IMPLEMENTATION OF QUALIFIED HEALTH PLAN CERTIFICATION REQUIREMENTS

	Requirements	Federal Source	District Source	DISB Role	HBX Role
	Licensed to offer health insurance and in good standing	ACA §1301 (a)(1)(C) 45 CFR § 156.200(b)(4)	§ 31-3171.09(a)(5)(A)	– Carrier attests in Federal Attestation Form-Federally required Program Attestations for State Based Exchanges filed on SERF. – DISB verifies directly through evidence that requirement is met. – Some carriers submit additional evidence such as copies of license. – DISB confirms as regulator.	– DISB performs check for HBX. No additional steps are taken by HBX.
	Risk adjustment program	ACA §1343 45 CFR §156.200(b); 45 CFR §155.1000(c)(2)		– Carrier attests in Federal Attestation Form-Federally required Program Attestations for State Based Exchanges filed on SERF. – DISB verified compliance with risk adjustment, reinsurance, and risk corridors ad hoc.	– HBX opted into the federal government operation of the risk adjustment program for QHPs.
	Offered Products are in the interest of consumers.	ACA §1311(e)	§ 31-3171.09(a)(7)	N/A	– No specific pre-certification check, integrated into other certification requirements.
	Benefit Standards and Product Offerings			– Carrier attests in Federal Attestation Form-Federally required Program Attestations for State Based Exchanges filed on SERF. – DISB performs check with its required forms review of each plan.	– DISB performs check for HBX. No additional steps are taken by HBX.

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	☐ Covers the Essential Health Benefit Package District specific requirements include: • Behavioral health without day or visit limitations • Comply with Mental Health Parity • Drug Formulary Minimum for Each Category and Class • Offers the EHB without benefit substitution • Additional benefit may be offered • Habilitative services defined	ACA §1302	§ 31-3171.09 (District specific requirements added by resolutions and statute)	– DISB performs check with its required forms review of each plan.	– DISB performs check for HBX. No additional steps are taken by HBX.
	☐ Complies with Annual Limitation on Cost Sharing. ☐ Cost-sharing shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage. FOR SHOP ONLY: ☐ Complies with Annual Limitations on Deductibles for Employer-Sponsored Plans.	ACA §1302(c)	§ 31-3171.09(a)(4)	– DISB performs check with its required forms review of each plan.	– DISB performs check for HBX. No additional steps are taken by HBX.
	☐ Offers through the Exchange: one bronze level plan (AV 60%), **AND** one silver level plan (AV 70%), **AND** one gold level plan (AV 80%).	ACA §1301 (a)(1)(C)(ii) 45 CFR §156.200 (c)(1) (silver and gold)	§ 31-3171.09 (District added bronze plan requirement)	– DISB performs check with its required forms review of each plan.	– DISB performs check for HBX. No additional steps are taken by HBX.
	☐ Offers a child-only plan at the same level of coverage—bronze, silver, gold, or platinum—as any other plan offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained age 21.	ACA §1302(f) 45 CFR §156.200(c)		– DISB performs check with its required forms review of each plan.	– DISB performs check for HBX. No additional steps are taken by HBX.
	☐ Summary of Benefits and Coverage - Submits a	ACA §1001, PHSA		– DISB verifies submission of	– Carriers submit a Summary of Benefits and

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	description of covered benefits and cost-sharing provisions to the Exchange at least annually.	§ 2715 45 CFR §156.210(b)		Summary of Benefits and Coverage with forms submission.	Coverage for each health plan. – HBX reviews and verifies submissions. – Carrier sends updates typically to correct inaccuracies.
	Offers plans subject to the meaningful difference standard by CCIIO in 2013 or as defined by the Executive Board. 2013 FFM Standard ☐ Part 1: Benefit package or plan costs are substantially different from other issuer plans considering metal level service area, provider network, premium, cost sharing, benefits, formulary structure. ☐ Part 2: Are consumers likely to be able to distinguish. Carrier can amend filing or submitted supporting documentation explaining how a plan is substantially different.		§ 31-3171.09(a)(5)(H)	– DISB does not perform a specific health plan level check; however, there is a broad check by carrier and metal tier with its required forms and rate review.	– DISB performs check for HBX. No additional steps are taken by HBX.
	Offers one or more standardized plans at each metal level		§ 31-3171.09(a)(5)(G)	– Standardized plans have not been approved by HBX Executive Board.	– Standardized plans have not been approved by HBX Executive Board.
	Discrimination				
	☐ Carrier does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.	ACA §1201, PHSA §2706 45 CFR §156.200(e)		– DISB investigates and acts on complaints as appropriate. – No complaints have been filed on this basis.	– HBX refers complaints to DISB.
	☐ Health plan does not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.	ACA §1311(c) 45 CFR §156.225(b)		– DISB performs general check with its required forms review of each plan. – Specific checks: o DISB checks if plan passes the Non-Discrimination Formulary Outlier Tool which identifies plans with an	– DISB performs check for HBX. No additional steps are taken by HBX.

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				unusually large number of drugs that require step therapy or prior authorization in one of five categories and classes: insulins, antidiabetic agents, immunomodulators, immune suppressants, and anti-HIV agents. o DISB checks if plan passes the Non-Discrimination Clinical Appropriateness Tool which ensures access to drugs recommended in clinical guidelines for four diseases: diabetes, schizophrenia, bipolar disorder, and rheumatoid arthritis.	
	☐ Marketing practices do not discourage the enrollment of individuals with significant health needs.	ACA §1311(c)(1)(B) 45 CFR §156.225(b)		– DISB investigates and acts on complaints as appropriate. – No complaints have been filed on this basis.	– HBX refers complaints to DISB.
	Rate Filings and other Rate Disclosure Requirements			– DISB performs rate review under its own authority based on carrier filings. – DISB shares information on filings and outstanding questions with HBX hired actuaries. – DISB approves final rates for QHPs. – Carrier submits the following: • Federal Uniform Rate Review Template (data for market-	– HBX hired actuaries to work with DISB to inform actuarial analysis of justifications for premium increases. – HBX shares results analysis and recommendations with DISB. – HBX accepts final rates as approved by DISB.

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				wide review) • DISB Actuarial Value Input Template (includes actuarial value data) • DISB Rate Requirements in Appendix C of Carrier Manual	
	☐ Files rates for prior approval.		§ 31-3311.04	– DISB performs rate review under its own authority based on carrier filings through SERF.	– DISB shares information through SERF.
	☐ Submits rate information to the Exchange at least annually.	ACA §1311(e)(2) 45 CFR §155.1020 45 CFR §156.210	§ 31-3171.09(c) and (f)	– Carrier submits rate information and justification information to DISB. – DISB shares information with HBX.	– DISB shares information through SERF.
	☐ Submits to the Exchange a justification for a rate increase prior to the implementation of the increase.	ACA §1311(e)(2) 45 CFR §155.1020 45 CFR §156.210	§ 31-3171.09(c) and (f)	– Carrier submits rate information and justification information to DISB. – DISB shares information with HBX.	– DISB shares information through SERF.
	☐ Prominently posts the rate increase justification on carrier Web site prior to the implementation of the increase.	ACA §1311(e)(2) 45 CFR §155.1020 45 CFR §156.210	§ 31-3171.09(c) and (f)	– Carrier mostly do not post this specific information on their websites. – Filings are public on DISB website at: http://disb.dc.gov/node/850862	
	Rating Standards—General				
	☐ Sets rates for an entire benefit year, or for the SHOP, quarterly by plan year.	45 CFR §156.210(a)		– DISB performs rate review under its own authority based on carrier filings through SERF.	– DISB performs check for HBX. No additional steps are taken by HBX.
	☐ Rates must be the same for products inside and outside Exchange.	ACA §1301 (a)(1)(C)(iii)		– DISB reviews rate variations under its own authority based on carrier filings through SERF.	– DISB performs check for HBX. No additional steps are taken by HBX.

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		45 CFR §156.255(b)			
	☐ Varies rates only based on: ☐ age (DC age rating curve, narrower than 3 to 1) ☐ family composition: ☐ Individual; ☐ Two-adult families; ☐ One-adult family with child(ren) ☐ All other families. No variation based on geographic area or tobacco use.	ACA §1201, PHSA §2701 45 CFR §156.255	HBX resolution and DISB standards DISB age rate table No geographic or tobacco rating differentials permitted by DISB	– DISB reviews rate variations under its own authority based on carrier filings through SERF.	– DISB performs check for HBX. No additional steps are taken by HBX.
	Network Adequacy Requirements	ACA §1311(c)(1)(B) 45 CFR §155.1050; 45 CFR §156.230	HBX Resolution on Network Adequacy		
	Timing in Accessing a Provider - Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.	45 CFR §156.230(a)(2)		– Carrier files Federal Network Template. – Carrier is required to be accredited, which includes meeting network adequacy standards. – Carriers submit federal carrier NCQA or Federal Carrier URAC Template.	– DISB performs check for HBX. No additional steps are taken by HBX.
	Various Types of Providers - Network must include providers that specialize in mental health and substance abuse services.	45 CFR §156.230(a)(2)		– Carrier files Federal Network Template. – Carrier is required to be accredited, which includes meeting network adequacy standards. – Carriers submit federal carrier	– DISB performs check for HBX. No additional steps are taken by HBX.

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				NCQA or Federal Carrier URAC Template.	
	Geographic Distribution of Providers **-** Has a network with sufficient geographic distribution of providers for each plan.	45 CFR §156.230(a)(2)		– Carrier files Federal Network Template. – Carrier is required to be accredited, which includes meeting network adequacy standards. – Carriers submit federal carrier NCQA or Federal Carrier URAC Template.	– DISB performs check for HBX. No additional steps are taken by HBX.
	Essential Community Providers **-** Has sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area.	ACA §1311(c)(1)(C) 45 CFR §156.230(a)(1) and 45 CFR §156.235		– Carrier files Federal Essential Community Providers Template which includes a list of ECPs by network. – Network templates submitted separately. – ECP template – For each individual plan, would be hard to piece. – Would need information submitted in a different format.	– DISB performs check for HBX. No additional steps are taken by HBX.
	Alternate standard for QHP carriers that provide major services through employed physicians or a single medical group	45 CFR §156.235(b)		– DISB has not developed an alternative standard.	– HBX has not developed an alternative standard.
	Provider Directory **-** Makes its provider directory available: ☐ to the Exchange for publication online in accordance with guidance from the Exchange; and ☐ to potential enrollees in hard copy upon request.	45 CFR §156.230(b)		– No specific precertification review by plan. – DISB reviews website links to ensure they are live on an ad hoc basis. – DISB checks last update date on an ad hoc basis.	– HBX has contracted with Consumers' CHECKBOOK and is working with carriers to develop an integrated on-line provider directory for DC Health Link.

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	Provider directory identifies providers that are not accepting new patients.				
	Collection of Data to assess procedures and processes, learn the scope of gaps, impact of ACA on network adequacy standards		HBX Resolution on Network Adequacy	No specific DISB role.	– HBX has contracted with Consumers' CHECKBOOK to assess accuracy of provider directory data. – HBX Standing Advisory Board subcommittee performed secret shopper analysis of provider directories and will be reporting on them.
	Access Plans – Carriers are required to submit an access plan by July 2014 that includes information on: • sufficiency of providers taking into account time and distance, wait time, provider to patient ratios • access to essential community providers • provider directory accuracy		HBX Resolution on Network Adequacy	– DISB did not provide an access plan template for submission. Thus, carriers did not submit an access plan.	– HBX did not provide an access plan template for submission. Thus, carriers did not submit an access plan.
	Applications and Notices				
	☐ Provides to applicants and enrollees all material: ☐ in plain language; and ☐ in a manner that is accessible and timely to: ☐ individuals living with disabilities, and ☐ to individuals with limited English proficiency through the provision of language services at no cost to the individual.	ACA §1311(e)(1)(A) 45 CFR §156.250 and 45 CFR §155.230		– DISB reviews certain notices through forms review. – Renewal and discontinuation notices are separately and specifically reviewed.	– DISB performs check for HBX. No additional steps are taken by HBX. – DC Health Link Application is the only insurance application used and that is developed and maintained by HBX.
	☐ Complies with DC minimum language simplification standards.		Language Access Act of 2004	– District law is generally not applicable to carriers.	– District law is generally not applicable to carriers.
	Transparency Requirements ☐ Makes available to the public, the Exchange, and	ACA §1311(e)(3)(A)			– CCIIO has delayed carrier reporting of transparency requirements until the second

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	the insurance commissioner in an accurate and timely manner, and in plain language: ☐ Claims payment policies and practices; ☐ Periodic financial disclosures; ☐ Data on enrollment; ☐ Data on disenrollment; ☐ Data on the number of claims that are denied; ☐ Data on rating practices; ☐ Information on cost-sharing and payments for out-of network coverage; ☐ Information on enrollee rights under title I of the Affordable Care Act (includes insurance market reforms and Patient's Bill of Rights).	45 CFR §155.1040; 45 CFR §156.220 ACA §1311(e)(3)(C)			plan year (2015). See http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html – HBX is awaiting federal guidance for transparency data collection.
	☐ Makes available the amount of enrollee cost sharing for a specific item or service by a participating provider in a timely manner upon the request of the individual. ☐ Makes available such information through: ☐ Internet Web site; and ☐ Other means for individuals without access to the Internet.	ACA §1311(e)(3)(C)		– No specific precertification check is performed.	– No specific precertification check is performed.
	☐ Provides required notices on internal and external appeals in a culturally and linguistically appropriate manner.	45 CFR §147.136(e)		– No specific precertification check is performed. – DISB will include an evaluation of this for 2016 certification.	– No specific precertification check is performed.
	Enrollment Periods	ACA§1311(c) Title 27 of PHSA			
	☐ Provides an <u>initial open enrollment</u> period October 1, 2013 to March 31, 2014.	ACA§1311(c)(6) 45 CFR §155.410(b)			– No specific precertification check is performed. – HBX works with carriers on an on-going basis to ensure compliance.

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	☐ Provides an annual open enrollment period.	ACA§1311(c)(6) 45 CFR §155.410(e)			– No specific precertification check is performed. – HBX works with carriers on an on-going basis to ensure compliance.
	☐ Enrolls qualified individuals under open enrollment periods with the proper effective coverage date.	ACA§1311(c)(6) 45 CFR §155.410(c			– No specific precertification check is performed. – HBX Electronic Data Interchange Team (EDI) works with carriers on an on-going basis to ensure compliance.
	☐ Provides special enrollment periods for qualified enrollees with proper effective coverage date.	ACA§1311(c)(6) 45 CFR §155.420			– No specific precertification check is performed. – HBX works with carriers on an on-going basis to ensure compliance.
	Enrollment Process for Qualified Individuals				
	☐ Enrolls a qualified individual when Exchange notifies the carrier that the individual is a qualified individual and transmits information to the carrier.	ACA§1311(c)(6), ACA§1314, HIPAA standard transactions for Electronic Data Interchange (EDI) 45 CFR §156.265 (b)(1)			– No specific precertification check is performed. – HBX Electronic Data Interchange Team (EDI) works with carriers on an on-going basis to ensure compliance.
	☐ If an applicant initiates enrollment directly with the carrier for enrollment through the Exchange, the carrier either: ☐ Directs the individual to file an application with the Exchange; or ☐ Ensures that the individual received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site. In the District: If an applicant initiates enrollment	ACA§1311(c)(6) 45 CFR §156.265 (b)(2)	Resolution Certified Application Counselors (CACs)		– No specific precertification check is performed. – There is a certification requirement for carriers becoming CACs.

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	directly with the carrier for enrollment through the Exchange, the carriers are currently directing the individual to file an application with the Exchange. The carrier has the option to become a CAC.				
	☐ Accepts enrollment information consistent with the privacy and security requirements established by the Exchange.	ACA§1314, HIPAA standard transactions for Electronic Data Interchange (EDI) 45 CFR §155.260			– HBX security team ensures private and secure transmittals.
	☐ Uses the premium payment process established by the Exchange.	ACA§1312(b) 45 CFR §156.265 (d)			– No specific precertification check is performed. – HBX works with carriers on an on-going basis to ensure compliance.
	☐ Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards.	§508 of the Rehabilitation Act of 1973, 45 CFR §156.265 (e)			– No specific precertification check is performed. – Significant on-going compliance based on complaints.
	☐ Reconciles enrollment files with HHS and the Exchange no less than once a month.	ACA§1314, HIPAA standard transactions for Electronic Data Interchange (EDI) 45 CFR §156.265 (f); 45 CFR §156.400 (d)			– No specific precertification check is performed. – HBX works with carriers to reconcile enrollments.

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	☐ Acknowledges receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards.	ACA§1314, HIPAA standard transactions for Electronic Data Interchange (EDI) 45 CFR §156.265 (g)			– HBX Electronic Data Interchange Team (EDI) works with carriers on an on-going basis to ensure compliance.
	Termination of Coverage of Qualified Individuals	Title 27 of PHSA 45 CFR §155.430; 45 CFR §156.270			
	☐Terminates/Cancel/Rescinds coverage only if: ☐ Enrollee initiated terminations; ☐ Enrollee is no longer eligible for coverage through the Exchange; ☐ Enrollee's coverage is rescinded; ☐ QHP terminates or is decertified; ☐ Enrollee switch coverage: ☐ during an annual open enrollment period; ☐ special enrollment period; or ☐ obtains other minimum essential coverage. ☐ For non-payment of premium only if: ☐ Applies termination policy for non-payment of premium uniformly to enrollees in similar circumstances; ☐ Enrollee is delinquent on premium payment; ☐ Provides the enrollee with notice of such payment delinquency; and ☐ Provides a grace period of at least 3 consecutive months if an enrollee is receiving advance payments of the premium tax credit and has previously paid at least one month's premium.	45 CFR §155.430(b); 45 CFR §156.270		– DISB reviews plan discontinuation notices.	– No specific precertification check is performed. – Carrier or HBX enrollment and eligibility team executes terminations depending on reason. o Carriers cancels for non-payment or terminates/rescinds for fraud. o HBX terminates in all other cases.

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	☐ Provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination.	45 CFR §155.430 (d); 45 CFR §156.270 (b)			– No specific precertification check is performed. – HBX works with carriers on an on-going basis to ensure compliance.
	☐ Maintains records of terminations of coverage for auditing.	ACA§1314, HIPAA standard transactions for Electronic Data Interchange (EDI) 45 CFR §155.430(c); 45 CFR §156.270(h)			– No specific precertification check is performed. – HBX Electronic Data Interchange Team (EDI) works with carriers on an on-going basis to ensure compliance.
	Accreditation Standards ☐ Accredited within the timeframe established by the Exchange ☐ Maintains accreditation	ACA §1311(c)(1)(D) 45 CFR §1045; 45 CFR §156.275		– Carriers submit federal carrier NCQA or Federal Carrier URAC Template. – Some carriers submit additional evidence in the form of an accreditation statement from accreditor.	– DISB performs check for HBX. No additional steps are taken by HBX.
	☐ Accredited on the basis of local performance in the following categories by an accrediting entity recognized by HHS: ☐ Clinical quality measures, such as the HEDIS; ☐ Patient experience ratings on a standardized CAHPS survey; ☐ Consumer access; ☐ Utilization management; ☐ Quality assurance; ☐ Provider credentialing; ☐ Complaints and appeals;	ACA §1311(c)(1)(D) 45 CFR §156.275(a)(1)	(Standardized CAHPS data will not be captured in SERFF for plan year 1)	– DISB does not receive specific accreditation review information. – Accreditation organization requires payment for information.	– HBX does not receive specific accreditation review information. – Accreditation organization requires payment for information.

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	☐ Network adequacy and access; and ☐ Patient information programs.				
	☐ Authorizes the accrediting entity to release to the Exchange and HHS a copy of its most recent accreditation survey and survey-related information.	45 CFR §156.275(a)(2)		– DISB does not receive specific accreditation review information. – Accreditation organization requires payment for information.	– HBX does not receive specific accreditation review information. – Accreditation organization requires payment for information.
	Quality Assurance Program				
	☐ Quality Improvement Plan - Implements and reports on a quality improvement strategy or strategies used to reward quality through the use of market based incentives. 2014 – Carriers to submit current QIPs Report off the shelf quality measures CAHPS or HEDIS 2015 – Carriers to submit a standardized QIP as determined by HBX Post QIPs on exchange website Quality improvement strategies include any strategy that includes increased reimbursement or other financial incentive for: • Improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including use of the medical home model, for treatment or services under the plan or coverage; • Implementation of activities to prevent hospital readmissions through a comprehensive program that includes patient-centered education and counseling, comprehensive	ACA §1001, PHSA §2717(a) ACA §1311(g) and (h) and 45 CFR §156.200 (b)(5)	Resolution Resolution Resolution	– Carrier have submitted QIPs to DISB. – QIPs have not been applied as a specific precertification requirement.	– DISB performs check for HBX. No additional steps are taken by HBX. – HBX working towards posting QIPs – HBX has not specified reporting of quality measures. – Accreditation includes clinical quality measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS) and patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey – HHS is developing a Quality Rating System (QRS). QHP issuers that offer coverage during the 2014 coverage year are required to participate in the 2015 beta test for the QRS and QHP Enrollee Experience Survey. – The 2015 HHS beta test will provide QRS ratings feedback to QHP issuers and Marketplaces prior to public reporting of these data to consumers during the 2016 open enrollment period for the 2017 coverage year.

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	discharge planning, and post discharge reinforcement by an appropriate health care professional; • Implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology; • Implementation of wellness and health promotion activities; and • Implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.				
	Segregation of Funds – Does not use federal funds for abortion.	ACA §1303(b) 45 CFR §156.280		– The carriers submit information to DISB regarding segregation of funds.	– DISB performs check for HBX. No additional steps are taken by HBX.
	Other Substantive Requirements				
	☐ Complies with internal claims and appeals and external review processes.	ACA §1001, PHSA §2719 45 CFR §147.136		– No specific precertification check is performed. – DISB works with carriers on an on-going basis to ensure compliance. – Much of the activity is based on complaints.	– No additional steps are taken by HBX.
	☐ If provides coverage through a direct primary care medical home: ☐ medical home meets criteria established by HHS; ☐ carrier meets all requirements otherwise required; and ☐ carrier coordinates the services covered by the direct primary care medical home.	ACA §1301(a)(3) 45 CFR §156.245		– No specific precertification check is performed.	– No specific precertification check is performed.

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	Other Reporting Requirements				
	☐ Reports to HHS on prescription drug distribution and cost the following information (paid by Pharmacy Benefits Manager (PBM) or carrier): ☐ Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and ☐ Percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type: ☐ independent pharmacy, ☐ supermarket pharmacy, and ☐ mass merchandiser pharmacy. ☐ Aggregate amount and type of rebates, discounts or price concessions that the carrier or its contracted PBM negotiates that are: ☐ attributable to patient utilization, and ☐ passed through to the carrier. ☐ Total number of prescriptions that were dispensed. ☐ 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.	ACA §6005 45 CFR §156.295		– No specific precertification check is performed.	– No specific precertification check is performed.