Carrier Reference Manual

May 2013
Version 4

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Introduction

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

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

(1) Enable individuals and small employers to find affordable and easier-to understand health insurance;
(2) Facilitate the purchase and sale of qualified health plans;
(3) Assist small employers in facilitating the enrollment of their employees in qualified health plans;
(4) Reduce the number of uninsured;
(5) Provide a transparent marketplace for health benefit plans;
(6) Educate consumers; and
(7) Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions.[1]

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

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

The *Health Benefit Exchange Authority Establishment Act of 2011* allows the Executive Board of the DC Exchange to adopt rules and policies. The adoption of rules and policies enables the DC Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. This manual and appendices document the rules and policies that have been adopted by the DC Exchange Executive Board to guide the initial year of qualified health plan and qualified dental

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

plan development and oversight. Health carriers offering coverage in the individual and small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in this manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

Manual Updates for Version Two

The second version of the carrier reference manual included the following additional and updated information:

- New Executive Board resolutions related to dental plans
- Additional information on the merged risk pool and publication of rates
- Updated carrier submission process with new District template
- New dental plan submission process
- Updated information on health insurance rate filing requirements (Appendix C)

Manual Updates for Version Three

The third version of the carrier reference manual included the following additional and updated information:

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- Additional information on establishing rates with the merged risk pool
- An update to the rate filing deadline for QHPs from May 15 to May 31
- Additional information on dental plan filing requirements
- New resolutions adopted by the Board in the appendices

Manual Updates for Version Four

This update of the carrier reference manual includes the following information:

- An update to the QDP submission deadline from May 30th to June 3rd
- Removal of federal drug formulary template from dental submission requirements

Carrier Participation

The DC Exchange is open to all health carriers and health benefit plans that meet the requirements set forth in Section 1301 of the ACA and by the DC Exchange. The DC Exchange intends to contract with all licensed health carriers that meet minimum requirements for

certification as a qualified health plan (QHP) under federal and District law and DC Exchange requirements. Licensed health carriers include an accident and sickness insurance company, a health maintenance organization (HMO), a hospital and medical services corporation, a non-profit health service plan, a dental plan organization, a multistate plan, or any other entity providing a health benefit plan.

Essential Health Benefits

Pursuant to HHS requirements, the District designated the Group Hospitalization and Medical Services, Inc. BluePreferred PPO Option 1 as the base-benchmark plan.[2] Pediatric vision and dental benefits in the Federal Employees Dental and Vision Insurance Program (FEDVIP) with the largest national enrollment have been defined as the pediatric vision and pediatric dental essential health benefits. Habilitative services have been defined as services that help a person keep, learn, or improve skills, and functioning for daily living, including, but not limited to, Applied Behavioral Analysis for the treatment of autism spectrum disorder.

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

1. One drug in each category and class of the United States Pharmacopieal Convention (USP), or
2. The number of drugs in each USP class and category in the Essential Health Benefits package.[3]

Rating Rules and Rate Review

Merged Risk Pool

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

[2] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule." 78 Federal Register 37 (25 February 2013). pp. 12834 – 12872.
[3] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule." 78 Federal Register 37 (25 February 2013). pp. 12834 – 12872.
[4] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule." 78 Federal Register 39 (27 February 2013). pp. 13406 – 13442.
[5] Id.

merged risk pool include student health plans, and grandfathered health plans.[6] Catastrophic plans must be developed by making plan level adjustments to the index rate.[7]

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

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

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

Step 2: Develop the Index Rate by projecting PMPM from the result of Step 1 and adjusting for the following items:

(a) Trend (including cost, utilization, changes in provider mix, etc.)
(b) Future population morbidity changes for the combined individual and small group markets (due to the impact of items such as guarantee issue, premium subsidies, impact of adjusted community rating, etc.)
(c) Adding or removing benefits to arrive at the projected Essential Health Benefits (EHB) benchmark.

Step 3: Apply modifiers to the Index Rate separately for individual and small group:

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

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

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

[6] Id.
[7] 45 CFR 156.80(d)(2)
[8] "Rate Changes for Small Group Market Plans and System Processing of Rates." Centers for Medicare and Medicaid Services Memorandum (April 8, 2013).

Permissible Rating Factors

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

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

Rate Development and Review

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

The Exchange, through consulting actuaries, will review proposed rate submissions for QHPs and provide input to DISB during the rate review process. The Exchange will not negotiate rates with carriers, but will accept DISB's approval of QHP rates. Additional information on the rate submission process and timeline is included below.

DISB shall, after the May 15 due date, make all rate filings, including all supporting documentation, amended filings, and reports available for public inspection either at the Department or on its website. DISB will consider comments received on any rate filings during the review of the rates.

Carrier Submission Process

The DC Exchange, in coordination with DISB, has set forth the following plan and timeline for QHP certification for 2014.

Step 1: Letter of Intent (Requested By April 15, 2013)

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

All carriers, including those offering stand-alone dental plans, should submit a Letter of DC Exchange Participation Intent by April 15, 2013; the Intent Letter will be accepted through May 15, 2013. As part of this letter, carriers are asked to provide the following information:

- Estimated number of plans to be offered per metal tier and at the catastrophic level
- Types of plans to be offered through the DC Exchange

Step 2: Plan Rate and Form Filings and Carrier Certification
There are two categories of forms that carriers must complete: Plan Rate and Form Filings and Carrier Certification. DISB will review and approve/disapprove forms and rates to ensure that QHPs meet District and federal Exchange standards for rates and benefits. DISB will also review and approve/disapprove Carrier Certification submissions on behalf of the DC Exchange.

All federal templates referenced below can be found at:
http://www.serff.com/plan_management_data_templates.htm.

Step 2A: Plan Form Filings and Certification Application (April 15, 2013-May 15, 2013)

Form Filings: All carriers must submit the following information in SERFF:

1. Federal Administrative Data Template – Collects general company and contact information.
2. Form Submissions

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

1. Federal Essential Community Providers (ECPs) Template – Collects information identifying a carrier's network.
2. Federal Network Template – Collects information identifying a provider's network.
3. Federal Carrier NCQA Template OR Federal Carrier URAC Template – Accreditation status.

Step 2B: Plan Rate Filings (April 15, 2013-May 31, 2013)

Rate Filings: All carriers must submit the following information in SERFF:

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

Step 3: Notification to Carriers on Rate and Form Filings and Certification (by June 30, 2013)
DISB will notify carriers of approval or disapproval for the following:

- Plan rate and form filings
- Carrier certification application

Step 4: Additional QHP and Carrier Information Submission (June 30, 2013 – August 1, 2013)
After DISB has approved rate and form filings and certified carriers for offering plans through the District Exchange, carriers will submit additional information, including required transparency data, for final QHP certification. Carriers will also submit plan information for display on the District Exchange web portal provided by Connecture StateAdvantage.

Final Carrier Certification Documentation: All carriers must submit the following information in through Connecture StateAdvantage:

1. Federal and District Attestation Forms – Allows carriers to accurately attest to all required federal and District attestations. See Appendix B for the District Attestation Form.

QHP Data for Exchange Marketplace: All carriers must submit the following information through Connecture StateAdvantage:

1. Federal Plan/Benefit Template
2. Federal Rate Data Templates
3. Federal Prescription Drug Template

Step 5: Notification to Carriers on Certification (by August 15, 2013)
DISB will notify carriers of final carrier certification.

Step 6: Contracting
The ACA requires exchanges to have contracts with health carriers offering QHPs. Consequently, health carriers that offer coverage through the DC Exchange will be required to enter into a contract with the DC Health Benefit Exchange Authority. A standard contract will be used. The DC Health Benefit Exchange Authority does not intend to negotiate contract terms with each carrier individually. If any carrier objects and strongly believes that contract negotiations must be conducted, then the Authority will reconsider the preliminary decision to streamline contracting with carriers. A draft standard contract will be provided. There will be a 15 day period for feedback from carriers. The terms and conditions of the contract will include requirements for health carriers to comply with federal and District laws, and DC Exchange rules and policies.

Dental Submission Process

QDP submissions will follow a similar process to that of QHPs. The Exchange intends to leverage federal templates for the dental submission process; however, CCIIO has not yet released templates for stand-alone dental plans. It is anticipated that these templates will be available by mid-May. Additional submission guidance will be provided at that time.

The DC Exchange, in coordination with DISB, has set forth the following timeline for QDP certification for 2014.

Step 1: Letter of Intent (Requested by April 15, 2013)
All carriers, including those offering stand-alone dental plans, should submit a Letter of DC Exchange Participation Intent by April 15, 2013, as described above.

Step 2: Dental Plan Rate and Form Filings (May 15, 2013-June 3, 2013)
DISB will review and approve/disapprove Dental plan submissions on behalf of the District Exchange.

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Plan Rate and Form Filings: All carriers must submit the following information:

1. Federal Administrative Data Template
2. Federal Essential Community Providers (ECPs) Template – Collects information identifying a carrier's network.
3. Federal Network Template – Collects information identifying a provider's network.
4. DISB Dental Rate and Form Requirements (See Appendix C)

Step 3: Notification to Carriers on Rate and Form Filings (by July 15, 2013)
DISB will notify carriers of approval or disapproval of the plan rate and form filings.

Step 4: Additional QDP Information Submission (July 15, 2013 through August 1, 2013)
After DISB has approved rate and form filings for offering stand-alone dental plans through the District Exchange, carriers will submit plan information for display on the District Exchange web portal provided by Connecture StateAdvantage, as well as attestations to District and federal requirements.

All carriers must submit the following information through Connecture StateAdvantage:

1. Federal Dental Plan/Benefit Template
2. Federal Rate Data Templates

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Step 5: Notification to Dental Carriers on Certification (by August 15, 2013)
DISB will notify carriers of final carrier certification.

Step 6: Contracting

Like with carriers offering QHPs, the DCHBX will enter into contracts with carriers offering stand-alone QDPs. A standard contract will be used. The DC Health Benefit Exchange Authority does not intend to negotiate contract terms with each carrier individually. If any carrier objects and strongly believes that contract negotiations must be conducted, then the Authority will reconsider the preliminary decision to streamline contracting with carriers. A draft standard contract will be provided. There will be a 15 day period for feedback from carriers. The terms and conditions of the contract will include requirements for health carriers to comply with federal and District laws, and DC Exchange rules and policies.

Appendix A

District of Columbia Age Rating Table

Age	DC Age Factors	3:1 Ratio Comparison	4% per year Comparison
0-20	0.727	1.000	1.0000
21	0.727	1.000	1.0000
22	0.727	1.000	1.0000
23	0.727	1.000	1.0000
24	0.727	1.000	1.0000
25	0.727	1.000	1.0000
26	0.727	1.000	1.0000
27	0.727	1.000	1.0000
28	0.727	1.000	1.0000
29	0.727	1.000	1.0000
30	0.727	1.000	1.0000
31	0.727	1.000	1.0000
32	0.727	1.026	1.0261
33	0.746	1.066	1.0389
34	0.775	1.107	1.0387
35	0.805	1.150	1.0385
36	0.836	1.195	1.0395
37	0.869	1.242	1.0391
38	0.903	1.290	1.0388
39	0.938	1.341	1.0394
40	0.975	1.393	1.0390
41	1.013	1.448	1.0395
42	1.053	1.505	1.0389
43	1.094	1.564	1.0393
44	1.137	1.624	1.0387
45	1.181	1.688	1.0390
46	1.227	1.754	1.0391
47	1.275	1.823	1.0392
48	1.325	1.894	1.0392
49	1.377	1.968	1.0392
50	1.431	2.045	1.0391
51	1.487	2.125	1.0390
52	1.545	2.208	1.0388
53	1.605	2.294	1.0393
54	1.668	2.384	1.0390
55	1.733	2.477	1.0392
56	1.801	2.574	1.0389
57	1.871	2.674	1.0390
58	1.944	2.779	1.0391
59	2.020	2.887	1.0391
60	2.099	3.000	1.0391
61	2.181	3.000	1.0000
62	2.181	3.000	1.0000
63	2.181	3.000	1.0000
64 and	2.181		

Appendix B

District of Columbia Health Benefits Exchange
District Carrier Attestation Form

Instructions: Review each of the attestations and sign at the end of the document. **The Data Submitter must sign this attestation document.**

General Carrier Attestations

1. Applicant attests that is authorized by the District of Columbia Department of Insurance, Securities, and Banking (DISB) to offer health insurance in the District of Columbia and faces no outstanding licensing sanctions imposed by DISB and is not under a formal corrective action plan related to solvency.
2. Applicant attests that it will serve the entire District of Columbia.
3. Applicant attests that it has the appropriate structure, staffing, and management to participate in and abide by requirements of the District of Columbia Health Benefits Exchange (DC HBX) now and in the future.
4. Applicant attests that the products to be sold are in the interest of qualified individuals.

Benefit Design Attestations

1. Applicant attests that its plans cover the essential health benefits (EHB) benchmark either with or without the pediatric dental essential health benefit.
2. Applicant attests that its plans comply with annual limitations on cost-sharing, pursuant to section 223(C)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage.
3. Applicant attests that if it participates in the Small Business Health Options Program (SHOP) it will comply with annual limitations on deductibles for employer-sponsored plans.
4. Applicant attests that it will offer one silver plan (AV 70%), one gold plan (AV 80%) and one bronze plan (AV 60%) through the DC HBX.
5. Applicant attests that it will offer a child-only plan at the same level of coverage as any other plan offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained age 21.
6. Applicant attests that it does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation in the issuance and administration of health insurance policies.
7. Applicant attests that it does not have benefit designs that have the intent of discouraging the enrollment of individuals with significant health needs.
8. Applicant attests that it will submit a description of covered benefits and cost-sharing provisions to the DC HBX at least annually.

Rate Filings and other Rate Disclosure Requirements

1. Applicant attests that it will file rates with DISB for prior approval.
2. Applicant attests that it will submit rate information to Exchange at least annually.
3. Applicant attests that it will submit to the Exchange a justification for a rate increase prior to the implementation of the increase after receiving approval from DISB for rate filing.

4. Applicant attests that it will prominently post the rate increase justification on carrier website prior to implementation of the increases.

Rating Standards Attestations

1. Applicant attests that it sets rates for an entire benefit year, or for the SHOP, plan year.
2. Applicant attests that rates shall be the same for products inside and outside of the Exchange

Allowable Rating Variation Attestations

1. Applicant attests that it varies rates only based on age, using the DISB promulgated age factor table, and family composition.

Marketing Attestations

1. Applicant attests that its marketing practices do not discourage the enrollment of individuals with significant health needs.

Network Adequacy Attestations

1. Applicant attests that it has a network for each plan offered with sufficient number and types of providers to ensure that all services are accessible without delay and that its network includes providers that specialize in mental health and substance abuse services.
2. Applicant attests that it has a network with sufficient geographic distribution of providers for each plan.
3. Applicant attests that it has a sufficient number and geographic distribution of Essential Community Providers (ECPs), 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.
4. If applicable, applicant attests that it meets the alternate standard for QHP carriers that provide major services through employed physicians or a single medical group.

Provider Directory Attestation

1. Applicant attests that it makes its provider directory available;
    a. To the Exchange for publication online in accordance with guidance from the Exchange, and
    b. To potential enrollees in hard copy upon request.
2. Applicant attests that its online provider directory identifies providers who are not accepting new patients.

Applications and Notices Attestations

1. Applicant attests that it provides to applicants and enrollees all applications and other materials in plain language and in a manner that is accessible and timely to individuals living with disabilities and individuals with limited English proficiency through the provision of language services at no cost to the individual.

2. Applicant attests that it complies with District of Columbia minimum language simplification standards.

Transparency Attestations

1. Applicant attests that it makes available to the public, the DC HBX, DISB, and the United States Department of Health and Human Services (HHS) in an accurate and timely manner and in plain language;
    a. Claims and payment policies and practices,
    b. Periodic financial disclosures,
    c. Data on enrollment,
    d. Data on disenrollment
    e. Data on the number of claims denied,
    f. Data on rating processes,
    g. Information on cost-sharing and payments for out-of-network coverage, and
    h. Information on enrollee rights under Title I of the Affordable Care Act.
2. Applicant attests that it makes available the amount of enrollee cost sharing for a specific item or service by a participating provider in a timely manner upon request of the individual and will make available through carrier website or other means for individuals without access to the Internet.
3. Applicant attests that it provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.

Enrollment Attestations

1. Applicant attests that it will provide an **initial open enrollment** period October 1, 2013 to March 31, 2014.
2. Applicant attests it will provide an **annual open enrollment** period October 15 to December 7.
3. Applicant attests it will enroll qualified individuals with the proper effective coverage date.
4. Applicant attests that it will provide **special enrollment periods** for qualified enrollees with proper effective coverage date.
5. Applicant attests that it will enroll a qualified individual when the DC HBX notifies the carrier that the individual is a qualified individual and transmits information to carrier.
6. Applicant attests that, if an individual initiates enrollment directly with the carrier for enrollment through the DC HBX, it will either
    a. Direct the individual to file an application with the DC HBX, or
    b. Ensures that the individual received an eligibility determination for coverage through the DC HBX through the DC HBX Internet web site.
7. Applicant attests that it will accept enrollment information consistent with the privacy and security requirements established by the DC HBX.

8. Applicant attests that it will provide new enrollees an enrollment information package that is compliant with accessibility and readability standards.
9. Applicant attests that it will reconcile enrollment files with HHS and the DC HBX no less than once a month.
10. Applicant attests that it will acknowledge receipt of enrollment information transmitted from the DC HBX in accordance with DC HBX standards.

Termination of Coverage Attestations

1. Applicant attests that it will terminate coverage only in the following cases;
    a. Enrollee is no longer eligible for coverage through the DC HBX,
    b. Enrollee's coverage is rescinded,
    c. QHP terminates or is decertified,
    d. Enrollee switches coverage during an annual open enrollment period, special enrollment period, or obtains other minimum essential coverage,
    e. For non-payment of premium only if the termination policy for non-payment of premium is applied uniformly to all enrollees, the enrollee is delinquent on premium payment and the carrier provides notice of such delinquency and provides a grave period of at least 3 consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously at least one month's premium.
2. Applicant attests that it will provide reasonable notice of termination of coverage to the DC HBX and enrollee, including effective date of termination.
3. Applicant attests that it will maintain records of terminations of coverage for auditing.

Accreditation Attestations

1. Applicant attests that it is accredited on the basis of local performance in the following categories by an accrediting entity recognized by HHS;
    a. Clinical quality measures, such as HEDIS,
    b. Patient experience ratings on a standardized CAHPS survey,
    c. Consumer access,
    d. Utilization management,
    e. Quality assurance,
    f. Provider credentialing,
    g. Complaints and appeals,
    h. Network adequacy and access, and
    i. Patient information programs.
2. Applicant attests that it authorizes the accrediting entity to release to the Exchange and HHS a copy of its most recent accreditation survey and survey-related information.

Appendix B

3. Applicant attests that it will be accredited (if not already) within the timeframe established by HHS and the DC HBX and will maintain accreditation.

Quality Assurance Program Attestations

1. Applicant attests that it implements and reports on a quality improvement strategy, pursuant to 45 CFR 156.200(b)(5) or strategies used to reward quality through the use of market based incentives.

Prescription Drug Attestations

1. Applicant attests that it will report to HHS on prescription drug distribution, cost, and the following information;
    a. Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies,
    b. Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type (independent, supermarket, and/or mass merchandiser pharmacy).
    c. Aggregate amount and type of rebates, discounts, or price concessions that the applicant or its contracted pharmacy benefits manager (PBM) negotiates that are attributable patient utilization and passed through to the carrier,
    d. Total number of prescriptions that were dispensed, and
    e. Aggregate amount of the difference between the amount the carrier pays its contracted PBM and the amounts that the PBM pays retail pharmacies and mail order pharmacies.
2. Applicant attests that its prescription drug formulary meets HHS and DC HBX standards

Financial Management Attestations

1. Applicant attests that it will use the premium payment process established by the DC HBX.
2. Applicant attests that it will not use federal funds for abortion services.

Signature Date

Printed Name Title/Position

Health Insurance Rate Filing Requirements

Health insurance rate filings should be submitted to DISB through SERFF and include the following information as pertinent to the nature of the purpose of the filing.

For dental carriers: Please respond to the following requirements in all product filings. If a requirement is not applicable, please indicate in response.

1) Cover Letter (includes)

A. Company Name
B. NAIC Company Code
C. Marketing Name of Product(s)
D. Date Filing Submitted
E. Proposed Effective Date
   i. First effective date when quarterly trend increases are being filed for the small group market
F. Type of Product
G. Market (Individual or Small Group)
H. Scope and Purpose of Filing
I. Indication Whether Initial Filing or Rate Change
J. Overall Premium Impact of Filing on DC Policyholders
K. Contact information, Name, Telephone, E-mail

2) For Renewal Filings, One Page Consumer Summary (includes)

A. Marketing Name of Company Issuing Product
B. Marketing Name of Product
C. Renewal Period for which Rates are Effective (Start and End Dates)
D. Proposed Rate Increase/Decrease
E. 5 Year History of Rate Increases/Decreases for this Product
F. Justification for Rate Increase/Decrease in Plain Language

3) Actuarial Memorandum (includes)

A. Description of Benefits
B. Issue Age Range
C. Marketing Method
   i. Describe the marketing method(s) used to information consumers of the availability and details of the product(s)
   ii. Identify which, if any, products are marketed through an association
D. Premium Basis
   i. Confirm member level rating will be used in the individual market

ii. If composite rates are used in the small group market, describe the methodology that will be used to calculate composite rates from the total member based premium for the group

E. Nature of Rate Change and Proposed Rate/Methodology Change
   i. A brief description of how rates were determined

F. For Each Change, Indication if New or Modified

G. For Each Change Comparison to Status Quo

H. Summary of How Each Proposed Modification Differs from Corresponding Current/Approved Rate/Methodology

I. Annual Rate Change for DC Policyholders
   i. State the average rate change across the entire market to which the filing applies
   ii. State the average cumulative rate change over the prior 12 months in a manner consistent with the calculation of the threshold increase as defined by CCIIO
   iii. State the minimum and maximum rate adjustment that any policyholder will receive
   iv. A completed copy of the following chart, indicating the number of contracts and members that would receive rate and premium changes for each of the ranges indicated. A rate change reflects the impact of items which alter the underlying rate tables (e.g., trend, the impact of adjusted community rating, changes in covered benefits, changes in the average morbidity of the population, impact of new taxes and fees, etc.). A premium change reflects the items underlying a rate change plus any additional items that impact the premium paid by a given policyholder (e.g., aging, changes in plan cost sharing design).

	Rate Impact		Premium Impact	
	# of Contracts Impacted	# of Members Impacted	# of Contracts Impacted	# of Members Impacted
Reduction of 15% or more				
Reduction of 10.01% to 14.99%				
Reduction of 5.01% to 10.00%				
Reduction of 0.01% to 5.00%				
No Change				
Increase of 0.01% to 5.00%				
Increase of 5.01% to 10.00%				
Increase of 10.01% to 14.99%				
Increase of 15.00% or more				
Total				

J. Base Period Experience
   i. Confirm the base period experience represents all of the carrier's non-grandfathered individual and small group business in the DC market
   ii. State the dates of service represented by the base period claims experience, and the date through which payments were made on claims incurred during the base period
   iii. State the estimate included for claims incurred but not paid as of the paid through date
   iv. Demonstrate any adjustments made for large claim pooling, including claims pooled and the pooling charge added, if applicable
K. Projected Base Period Experience
   i. Demonstrate and support each adjustment made to the base period experience for:
      1. Removal of claims for services covered during the base period that are not an essential health benefit
      2. Addition of cost for services not covered during the base period, that represent essential health benefits required to be covered during the projection period.
   ii. Describe and provide support for the development of each of the following projection factors applied to the base period:
      1. Medical and prescription drug trends including a description of the methodology used for calculating, data relied upon, and all adjustments made to the data (e.g., normalization factors) and quantitative support
         a. In addition to unit cost and utilization, the issuers must disclose if the following factors were utilized in their trend determination:
            i. Deductible leveraging
            ii. Benefit buy-down impact
            iii. Future/new benefits and/or mandates
            iv. Risk profile changes
            v. Aging of population (both utilization and mix of service changes)
            vi. Increased portion of pool from conversion policies
            vii. Changes in gender and other demographic characteristics
      2. Projected changes in the underlying demographics of the population anticipated to be insured in the merged individual and small group pool, including a description of the factors used to adjust the base period experience

3. Projected changes in the average morbidity of the population anticipated to be insured in the merged individual and small group pool, including but not limited to the separately identifying the impact of guaranteed issue, premium and cost sharing subsidies, a mandate that most individuals obtain coverage, pent-up demand, and termination of current high risk pools
4. The impact on utilization due to projected changes in average cost sharing in force across the merged individual and small group pool

L. Manual Rate Development
   i. Support for the appropriateness of the data used for developing the manual rate
   ii. A description of the methodology used and support for the development of the manual rate, if applicable
      1. Source of data used as a basis for the manual rate
      2. Support that the data used is fully credible
      3. Demonstration that the underlying benefits represent the essential health benefit package for DC
      4. Adjustments made to the data to reflect the carrier's provider contracts
      5. Adjustments made to the data to reflect the demographics, benefits and morbidity of the merged individual and small group population anticipated to be covered during the projection period
   iii. Demonstration that any capitation payments were included

M. Credibility
   i. Describe the credibility methodology used and demonstrate it is consistent with standard actuarial practice
   ii. State and support the credibility level assigned to the projected base period experience
   iii. Provide adjustments made to the credibility calculation when the base period experience also represents a portion of the manual rate, in order to assign the appropriate level of credibility

N. Projected Index Rate
   i. Confirm the index rate represents the average allowed claim cost per member per month for coverage of essential health benefits for the market (individual or small group), prior to adjustment for payments and charges under the risk adjustment and transitional reinsurance programs, as defined by 45 CFR 156. 80(d)
   ii. Indicate whether allowed or paid claims were used as a basis for developing the index rate. If paid claims were used, describe how they were adjusted to reflect the allowed claims which the index rate represents
   iii. Demonstrate how the projected claims experience and the manual rate were combined to reflect the credibility blended experience, if applicable

iv. Demonstrate how the projected credibility blended merged individual and small group experience was adjusted to represent the average demographics and utilization (cost sharing induced only) of the market (individual or small group) which is the subject of this filing. Demonstrate that an adjustment for differences in anticipated morbidity between the individual and small group markets is not included

O. Market-wide Adjustments to the Index Rate

i. Support for the market-wide risk transfer payment/charge assumed, including the following support

1. A description of the data used for the calculation
2. A discussion of the methodology used
3. The assumed risk of the carrier's projected population for the market and the assumed risk of the market (individual or small group) statewide, and support for these assumptions.
4. The resulting risk transfer payment on a PMPM basis
5. Actual historical risk transfer payments PMPM for the last three years, once available

ii. Support for the market-wide adjustment for assessments and recoveries under the transitional reinsurance program

1. Demonstrate that the assessment is consistent with the amount published in the Annual Notice of Benefit and Payment Parameters
2. For the individual market, describe the data used to calculate the estimated recoveries, the methodology used to calculate the estimate, confirmation that the attachment point and claims limit used is consistent with that for the projection year as published by HHS, and the resulting estimated recovery on a PMPM basis

iii. The amount of any federal or District of Columbia Exchange user fees PMPM including, a demonstration of how they were calculated and that they were applied as an adjustment on a market-wide basis, if any

P. Plan Level Adjustments to the Index Rate

i. Adjustments to reflect the actuarial value and cost sharing design of each plan

1. Separately demonstrate the portion that reflects the paid-to-allowed ratio and the portion that reflects any expected differences in utilization due to differences in cost sharing
2. Describe the methodology used to estimate the adjustments

ii. Support for any differences at the plan level due to provider network, delivery system characteristics, and utilization management practices

iii. Support for additional costs added for benefits provided that are in addition to essential health benefits

iv. The expected impact of the specific eligibility categories for a catastrophic plan offered in the individual market, if applicable

Q. Non-Benefit Expenses
   i. Support for proposed non-benefit expenses included in the development of rates
      1. General administrative expenses
      2. Sales and marketing
      3. Commissions and broker fees
      4. Premium tax
      5. Other taxes, licenses and fees
      6. Quality improvement and fraud detection
      7. Other expenses
      8. Profit or contribution to surplus
      9. Any additional risk margin
   ii. Provide a comparison of current and proposed non-benefit expenses
   iii. Additional support if non-benefit expense loads do not represent the same PMPM or same percent of premium across all plans

R. Filed Loss Ratio
   i. State the anticipated traditional loss ratio (incurred claims divided by premium)
   ii. State the anticipated Federal Medical Loss Ratio (MLR)
      1. Do not include the adjustment for credibility outlined in 45 CFR 158.230 as the projected claims should represent the actuary's best estimate
      2. State the adjustments made to claims in the numerator and premium in the denominator

S. Actuarial Certification
   i. Identify the certifying actuary
   ii. Certification that the index rate is in compliance with 45 CFR 156.80(d)(1) and developed in compliance with applicable ASOPs
   iii. Certification that the index rate and only the allowable modifiers in 45 CFR 156.80(d)(1) and (2) were used to generate the plan level rates
   iv. Certification that the standard AV calculator was used to develop the Metal AV except for any plans specified
   v. Certification that the rates are reasonable in relation to the benefits provided, are not excessive, deficient nor unfairly discriminatory
   vi. Certification that the rates comply with all applicable District of Columbia and Federal laws and regulations

T. District of Columbia Loss Ratio Analysis (Include Countrywide Loss Ratio Analysis separately, if applicable)
   i. Evaluation Period (Experience Year, etc)

ii. Earned Premiums
iii. Claims
iv. Number of Claims
v. Loss Development Factors
vi. Loss Ratio Demonstrations
vii. Permissible Loss Ratio (includes)
    1. Expenses
    2. Profit & Contingency Provision
viii. Credibility Analysis (if applicable)
    1. DC Credibility
    2. Countrywide Credibility
    3. Complimentary Credibility
ix. Determination of Overall Annual Rate Change

U. District of Columbia and Countrywide Experience
i. Earned Premium
ii. Number of Contracts/Policyholders
iii. History of Past Rate Changes
    1. Include SERFF tracking numbers for all rate changes effective during the past 12 months

4) Rate Tables

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish the minimum employer contribution and minimum employee participation standards within the District of Columbia Small Business Health Options Program (SHOP) marketplace.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(2)) requires the Authority to establish a SHOP Exchange and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, §1201 of the ACA made guaranteed renewability a requirement in the small group and individual marketplace (§2703 of the Public Health Service Act, 42 U.S.C. 300gg-2)), and made non-compliance with material plan provisions relating to participation or contribution rules an exception allowing non-renewal of group coverage (42 U.S.C. 300gg-2(b)(3));

WHEREAS, 45 C.F.R. §147.106(b)(3)(i) defines "employer contribution rule" as a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

WHEREAS, 45 C.F.R. §147.106(b)(3)(ii) defines "group participation rule" as a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

WHEREAS, 45 C.F.R. §§155.705(b)(10) & 156.285(e) permit SHOP Exchanges to restrict participating QHP issuers to a uniform group participation rule for the offering of health insurance coverage in the SHOP, with the caveat that such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer;

WHEREAS, minimum contribution and participation requirements do not apply to employers who enroll during an annual open enrollment;

WHEREAS, employers have broad flexibility in the amount and percentage they can choose to contribute to help pay for health insurance for their workers;

WHEREAS, on March 26, 2013, the Employer and Employee Choice Working Group presented a non-consensus recommendation, for referral to the Board's Insurance Working Committee, relating to minimum SHOP employer contribution and minimum SHOP employee participation; and

WHEREAS, on March 28, 2013, the Insurance Working Committee deliberated on the "employer contribution rule" and the "group participation rule", at a meeting open to the public, and approved a recommendation for Board consideration.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation presented by the Insurance Working Committee based on current market practices:

Minimum Contribution and Participation Requirements:

As a requirement to offer coverage through the SHOP Exchange, an issuer's 'minimum contribution rate' must be at 50% of the employee's individual reference plan premium and 'minimum participation rate' at 2/3 of qualified SHOP employees who do not waive coverage due to having coverage elsewhere.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**8th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date

District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To prohibit tobacco use as a rating factor.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152).

WHEREAS, §1201 of the ACA prescribed permissible rating factors in the small group and individual marketplaces (§2701 of the Public Health Service Act, 42 U.S.C. 300gg(a)(1)), and specifically limited rating variations based on tobacco use to no more than a ratio of 1.5:1;

WHEREAS, the U.S. Department of Health and Human Services has determined that the federal statute, and its own regulation, does not prevent states from prescribing a narrower ratio or from prohibiting the variation of rates based on tobacco use, or from having requirements for health insurance issuers that are more consumer protective than those under federal law (78 Fed. Reg. 13406, 13414 (Feb. 27, 2013) (interpreting the preemption and state flexibility rules at §2724 of the Public Health Service Act, 42 U.S.C. 300gg-23(a)(1));

WHEREAS, the Standing Advisory Board was asked for a recommendation on allowing use of tobacco rating factors in the individual and small group health insurance markets, as well as if allowed what permissible limits should be. After receiving public input and reviewing written reports, the Standing Advisory Board recommended to prohibit tobacco use as a rating factor in a vote of 6 to 2, with one abstention;

WHEREAS, current market practice in the District of Columbia is not to vary rates in the small group and individual marketplaces based on tobacco use;

WHEREAS, on April 4, 2013, the Insurance Working Committee deliberated on the topic of tobacco use as a rating factor, at a meeting open to the public, and approved a recommendation for Board consideration in a two to one vote to prohibit tobacco use as a rating factor; and

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation presented by the majority of the Insurance Working Committee:

Rate Variations Based on Tobacco Use: Issuers may not vary rates based on tobacco use.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**8th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish the range of plan selection choices, for plan year 2014, within the District of Columbia Small Business Health Options Program (SHOP) Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, section 5 of the Act (D.C. Official Code §31-3171.04(a)(2)) requires the Authority to establish a SHOP Exchange and ensure that qualified employers are able to specify a level of coverage available to qualified employees;

WHEREAS, 45 C.F.R. §155.705(b)(3), as proposed in 78 Fed. Reg. 15553, 15557 (Mar. 11, 2013), provides state-based SHOP exchanges with broad discretion to establish plan selection choices for qualified SHOP employers in plan year 2014;

WHEREAS, on March 26, 2013, the Employer and Employee Choice Working Group presented a non-consensus recommendation, on employee choice models, that was referred to the Board's Insurance Working Committee for further consideration; and

WHEREAS, on March 28, 2013, the Insurance Working Committee deliberated on employee choice models, at a meeting open to the public, and approved a recommendation for Board consideration.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation presented by the Insurance Working Committee:

Employee Choice Models

The Exchange will offer qualified SHOP employers three options to pick from in establishing the range of QHPs qualified employees may enroll in:

- *Option 1*: *All Issuers & QHPs/One Tier* – all issuers and all Qualified Health Plans (QHPs) on one actuarial value (AV) metal level.

- *Option 2*: *One-issuer/two Metal Levels* – all the QHPs that one issuer offers on any two contiguous AV metal levels, if feasible and practicable. If not, then all AV metal levels.

- *Option 3*: *One-QHP* – a single QHP offered by a single issuer.

BE IT FURTHER RESOLVED that, after a reasonable time to collect valid data, the Authority shall conduct a market study, which must include, at a minimum:

- A survey of employees and employers examining their experience with employee choice options and employees' satisfaction with the range of health plan choices made available to them by their employer in the Exchange;
- An actuarial analysis of premiums;
- An examination of options to expand employee choice; and
- An evaluation of employers', carriers', and the Exchange's experience in administering employee choice.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**4th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a premium rating and employer contribution approach within the District of Columbia Small Business Health Options Program (SHOP) marketplace.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(2)) requires the Authority to establish a SHOP Exchange and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, §1201 of the ACA made premium fairness a requirement in the small group and individual marketplace (§2701 of the Public Health Service Act, 42 U.S.C. 300gg);

WHEREAS, 45 C.F.R. §147.102(c)(3) allows states to require composite premium rating in the small group market; and

WHEREAS, on March 26, 2013, the Employer and Employee Choice Working Group presented a consensus recommendation on a premium rating and employer contribution approach.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the "Reallocated Composite Premium, with qualified SHOP employees paying the difference in list billing between the reference plan and the plan they select" method as the premium rating approach in the SHOP marketplace. As recommended by the Employer and Employee Choice Working Group, this rating approach would operate as follows:

- Issuers receive list bill premiums.
  - The only exception to this may be with regard to mid-year census changes.
- Composite rates are calculated for all plans that employees of a group could select.
  - Rates for any one plan are calculated based on the assumption that all qualified employees of a group enroll in that plan.
- A reference Qualified Health Plan (QHP) and contribution amount is selected by the

employer.

- The employer pays the same dollar amount for each employee, regardless of age or plan selected by the employee.
- For employees who select the reference plan, their premium payments are the same dollar amount, regardless of age.
- In addition to the employee contribution for the reference plan, if an employee selects a plan other than the reference plan, the employee pays (or receives) the difference between the list bill of the selected plan and the list bill of the reference plan with employees paying the difference in list billing between the reference plan and the plan they select.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**4th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date

District of Columbia Health Benefits Exchange Authority

RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish further Essential Health Benefit standards and to establish additional Qualified Health Plan (QHP) certification standards to promote benefit standardization in the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1302(a) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) requires the Qualified Health Plans certified by the District of Columbia Health Benefit Exchange provide a benefits package that meets or exceeds the Essential Health Benefit (EHB) benchmark;

WHEREAS, §1301(a)(1)(C)(ii) of the ACA requires QHP issuers to offer one silver-level and one gold-level plan at a minimum;

WHEREAS, 45 C.F.R. §155.1000(c) allows state exchanges to limit certification to those plans that it finds are in the best interest of qualified individuals and employers and 45 C.F.R. §156.200(d) allows state exchanges to require additional certification requirements beyond the federal minimums;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHPs;

WHEREAS, the Executive Board received a series of non-consensus recommendations from the EHB Working Group on February 13, 2013 and from the Plan Offering and Qualified Health Plan Benefit Standardization Working Group on March 7, 2013,

WHEREAS, on March 7, 2013, the Executive Board referred these non-consensus recommendations to its Insurance Working Committee; and

WHEREAS, on March 19, 2013, the Insurance Working Committee deliberated on these recommendations at a meeting open to the public.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation from the Insurance Working Committee as part of the EHB standard in the District of Columbia:

1. DC's essential health benefit habilitative services category shall be defined as: Health care services that help a person keep, learn or improve skills and functioning for daily living, including, but not limited, to applied behavioral analysis (ABA) for the treatment of autism spectrum disorder.

BE IT FURTHER RESOLVED that the Board hereby approves the Insurance Working Committee's recommendations regarding additional certification standards for QHPs in the District of Columbia:

1. The Board recommends no limits on the number of QHPs. The Board asks DISB to monitor the number and diversity of plan offerings and to report back to the exchange on consumer choices and reports of satisfaction.

2. The Executive Board asks the Department of Insurance, Securities, and Banking (DISB) to apply the Federally Facilitated Exchange's "meaningful difference" standard, the elements of which are outlined in a letter from the Centers for Consumer Information and Insurance Oversight (CIIO) and the Centers for Medicare and Medicaid Services (CMS) to issuers dated March 1, 2013 (available at http://cciio.cms.gov/resources/files/issuer-letter-3-1-2013.pdf, see page 16), as a part of their certification of qualified health plans for the 2014 plan year. The Executive Board asks that the marketplace offerings continue to be monitored and the "meaningful difference" standard updated as needed to provide for meaningful consumer choices.

3. The Executive Board asks DISB to develop one or more standardized benefit plans (benefits and cost sharing) at the silver and gold metal level for the 2015 plan year and at the bronze and platinum metal level not later than the 2016 plan year based on input from consumers, employers, carriers, and based on early purchaser preferences. Carriers will be required to offer one or more standardized plans at each metal level in which the carrier is participating for plan years where there is a standardized plan in addition to other plans the carrier may offer.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 22 day of March 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

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Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a process for certification of Qualified Health Plan (QHP) Issuers in the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(c) of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152) and 45 CFR Part 156, Subpart C establish minimum certification standards for Qualified Health Plans (QHPs) offering coverage on American Health Benefit Exchanges;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHP issuers;

WHEREAS, the Executive Board established an Issuer Certification Process Workgroup, which included health insurance carriers, consumer advocates, and employers, to recommend a process for certifying insurance companies as QHP issuers; and

WHEREAS, the Issuer Certification Process Workgroup presented recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the certification process consensus recommendations, as reflected in the Workgroup's February 28, 2013 report (as corrected – "recertification") (attached).

I HEREBY CERTIFY that the foregoing Resolution was adopted on this **___13th___** day of **_March____**, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date

District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

RESOLUTION OF THE EXECUTIVE BOARD DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a transition process for individual and small business health benefit plan enrollees into the District of Columbia Health Benefit Exchange ("Marketplace Exchange").

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §7 of the Act (D.C. Code §31-3171.06) authorizes the Executive Board to take actions necessary to carry out the functions necessary to establish an American Health Benefit Exchange;

WHEREAS, on October 3, 2012, the Executive Board voted unanimously to create one large marketplace for the sale of individual coverage and small group coverage to businesses with 50 or fewer employees. One big marketplace means all individual and small group coverage is sold through one distribution channel – the Exchange. This does not apply to grandfathered plans;

WHEREAS, the Executive Board directed the Executive Director to consult with a broad array of stakeholders – insurers, employers, producers, consumer and patient advocates, and providers – to identify the optimal way to move from the current market to this new marketplace and return with a recommendation to the Executive Board;

WHEREAS, in addition to consultations with stakeholders, the Executive Director requested that the Standing Advisory Board provide recommendations to the Executive Director on the transition considering a one and two year transition period;

WHEREAS, the Standing Advisory Board held three public meetings to consider options for a market transition with the support of Linda Blumberg, PhD, an economist and senior fellow with the Urban Institute, who provided valuable information on market competition and transition options as well as pros and cons associated with the options;

WHEREAS, the Standing Advisory Board accepted written and oral testimony from a variety of stakeholders, including insurance carriers, brokers, employers, and consumer/patient advocates; and

WHEREAS, the Executive Director adopted the recommendations of the Standing Advisory Board after a review of the work of the Standing Advisory Board, a review of materials including testimony, Dr. Blumberg's written materials prepared for the Standing Advisory Board, and the majority and minority reports provided by the Standing Advisory Board. The Executive Director's recommendations were presented to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Board hereby approves the following as recommended by the Executive Director, based on the majority recommendations of the Standing Advisory Board:

- In the individual market, consumers should enter the Marketplace Exchange in CY2014.
- New entrants to the small group market should enter the Marketplace Exchange in CY2014.
- Currently insured small businesses wishing to change carriers or stay with their current carrier should transition into the Marketplace Exchange over a two-year period. In CY2015, renewals will be through the Exchange web portal.
- All plans sold outside of the Marketplace Exchange during the two-year transition period should be required to comply with all of the requirements applicable to coverage sold through the Marketplace Exchange.
- Beginning in 2016, the small group market will expand to include businesses with 51 to 100 employees. The addition of this market segment should be addressed in subsequent years (assuming there are no related amendments to the ACA).

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a process whereby Qualified Health Plan applying for certification by the District of Columbia Health Benefit Exchange will demonstrate compliance with network adequacy standards.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(c)(1)(B) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) and D.C. Official Code §31-3171.09(a)(6)(B) establishes network adequacy as a minimum certification standard for Qualified Health Plans (QHPs) offering coverage on the District of Columbia Health Benefit Exchange;

WHEREAS, 45 C.F.R. §155.1050 requires states to ensure all QHPs meet the minimum network adequacy standards specified in 45 C.F.R. §156.230, but also allows states to develop standards in a way that meets their own unique healthcare market;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHPs;

WHEREAS, the Executive Board established a Network Adequacy Workgroup, composed of insurance carriers, small businesses, brokers, health care providers, and consumer advocates, to review existing network adequacy requirements and recommend any new standards/changes if necessary; and

WHEREAS, the Network Adequacy Workgroup presented recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the network adequacy consensus recommendations, as reflected in the Workgroup's March 5, 2013 report (attached).

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish premium collection standards and processes within the Individual Marketplace of the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, 45 C.F.R. §155.240(c) provides options to state exchanges, which includes the option of establishing a process to facilitate the collection and payment of premiums from individuals;

WHEREAS, the Executive Board established an Individual Premium Billing Workgroup, which included health insurance carriers, a broker, and consumer advocates, to assess the various options available to the Exchange and recommend a course of action with respect to premium billing for individuals;

WHEREAS, the Individual Billing Workgroup focused on four criteria for evaluating options and making a recommendation:

- The ability of the Exchange's selected vendor and carriers to implement billing systems in a timely manner;
- Providing the enrollee with a smooth, easy enrollment experience and good customer service;
- Strategic considerations related to ongoing communications with enrollees; and
- The cost of performing premium billing and collection.

WHEREAS, Individual Premium Billing Workgroup presented a summary of its work and

recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations for individual (non-group) premium collection standards for QHPs in the District of Columbia:

(1) All billing and collection of payments for an individual's initial enrollment (or subsequently switching issuers) will be performed by the Exchange.

(2) The Exchange will then pass the first month's premiums and enrollee information to the issuer(s) for effective enrollment.

(3) After the first month's billing and payment are completed and the enrollment information is passed from the Exchange to the issuer(s), the responsibility for subsequent month's billing and collection functions pass to the respective Issuer of a Qualified Health Plan(s) selected by the household.

(4) The Exchange will develop policies and procedures to address billing and collections during future open enrollment periods; during enrollment periods a change in carrier would result in an initial billing from the Exchange while renewal with the same carrier would result in a continuation of billings from the existing carrier.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish additional Qualified Health Plan (QHP) certification standards to promote benefit standardization in the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(c)(1)(A) of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152) establishes non-prejudicial benefit design as a minimum certification standard for Qualified Health Plans (QHPs) offering coverage on American Health Benefit Exchanges;

WHEREAS, §1301(a)(1)(C)(ii) of the ACA requires QHP issuers to offer one silver-level and one gold-level plan at a minimum;

WHEREAS, 45 C.F.R. §155.1000(c) allows state exchanges to limit certification to those plans that it finds are in the best interest of qualified individuals and employers and 45 C.F.R. §156.200(d) allows state exchanges to require additional certification requirements beyond the federal minimums;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHPs;

WHEREAS, the Executive Board established a Benefit Standardization Workgroup, composed of health insurance carriers, small businesses, brokers, health care providers, benefit consultants, and consumer advocates, to make recommendations on additional plan offering and standardization options; and

WHEREAS, the Benefit Standardization Workgroup presented recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations regarding additional certification standards for QHPs in the District of Columbia:

(1) QHP issuers should be allowed to add benefits, defined as services eligible for claims submission and reimbursement, in excess of the Essential Health Benefit (EHB) benchmark.

(2) QHP issuers must offer at least one bronze-level plan.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To recommend further policy regarding the Essential Health Benefit (EHB) benchmark standard for the District of Columbia.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1302(a) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) requires the Qualified Health Plans certified by the District of Columbia Health Benefit Exchange provide a benefits package that meets or exceeds the Essential Health Benefit (EHB) benchmark;

WHEREAS, §7 of the Act (D.C. Code §31-3171.06) authorizes the Executive Board to take actions necessary to carry out the functions necessary to establish an American Health Benefit Exchange;

WHEREAS, the District of Columbia Department of Insurance, Securities, and Banking (DISB) selected the largest small group plan available in the District, BlueCross BlueShield CareFirst Blue Preferred PPO Option 1, as its EHB benchmark plan and the FEDVIP BlueVision plan and FEDVIP MetLife plan as supplementary standards for the pediatric vision and pediatric dental benefits respectively;

WHEREAS, the EHB Working Group was established with membership composed of patient and consumer advocacy groups, physicians and other providers, health insurers, insurance brokers, and many other stakeholders to review outstanding policy questions related to the EHB benchmark selection for the District of Columbia and make recommendations to the Executive Board, including questions of (1) parity with the mental health and substance abuse benefits, (2) drug formulary compliance with federal minimum standards, (3) substitution of benefits, and (4) definition of habilitative services;

NOW, THEREFORE, BE IT RESOLVED that the Board hereby approves the following consensus recommendations (brackets [] indicate word change due to reference to appendix in the Working Group's final report) for adoption as part of the EHB standard in the District of Columbia.

Behavioral Health (Mental Health and Substance Abuse):

Behavioral health inpatient and outpatient services be covered without day or visit limitations to the benefit.

Prescription Drug Formulary

The drug formulary of every issuer of qualified health plans include at least the number of drugs listed in each category [found in the benchmark plan's formulary and in compliance with the minimum number of drugs, by category, as established by the federal Center for Consumer Information and Insurance Oversight (CCIIO).]

Substitution of Comparable Benefits

Issuers not be allowed to substitute coverage of one [benefit] for another, at least for 2014.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**February**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

CORPORATE ACTION OF THE EXECUTIVE BOARD

DISTRICT OF COLUMBIA

HEALTH BENEFIT EXCHANGE AUTHORITY

WHEREAS, over the past four weeks, the Health Benefit Exchange Insurance Working Committee has been meticulously reviewing the market recommendations proposed by the Insurance Subcommittee in April 2012. This included an in-depth review of the Mercer deliverables, supplemental materials, stakeholder comment, and consultation with District staff.

WHEREAS, the Insurance Subcommittee recommendations are listed below with DC Health Benefit Exchange Insurance Working Group actions listed after each:

1. Health insurance plans that meet minimum requirements set forth by the ACA for qualified health plans (QHPs) as well as any additional requirements set forth by the DC HBX Authority can be offered in the DC HBX insurance marketplace.
    - *The working committee supports this recommendation to preserve and expand current health insurance plan choices and presents it for formal consideration to the Executive Board.*

2. The DC HBX insurance marketplace should be the sole marketplace in the District of Columbia for the purchase of individual and small group health insurance plans.
    - *The working committee supports this recommendation to promote fair competition in the small group and individual health insurance markets and presents it for formal consideration to the Executive Board.*

3. The risk pools of the small group market and individual markets in the DC HX insurance marketplace should be merged into one single risk pool.
    - *The working committee supports this recommendation in recognition of the need to make quality, affordable health coverage seamlessly available to all District residents irrespective of employment status and presents it for formal consideration to the Executive Board.*

4. Small group size in the District of Columbia should be defined as 2-100 as opposed to the current practice of 2-50.
    - *The working committee amends this recommendation to maintain the current practice of defining small group as 2 to 50 as opposed to 2 to 100 and presents it for formal consideration to the Executive Board.*
        - *Along with this amendment is direction to the Insurance Subcommittee to research and analyze methods to regulate stop-loss insurance for self-funded plans.*

5. The District of Columbia should opt into the federal administered risk adjustment and reinsurance programs for the DC HBX insurance marketplace.
    - *The working committee supports this recommendation and presents it for formal consideration to the Executive Board.*

WHEREAS, the DC Health Benefit Exchange Insurance Working Group emphasizes that these recommendations, if adopted, will be implemented with the aid of a detailed work plan developed in conjunction with stakeholders and with final approval by the Exchange Board. In the course of developing such a work plan for implementing these recommendations, the DC Health Benefit Exchange working group strongly supports continued consultation with all interested parties to help ensure that these principles are adopted in a way that minimizes market disruption and enables a smooth transition for D.C. residents.

NOW, THEREFORE, BE IT RECORDED that the Board hereby adopts the HRIC insurance market recommendations endorsed by the Insurance Market Working Committee.

I HEREBY CERTIFY that the foregoing Corporate Action was adopted on the 3rd day of October, 2012, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Dental Working Group Report

April 13, 2013

This report is submitted to the Health Benefit Exchange Authority by the Dental Plan Advisory Working Group Chair (Leighton Ku) and Co-Vice Chairs (Katherine Stocks and Anupama Rao Tate). The purpose of this report is to outline the recommendations of the Dental Plan Advisory Working Group regarding what stand-alone dental plan issuers will be required to submit the DC Health Benefit Exchange Authority (HBX) with respect to becoming certified to sell stand-alone dental plans covering the Essential Health Benefit pediatric dental benefits, and non-pediatric dental benefits if chosen by the issuer, through the HBX.

Background

For dental 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 dental plans based on price, coverage and other factors. Dental plan issuers must be certified as meeting minimum standards in order to participate in the exchange and issue qualified dental 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.

Dental Issuer Certification Process

Discussion

The working group was charged with coming to consensus on the process by which dental carriers become certified to offer dental plans in the DC HBX. To assist in its discussions and deliberations, the working group used a checklist approved by the Board for use with QHP issuer certification, modified as appropriate for stand-alone dental plans. That document is attached. (Attachment A)

Additional information provided to the Working Group was the narrative regarding Departments of Insurance (DOIs) across the states, including DC's Department of Insurance Securities and Banking (DISB), use of attestations of compliance with required standards, as recited in the QHP Issuer Certification Process Working Group report:

> 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 recertification 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.

Consensus Recommendation

The Working Group reached a consensus recommendation to follow the general certification process adopted by the Board for QHP issuers, with certain categories modified or deleted as appropriate to dental plans.

I – Licensed and in good standing

- 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 QDP issuer has appropriate structure, staffing, management, etc. to administer QDP effectively and in conformance with federal requirements now and in the future

II – Benefit Standards and Product Offerings
III – Rate Filings, Standards and Disclosure Requirement
IV – Marketing

Attestations for all the standards in II, III and IV will be accepted.

V – Network Adequacy Requirements

Attestations for all the standards in V will be accepted.

VI– Applications and Notices
VII – Transparency Requirements
VIII– Enrollment Periods
IX– Enrollment Process for Qualified Individuals
X- Termination of Coverage of Qualified Individuals.
XI – Other Substantive Requirements

Attestations for all the standards in VI, VII, VIII, IX, X and XI will be accepted.

Non-Pediatric Dental Benefits

Discussion
The working group was charged with coming to consensus on the offering of non-pediatric dental benefits in QHPs and stand-alone plans.

The following are allowed EHB dental plans under DC law:

a. QHP that includes pediatric dental EHB (called "embedded")
b. Standalone dental plan that includes pediatric dental EHB (QDP)
c. QHP in conjunction with a QDP. In this case:
   i. The plans are priced separately
   ii. The plans are made available for purchase separately at the same price.

A QHP is not required to provide pediatric dental benefits if:

i. There is at least one QDP available and

ii. The carrier discloses there are no pediatric dental benefits in the plan and those benefits are available on the HBX.

The Secretary has expressly stated that stand-alone dental plans can offer additional benefits, including non-pediatric coverage. (Federal Register, Vol. 78, No. 37, Feb. 15, 2013, p. 12853). However, DC law does not require it.

Consensus Recommendation
The working group reached consensus recommendation that licensed District of Columbia issuers offering stand-alone pediatric dental plans may also offer non-pediatric dental benefits.

Reasonable Out-of-Pocket Maximums

Discussion
The Working Group was charged with coming to consensus on what a reasonable out-of-pocket maximum (OOP) (dollar amount) would be for a stand-alone pediatric dental plan. According to 45 CFR 156.150, the HBX must establish such a reasonable OOP. In a draft March 1 letter, the Center for Consumer Information and Insurance Oversight (CCIIO) stated that a $1,000 OOP would be considered reasonable (i.e. a safe harbor). However, it was not clear in the letter if that was per plan, or whether it could be applied to each child covered in the plan. Our neighbor jurisdiction, Maryland, has set the OOP at $1,000 if there is one child in the plan, and $2,000 if there are two or more children in the plan.

The dental issuers strongly support a $1,000 per child OOP and maintain that if it is less, premiums, deductibles and other cost-sharing will be higher. They maintain that at $1,000 per child, about 2% of children would reach the OOP. If the OOP were dropped to $500, then about 4% reach the OOP. One reason for the low percentages is that only medically necessary orthodontia is covered as an EHB, and according to the experts, the handicapping criteria to reach that threshold are extremely difficult. A pediatric dentist reported that children who reach the threshold have significant deformities.

Generally speaking, consumer advocates think a $1,000 per child OOP is too high, and even more so if there are several children in the plan. This creates a barrier to purchasing a plan because the pediatric dental benefit, although a required offer, is not a mandated purchase for childless adults and may result in less coverage. An actuarial study circulated by Milliman[1] that indicated the premium rise for a lower OOP was not significant (about $2-$3 to go from $1,000 to $270), but various parties disputed the age of the report and the assumptions used.

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[1] *Out of Pocket Maximum for Pediatric Dental and Orthodontia Benefit Plan to Prevent Catastrophic Dental Cost*. Milliman, November 5, 2012.

A working group member thought that CCIIO was going to revisit the $1,000 safe harbor, and a few working group members wanted to follow the federal safe harbor, whatever it turned out to be.

Non-Consensus Recommendation
The issue of the out-of-pocket maximum was discussed at both working group meetings, and the working group was unable to reach consensus on the OOP issue.

Subsequent to the working group meetings, on April 5, 2013, CCIIO released a revised letter that set the stand-alone dental OOP safe harbor at $700 per child, and $1,400 if there are two or more children covered by the plan.

Separate Pricing of Pediatric Dental Benefit Embedded in QHP

Discussion
The Working Group was charged with coming to consensus on whether an issuer offering QHP with the EHB pediatric dental benefit embedded in the plan should be required to display the cost of the pediatric dental benefit portion separately from the cost of the rest of the plan. The discussion of this issue showed that stand-alone dental plans and QHPs with an embedded have polar opposite views. Stand-alone dental plans insist they will be at a competitive disadvantage if the QHP is not required to separate out and display the pediatric EHB portion. QHP issuers are equally adamant that it is impossible to do since the pricing of the plan covers so many benefits and is spread among people who will never use the pediatric dental benefit. The Department of Insurance, Securities, and Banking also confirmed that separating the cost of dental benefits in these plans would not be feasible for comparison purposes.

Consensus Recommendation
In what can be considered a compromise, the working group reached consensus that a QHP should clearly label whether it does, or does not, include the pediatric dental EHB.

<u>Working Group Members</u>

The Dental Plan Advisory Working Group is comprised of representatives from dental plans, health plans and consumer advocates. Two meetings were held, on March 26 and April 2, 2013, both with in-person and conference call participation.

Leighton Ku	The George Washington University Center for Health Policy Research (DC HBX Board)
Katherine Stocks	The Goldblatt Group
Anupama Rao Tate	Children's National Medical Center
Mark Haraway	DentaQuest
Guy Rohling	UHC Dental

Jim Mullen, Kevin Wrege	Delta Dental
Louisa Tavakoli	Care First
Colin Reusch	Children's Dental Health Project
Amy Hall	DC resident
Tiffany	Kaiser Permanente
Jim Sefcik	Consultant
Mike Hickey	MetLife
Dean Rodgers	Dominion Dental
Jonathan Zuck	United Concordia
Meg Booth	CDHP
Claire McAndrew	Families USA

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a reasonable out-of-pocket maximum for Qualified Dental Plans.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, § 1311(d)(2)(B)(ii) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) ("ACA"), 45 CFR § 155.1065, and § 5(b) of the Act (D.C. Official Code § 31-3171.04(b)) permit a health carrier to offer a limited scope dental benefit either separately or in conjunction with a Qualified Health Plan, if the plan provides essential pediatric dental benefits meeting the requirements of §1302(b)(1)(J) of the ACA;

WHEREAS, § 10(e) of the Act (D.C. Official Code § 31-3171.09(e)) applies the certification requirements of the Act to Qualified Dental Plans to the extent relevant and permits health carriers to jointly offer a comprehensive plan through the exchanges in which the dental benefits are provided by a health carrier through a Qualified Dental Plan and the other benefits are provided by a health carrier through a Qualified Health Plan; provided, that the plans are priced separately and are also made available for purchase separately at the same price;

WHEREAS, the Dental Plan Working Group, which included ten dental and health carriers, consumer groups, and a DC resident, met on April 2, 2013and reached consensus on three recommendations and did not reach consensus on one recommendation;

WHEREAS, on April 15, 2013, the Insurance Market Working Committee deliberated on the non-consensus recommendation regarding an out of pocket maximum for the pediatric dental essential health benefit in a stand-alone dental plan;

WHEREAS, 45 C.F.R. §156.150 requires a stand-alone dental plan covering the pediatric dental essential health benefit to demonstrate that it has a reasonable annual limitation on cost-sharing as determined by the Exchange;

WHEREAS, on April 5, 2013, the Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services, issued a letter of guidance for federally facilitated and partnership exchanges defining a reasonable out-of-pocket maximum for the pediatric dental essential health benefit from 45 C.F.R. §156.150 as at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees; and

WHEREAS, the Insurance Market Working Committee in a 3-0 vote recommends an out-of-pocket maximum that is not greater than $1000 for one child, increasing to $2000 for two or more children for the pediatric dental essential health benefit in Qualified Dental Plans.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves an out-of-pocket maximum for Qualified Dental Plans that is not greater than $1000 for one child, increasing to $2000 for two or more children for the pediatric dental essential health benefit.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this **___18th___** day of **_April____**, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish effective dates for eligibility redeterminations resulting from changes reported during the benefit year.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.330(f)(2) permits the Exchange to determine a reasonable point in a month after which an eligibility change captured through a redetermination will not be effective until the first day of the second month after the redetermination is made; and

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated on this topic and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

For those individuals enrolled in a QHP who experience a change in eligibility during a benefit year, but who do not lose their eligibility for enrollment in a QHP, the District of Columbia Health Benefit Exchange will implement eligibility changes determined on or before the 15th day of the month to be effective the first day of the following month. For those eligibility

changes made on the 16th day or thereafter, the effective date of the change will be the first day of the second month following the date of the redetermination notice.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this **___9th___** day of **_May____**, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish default termination rules for Individual Exchange marketplace enrollees who are determined eligible for Medicaid.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange ("Exchange") for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, according to 26 U.S.C. §36B(c)(2)(B), individuals eligible for Minimum Essential Coverage are not eligible for the Advanced Premium Tax Credits used to lower premium costs for coverage in the Individual Exchange marketplace;

WHEREAS, according to 26 U.S.C. §5000A(f))(1)(A)(ii), Medicaid coverage is considered Minimum Essential Coverage;

WHEREAS, 45 C.F.R. §155.330(d)(ii) requires the Exchange to proactively and regularly monitor Medicaid eligibility determinations;

WHEREAS, the Authority is establishing a unified eligibility determination system in partnership with the Department of Health Care Finance (State Medicaid Agency) and will have knowledge of Medicaid eligibility determinations;

WHEREAS, Medicaid coverage in the District of Columbia offers a comprehensive benefit package at little or no cost-sharing for the enrollee; and

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated regarding this situation and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

Default Termination of QHP Coverage Based on Medicaid Eligibility Determination:

The District of Columbia Health Benefit Exchange will terminate an enrollee's QHP enrollment upon notification of Medicaid eligibility with the effective date dependent on the date of the Medicaid eligibility determination. Determinations made on or before the 15th of the month would have a default termination effective the first day of the next month, determinations made after the 15th would have a default effective date of the first day of the second month following the determination. An individual can request to continue enrollment in their QHP, without any subsidies, before the scheduled default QHP termination date. Individuals will be advised of their default termination date in the redetermination notice sent following the Medicaid eligibility determination. Default terminations do not alter an individual's right to terminate under 45 C.F.R. §155.430.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To define "exceptional circumstances" permitting a Special Enrollment Period.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (9)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including the establishment of enrollment periods, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.420(d)(1) – (8) establishes a series of circumstances in which QHPs must permit qualified individuals to receive a 60-day special enrollment period (SEP) to enroll in the Individual Exchange marketplace outside an Open Enrollment Period;

WHEREAS, 45 C.F.R. §155.420(d)(9) permits the Exchange to define "exceptional circumstances" establishing additional SEPs; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated on this topic and reached consensus recommendations to the Executive Board;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations presented by the Eligibility, Enrollment, and Churn Working Group:

The District of Columbia Health Benefit Exchange will consider it an exceptional circumstance, permitting a new special enrollment period, when an applicant or enrollee does not select a plan during Initial Enrollment, Open Enrollment, or an SEP granted on other grounds, due to one of the following circumstances if the individual does not otherwise qualify for an SEP under the categories in 45 C.F.R. §155.420(d)(1) – (8):

1) Based on the individual's self-attestation, he/she is eligible for Medicaid but the eligibility determination is pending paper verification of an eligibility factor and the

individual is ultimately determined ineligible for Medicaid after the enrollment period has expired. The first day of the SEP shall be the date of the notice of Medicaid ineligibility. This SEP would exclude Medicaid applicants who were denied due to their failure to timely provide the requested documentation.

2) An individual misses the Individual Exchange enrollment period while waiting for their employer to be approved for the SHOP. Under this scenario, an individual's employer applies to participate through SHOP during the individual open enrollment period and is ultimately denied due to not meeting minimum participation requirements. By the time the employee is notified that he/she cannot enroll through the SHOP, the individual's enrollment period has passed.

3) The individual's enrollment or non-enrollment in a QHP was unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a QHP issuer, or its instrumentalities as evaluated and determined by the D.C. Department of Insurance, Securities, and Banking. In such cases, the Exchange may trigger the SEP and take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To require Qualified Health Plan (QHP) issuers to establish polices that address transition of care for enrollees in the midst of active treatment at the time of transition into a QHP.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (19)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, there is a consensus among public health researchers that a substantial portion of individuals in the Individual Exchange marketplace will experience changes in eligibility during the benefit year causing them to move or "churn" between Medicaid, and coverage in a Qualified Health Plan (QHP);

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group discussed strategies to address "churn" and developed consensus recommendations.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations presented by the Eligibility, Enrollment, and Churn Working Group:

<u>Establishment of Care Transition Plans by QHP Issuers:</u>

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

Counseling by In-Person Assisters and Brokers:

In-Person Assisters under contract with the District of Columbia Health Benefit Exchange shall counsel individuals about transition risk upon changes in program eligibility. The training available to In-Person Assisters and Brokers shall include information on risks associated with transitioning from one form of coverage to another during a course of active treatment.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish outreach strategies to promote tobacco cessation programs and other preventive benefits that are covered without cost sharing.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and a Small Business Health Options Program (SHOP) Exchange (collectively the District of Columbia Health Benefit Exchange or DC HBX) and maintain a publicly available website with information available to enrollees and prospective enrollees, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, on December 12, 2012, the Executive Board established the Plan Management Advisory Committee to advise on qualified health plan (QHP) requirements, dental plan requirements, certification processes, QHP enrollment, and other issues as requested by the Executive Board or Authority staff;

WHEREAS, on April 8, 2013, the Executive Board requested that an appropriate advisory committee provide recommendations to the Executive Board on approaches for promoting outreach to beneficiaries on tobacco cessation programs and other preventive benefits provided without any cost sharing; and

WHEREAS, that responsibility was assigned to the Plan Management Advisory Committee, which met on April 11 and 24, 2013 to review these issues and developed a series of consensus recommendations.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendations presented by the Plan Management Advisory Committee to encourage the use of tobacco cessation programs and other preventive benefits by enrollees in the DC HBX:

1) As part of the general information on the DC HBX website, provide descriptive information on the ACA covered preventive services including tobacco cessation and, when feasible, link to carrier websites which describe the availability of their tobacco cessation/preventive benefits.

2) Recognizing that carriers now communicate with new enrollees, ensure that carriers include information about tobacco cessation and other preventive services in their new member communication. Note: this recommendation is not intended to duplicate existing communication or add to costs.

3) Recognizing that carriers now communicate with providers, ensure that carrier communications to their providers include up to date information on the preventive benefits and tobacco cessation programs to be provided with no cost sharing. Note: this recommendation is not intended to duplicate existing communication or add to costs.

4) As part of training for navigators, in-person assistors (IPAs), and certified application counselors (CACs), the DC HBX should provide descriptive materials on the availability of no cost preventive services including tobacco cessation for use in enrollment counseling sessions. These counselors should stress the importance of enrollees speaking directly with their carrier to obtain more information on these benefits.

5) Utilize alternative vehicles for communication, other than carriers, including providing educational materials to small business owners and benefit administrators on the availability of preventive services including tobacco cessation.

6) Maintain ongoing discussions with key stakeholder groups to identify additional opportunities to increase the use of preventive services including tobacco cessation. Stakeholder groups should include at least carriers, providers, and community organizations.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

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Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish an automatic enrollment policy for the Individual Exchange marketplace and to define "exceptional circumstances" permitting a Special Enrollment Period.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (9)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including the establishment of enrollment periods, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.410(g) enables the Exchange to enable individuals to be automatically enrolled into Qualified Health Plans(QHP), "subject to the Exchange demonstrating to HHS that it has good cause to perform such automatic enrollments."

WHEREAS, under 45 C.F.R. §155.335(j) an enrollee who remains eligible for coverage in a QHP upon annual redetermination will remain in the QHP selected the previous year unless such enrollee terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP;

WHEREAS, 45 C.F.R. §155.420(d)(1) – (8) establishes a series of circumstances in which QHPs must permit qualified individuals to receive a 60-day special enrollment period (SEP) to enroll in the Individual Exchange marketplace outside an Open Enrollment Period;

WHEREAS, 45 C.F.R. §155.420(d)(9) permits the Exchange to define "exceptional circumstances" establishing additional SEPs;

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated the issue and did not reach a consensus recommendation on the topic of auto-enrollment for existing enrollees whose plan was not going to be offered in the subsequent plan year. This non-consensus recommendation was referred to the Executive Board's IT Infrastructure and Eligibility Working Committee; and

WHEREAS, on May 3, 2013, the Executive Board's IT Infrastructure and Eligibility Working Committee discussed the topic of auto-enrollment for existing enrollees whose plan was not going to be offered in the subsequent plan year, and developed consensus recommendations for Executive Board consideration.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendations presented by the Executive Board's IT Infrastructure and Eligibility Working Committee:

Auto-Enrollment in Similar Plan; Allow an Additional SEP:

The District of Columbia Health Benefit Exchange (DCHBX) will enable an individual to be automatically enrolled if he or she does not select a new plan, and does not terminate such coverage when their existing plan is no longer offered in a subsequent plan year, into a similar plan, if available. A similar plan is defined as same carrier, metal tier, and provider network.

Additionally, a new 60-day SEP is established. The triggering date is the effective date for the plan in which the individual has been automatically enrolled. This provides the individual an additional opportunity to change plans.

No Auto-Enrollment if Similar Plan Not Available; Allow an Additional SEP to select new plan:

There is no automatic enrollment if there is no similar plan available.

Additionally, a new 60-day SEP is established. The triggering date is the first day coverage is terminated. This provides the individual an additional opportunity to select a new plan.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

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Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To allow a good faith extension of the period to resolve eligibility factor inconsistencies for eligibility or enrollment in the Individual Exchange marketplace

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.315(f)(3) allows Exchanges to extend the 90-day period provided to individuals to resolve inconsistencies regarding eligibility factors between data sources available to the Exchange and the individual's self-attestation when there has been a good faith effort; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated the issue and reached a consensus recommendation;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

<u>Extension of Inconsistency Period for Good Cause:</u>

Individuals who make a good faith effort shall be provided an additional 30 days, beyond the 90 days mandated in 45 C.F.R. §155.315(f)(2)(ii), to resolve any inconsistencies with Exchange

eligibility verification data sources. Good faith effort shall be defined as an individual requesting the additional 30 days from the Exchange either online, through the call center, in-person at a service center, or by mail.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

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Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority