Reference Document of Past Federal and DC Actions

August 2, 2017

Issue	Federal Action	DC Action
Limiting IVL Exchange Open enrollment*	Shortening open enrollment 1 year early to Nov 1-Dec 15, 2017 for 2018 Open Enrollment. Note: SBMs can use existing authority to extend for *one year* (using exceptional circumstance SEP authority) which HBX has elected to do.	See June 14, 2017 resolution approved by the HBX Standing Advisory Board and adopted by the HBX Executive Board Resolution. No further action needed.
IVL Market SEPs – Pre-enrollment verifications*	Adopting pre-enrollment verification in FFM and SBM- FP states. Consumers have 30 days to provide documentation that they are eligible for SEPs. Optional for SBMs. (state flexibility)	HBX not requiring pre-enrollment verification as FFM applying state flexibility. No further action needed.
IVL Market SEPs – Metal Level Changes*	Limiting the rights of SEP consumers to change metal levels if they are currently enrolled in exchange coverage. Applies to all IVL exchanges (no state flexibility)	State preempted from acting.
IVL Market SEPs – Delayed Effective Dates*	Limiting the ability of exchanges to move SEP effective dates where eligibility determination was delayed by the exchange. Exchanges now only permitted to start coverage sooner by 30 days if decision was delayed by exchanges. Consumers also have to pay all retroactive premiums at time of enrollment to effectuate coverage. Applies to all IVL exchanges (no state flexibility)	State preempted from acting.
IVL Market SEPs- Prior coverage requirement*	Requiring that consumers demonstrate that they had prior coverage when requesting a SEP related to marriage. (must prove that one of the spouses had prior coverage in past 60 days)	State preempted from acting.

* Final Federal Market Stabilization Regulations (April 18, 2017).

Issue	Federal Action	DC Action
	Applies to all IVL exchanges (no state flexibility)	
IVL Market SEPs -Exceptional Circumstances*	FFM is limiting its exceptional circumstances SEPs to 5 situations. State flexibility	HBX maintaining exceptional circumstances SEPs as approved by the HBX Advisory Board and adopted by the HBX Executive Board. No further action needed.
Actuarial Value of QHPs*	Amended permissible de minimus actuarial value variations. Now permitting variations of +2/-4 generally and permitting +5/-4 for bronze level plans in play year 2018. State flexibility	HBX following federal approach, will reassess with experience.
Network Adequacy*	HHS is deferring to state network adequacy reviews where states have authority that is at least equal to the reasonable access standard under §156.230 In both FFM and SBM states	See August 8, 2016 resolution adopted by the HBX Executive Board Resolution. DISB developing network adequacy regulations.
Essential Community Providers*	Lowering the ECP standard back to the 2014 standards. Lowering from 30% to 20% for play year 2018.	DISB addressing as part of network adequacy regulations.
Grandmothered plans*	Extending the grandmothered non-enforcement policy for another year in IVL and SM GP markets in February 23, 2017 guidance. Applies to coverage through December 31, 2018. State flexibility to end this transition earlier.	DISB prohibited in 2013. No further action required.

* Final Federal Market Stabilization Regulations (April 18, 2017).

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a Special Enrollment Period starting December 16, 2017 through January 31, 2018 to effectively extend the upcoming plan year 2018 open 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 ("HBX"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §8 of the Act (D.C. Official Code §31-3171.07) requires the Authority to create a Standing Advisory Board (SAB), and consult with the SAB on certain matters, including any policy or operational issues within the Executive Board's discretion;

WHEREAS, the SAB is comprised of a variety of stakeholders, including consumers, carriers, brokers, and small businesses;

WHEREAS, on April 18, 2017, the Centers for Medicare & Medicaid Services (CMS) promulgated a final rule, "*Patient Protection and Affordable Care Act; Market Stabilization* (Market Stabilization rule);

WHEREAS, the SAB met on May 18, 2017 to discuss policy issues that arose as a result of the Market Stabilization rule;

WHEREAS, in the Market Stabilization rule, CMS shortened the open enrollment period for plan year 2018 to six weeks, rather than the full three months previously required by federal regulation;

WHEREAS, in the Market Stabilization rule, CMS noted that State Based Exchanges may have operational difficulties this year transitioning to this shorter open enrollment period. CMS specifically noted that under "their [SBM] existing regulatory authority, those Exchanges may elect to supplement the open enrollment period with a special enrollment period, as a transitional measure, to account for those operational difficulties;"

WHEREAS, SAB members recognized that HBX has significant enrollment activity already within this timeframe -- numerous SHOP renewals occur in November and December 2017, and Congressional Open Enrollment also occurs in this window;

WHEREAS, the Contact Center budget planned for a three month open enrollment and was not set to accommodate hiring up and extending operating hours for a six week open enrollment period for the 2018 plan year;

WHEREAS, the Navigator and Assister budgets were planned for a three month open enrollment period and was not set to accommodate hiring up and extending operating hours for a six week open enrollment for the 2018 plan year;

WHEREAS, SAB members raised concern that there was little time to message this change which could reduce District residents' access to coverage thorough DC Health Link;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby adopts the consensus recommendation from the Standing Advisory Board as follows:

Establish a Special Enrollment Period starting December 16, 2017 through January 31, 2018. The regular open enrollment period and the one-time special enrollment period together provide for a three month period that had been planned.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 14th day of June, 2017, 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 that the District of Columbia adopt all sections of the NAIC Health Benefit Plan Network Access and Adequacy Model Act including network sufficiency, continuity of care, provider directory, and surprise out-of-network medical bill protections modified as necessary to meet the unique needs of the District.

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 ("HBX"), 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 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;

WHEREAS, the Network Adequacy Workgroup presented recommendations to the Board on March 7, 2013 and the Executive Board adopted the recommendations in a resolution on March 13, 2013;

WHEREAS, the Issuer Certification Process recommendations require the Executive Board to revisit these standards using additional data and experience gained;

WHEREAS, the Executive Board Insurance Market Working Committee met in five public meetings from October 2014 through January 2015 on the topic of qualified health plan certification requirements, including network adequacy, hearing from stakeholders, experts in the field, HBX and Department of Insurance, Securities and Banking staff;

WHEREAS, the Executive Board Insurance Market Working Committee recommended and the Executive Board adopted updated network adequacy certification requirements on February 9, 2015;

WHEREAS, November 2015, the National Association of Insurance Commissioners (NAIC) unanimously approved the Health Benefit Plan Network Access and Adequacy Model Act (NAIC Network Adequacy Model Act), Model #74 after a year of work through various NAIC subgroups;

WHEREAS, March 8, 2016, the Department of Health & Human Services promulgated a final rulemaking that includes limited network adequacy provisions and notes its "expectation that all States, including the FFE States, will actively implement these [NAIC Network Adequacy Model Act] provisions";

WHEREAS, on June 6, 2016, the Executive Board Insurance Market Committee met to review the topic Network Adequacy, hearing from stakeholders, experts in the field, HBX staff, Stephen Taylor, Commissioner of the Department of Insurance, Securities and Banking, and Department of Insurance, Securities and Banking staff, on the NAIC Network Adequacy Model Act, federal, local laws, and other state laws on network sufficiency, provider directory accuracy, and surprise medical bills and asked the Standing Advisory Board for a recommendation on network adequacy for the HBX Executive Board;

WHEREAS, on June 30, 2016, the Standing Advisory Board met to discuss the topic of network adequacy, hearing from stakeholders, experts in the field, the public, and HBX staff on the NAIC Network Adequacy Model Act, federal, local laws, and other state laws on network sufficiency, provider directory accuracy, and surprise medical bills and to consider a recommendation for the HBX Executive Board as requested by the Insurance Market Committee;

WHEREAS, on July 26, 2016, the Standing Advisory Board considered, gave an opportunity for public comment, and passed a consensus recommendation on network adequacy;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby adopts the consensus recommendation from the Standing Advisory Board that recommends the District of Columbia enact all sections of the NAIC Network Adequacy Model Act, including network sufficiency, continuity of care, provider directory, and surprise out-of-network bill protections, modified as necessary to meet the unique needs of the District, with further detail as follows:

I. Network Sufficiency

1) The District of Columbia shall adopt quantitative and, if appropriate, non-quantitative criteria to evaluate the network sufficiency of health benefit plans (based on Maryland HB 1318, enacted May 2016). Maryland HB 1318 requires the Commissioner, in consultation with stakeholders, to adopt regulations that may take the following into consideration:
    a. Geographic accessibility of primary care and specialty providers, including mental health and substance use disorder providers;
    b. Waiting times for an appointment with participating primary care and specialty providers, including mental health and substance use disorder providers;
    c. Primary care provider- to-enrollee ratios;
    d. Provider-to-enrollee ratios, by specialty;
    e. Geographic variation and population dispersion;

f. Hours of operation;
g. The ability of the network to meet the needs of enrollees, which may include:
    i. Low-income individuals
    ii. Adults and children with:
        1. Serious, chronic, or complex health conditions; or
        2. Physical or mental disabilities; and
    iii. Individuals with limited English proficiency or illiteracy;
h. Other health care service delivery system options, including telemedicine, telehealth, mobile clinics, and centers of excellence;
i. The volume of technological and specialty care services available to serve the needs of enrollees requiring technologically advanced or specialty care services;
j. Any standards adopted by the federal Centers for Medicare & Medicaid Services or used by the Federally Facilitated Marketplace; and
k. Any standards adopted by another state.

II. Provider Directory Accuracy

1) As is required currently for plans sold on DC Health Link under a resolution of the Executive Board enacted January 1, 2015, all District-licensed carriers shall be required to prominently post a phone number or email address on their online and print provider directories (not necessarily a dedicated phone number or email address) for consumers to report inaccurate provider directory information. Carriers will be required, within 30 days, to validate reports that directories are inaccurate or incomplete and, when appropriate, to correct the provider information. The carrier will be required to maintain a log of consumer reported provider directory complaints that would be accessible to DISB or HBX upon request.
2) The Commissioner shall review the NAIC Model Act, including drafting notes, and requirements implemented in other states, and adopt policies to ensure that carriers' provider directories are accurate and easily accessible for District residents.

III. Surprise Medical Bills

Emergency Protection: As in the NAIC Model Act, insurance enrollees should be protected from any costs beyond in-network cost-sharing in emergency situations, including if they receive services from out-of-network providers. Consumers should never face surprise bills in emergencies.

Non-Emergency Protection: Insurance enrollees should be protected from any costs beyond in-network cost-sharing when the enrollee receives care in an in-network facility and does not have the ability and opportunity to choose an in-network provider at the facility who is available to treat the enrollee.

Other states, such as Florida and New York, have implemented laws that may provide instruction to the District in implementing these protections.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 8th day of August, 2016, 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

Department of Insurance, Securities and Banking

Office Hours
Monday to Friday, 8:15 am to 4:45 pm, except District holidays

Connect With Us
810 First Street, NE, Suite 701,
Washington, DC 20002
Phone: (202) 727-8000
Fax: (202) 535-1196
TTY: 711
Email: disb@dc.gov

Listen

SHARE

Department Statement Regarding Non-Affordable Care Act-Compliant Health Plans

Wednesday, November 27, 2013

Today, the District of Columbia's Department of Insurance, Securities and Banking announced that it will not exercise the discretion delegated to state insurance commissioners in the U.S. Department of Health and Human Services' transitional policy from Nov. 14 that would permit carriers to continue renewing non-Affordable Care Act-compliant health plans for policy years starting between Jan. 1 and Oct. 1, 2014.

"The department carefully considered all factors involved in this decision – District residents, the industry and the unique characteristics of our market – and concluded that there are greater benefits to continuing the District's Affordable Care Act implementation efforts as planned," said Chester A. McPherson, interim commissioner for the department. "The department believes this approach provides more certainty for residents and carriers by subjecting all health plans to the same standard as outlined in the law."

Stephen C. Taylor
Commissioner

Specifically, the additional elements of the Affordable Care Act's essential health benefit requirement ensure that District residents have comprehensive coverage to meet their health care needs. Also, our review concluded that the future rate impact of the transitional policy would be more significant to District residents than continuing implementation as intended.

In making its decision, the department received input from the District's Health Benefit Exchange Authority, carriers operating in our market, public interest organizations and District residents. Residents or issuers with questions regarding the department's implementation of the Affordable Care Act should contact Philip Barlow, associate commissioner for insurance, at philip.barlow@dc.gov.