CFR §156.265 (c)		X	
	11.4	☐ Uses the premium payment process established by the Exchange.	45 CFR §156.265 (d)		X	
	11.5	☐ Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards.	45 CFR §156.265 (e)		X	
	11.6	☐ Reconciles enrollment files with HHS and the Exchange no less than once a month.	45 CFR §156.265 (f); 45 CFR §156.400 (d)		X	
	11.7	☐ Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.	45 CFR §156.265 (g)		X	
☐	XII	Termination of Coverage of Qualified Individuals	45 CFR §155.430; 45 CFR §156.270			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements

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						prior to [DATE]
	12.1	☐Terminates coverage only if: ☐ Enrollee is no longer eligible for coverage through the Exchange; ☐ Enrollee's coverage is rescinded; ☐ QHP terminates or is decertified; ☐ Enrollee switch coverage: ☐ during an annual open enrollment period; ☐ special enrollment period; or ☐ obtains other minimum essential coverage. ☐ For non-payment of premium only if: ☐ Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances; ☐ Enrollee is delinquent on premium payment; ☐ Provides the enrollee with notice of such payment delinquency; and ☐ Provides a grace period of at least 3 consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium.	45 CFR §155.430(b); 45 CFR §156.270		**X**	
	12.2	☐ Provides reasonable notice of termination of coverage to the Exchange and enrollee (this includes effective date of termination).	45 CFR §155.430 (d); 45 CFR §156.270 (b)		X	
	12.3	☐ Maintains records of terminations of coverage for auditing.	45 CFR §155.430(c); 45 CFR		X	

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			§156.270(h)			
☐	XIII	Accreditation Standards	45 CFR §1045; 45 CFR §156.275			1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
	13.1	☐ Accredited on the basis of local performance in the following categories by an accrediting entity recognized by HHS: ☐ Clinical quality measures, such as the HEDIS; ☐ Patient experience ratings on a standardized CAHPS survey; ☐ Consumer access; ☐ Utilization management; ☐ Quality assurance; ☐ Provider credentialing; ☐ Complaints and appeals; ☐ Network adequacy and access; **and** ☐ Patient information programs.	45 CFR §156.275(a)(1)	X (Standar-dized CAHPS data will not be captured in SERFF for plan year 1)	X (States could require CAHPS data be submitted via SERFF for plan year 1)	
	13.2	☐ Authorizes the accrediting entity to release to the Exchange and HHS a copy of its most recent accreditation survey and survey-related information.	45 CFR §156.275(a)(2)	X		
	13.3	☐ Accredited within the timeframe established by the Exchange. ☐ Maintains accreditation.	45 CFR §156.275(b)	X		

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	XIV	Quality Assurance Program				
☐	14.1	☐ Implements and reports on a quality improvement strategy or strategies used to reward quality through the use of market based incentives. Improvement strategy is any strategy that includes increased reimbursement or other financial incentive for: • Improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including use of the medical home model, for treatment or services under the plan or coverage; • Implementation of activities to prevent hospital readmissions through a comprehensive program that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; • 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; • Implementation of wellness and health promotion activities; and • Implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.	45 CFR §156.200 (b)(5) 42 U.S.C. §13031		X	

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☐	XV	Segregation of Funds				
	15.1	☐ Does not use federal funds for abortion.	45 CFR §156.280		X	
☐	XVI	Other Substantive Requirements				
	16.1	☐ Complies with internal claims and appeals and external review processes.	45 CFR §147.136		X	
	16.2	☐ If provides coverage through a direct primary care medical home: ☐ medical home meets criteria established by HHS; ☐ issuer meets all requirements otherwise required; **and** ☐ issuer coordinates the services covered by the direct primary care medical home.	45 CFR §156.245		X	
☐	XVII	Other Reporting Requirements				1. Regulator verifies directly through evidence that requirement is met. 2. Regulator will accept verification by company officer that requirement has been met. 3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to [DATE]
☐	17.2	☐ Reports to U.S. DHHS on prescription drug distribution and cost the following information (paid by PBM or issuer): ☐ Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and	45 CFR §156.295			

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		☐ Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: ☐ independent pharmacy, ☐ supermarket pharmacy, **and** ☐ mass merchandiser pharmacy. ☐ Aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are: ☐ attributable to patient utilization, and ☐ passed through to the issuer. ☐ Total number of prescriptions that were dispensed. ☐ Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.				

**SERFF is expected to collect data for analysis of the requirements in this column.*
***SERFF may be used to collect state-specific, document-based information to support review of requirements in this column.*.

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