

**DC Health Link  
Carrier Reference  
Manual**

2023

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V.2



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## I. Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. Subsequently, the District of Columbia enacted the *Reasonable Health Insurance Ratemaking Reform Act of 2010*<sup>1</sup>, effective from April 1, 2011 to expand the authority of the Commissioner of the Department of Insurance, Securities and Banking (DISB) alongside the Health Benefit Exchange Authority to review and approve health insurance premium rates. The law also included new consumer protections to prohibit discrimination in the underwriting and rate setting process and establish medical loss ratio (MLR) standards.

Alongside the ACA's goals of better state regulation of health insurance, a key provision of the ACA required all states to participate in an American Health Benefit Exchange as of 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*, (Establishment Act) effective March 3, 2012.<sup>2</sup>

The Establishment Act established 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.<sup>3</sup>

The DC Health Benefit Exchange Authority (HBX) is responsible for the development and operation of all core Exchange functions including the following:

- Certification of Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs)

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<sup>1</sup> 58 D.C. REG. 896 (May 13, 2011).

<sup>2</sup> 59 D.C. REG. 213 (Mar. 23, 2012).

<sup>3</sup> *Id.*

- Operation of a Small Business Health Options Program (SHOP)
- Consumer support for making coverage decisions
- Eligibility determinations for individuals and families
- Enrollment in QHPs and QDPs
- 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 HBX (the Executive Board) to adopt rules and policies. The adoption of rules and policies enables HBX 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 Executive Board to guide health and dental carriers offering coverage through DC Health Link in plan year 2023. Health and dental carriers offering coverage in the individual and/or 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.

## **II. Carrier Participation**

The DC Health Link is open to all health and dental carriers and qualified health and dental plans that meet the requirements set forth in section 1301 of the ACA and by HBX. HBX will contract with any licensed health carrier (“carrier”) that offers a health insurance plan that meets minimum requirements for certification as a qualified health plan (QHP) under federal and District law and 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 QHP.

HBX will also contract with any licensed dental carrier that offers a stand-alone dental plan for the individual market that meets minimum requirements for certification as a qualified dental plan (QDP) under federal and District law and exchange requirements.

### III. Essential Health Benefits

Pursuant to U.S. Department of Health and Human Services (HHS) rules requiring the adoption of a new benchmark for plan year 2017, the District designated the Group Hospitalization and Medical Services, Inc. (CareFirst) BluePreferred PPO \$1,000-100%/80% as the base-benchmark plan. The benchmark plan remains the same for plan year 2023.

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 following resources provide more detail on the District's benchmark plan:

1. [District-required Benefits](#)
2. [EHB Benchmark Plan Information](#)

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 Pharmacopoeial Convention (USP), or
2. The number of drugs in each USP class and category in the Essential Health Benefits package.<sup>4</sup>

Further guidance on the EHB benchmark package can be found at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>.

### IV. Network Adequacy

A carrier is required to submit the Center for Consumer Information & Insurance Oversight (CCIIO) Federal Network Template and the CCIIO Network Adequacy Template to DISB when the carrier files QHPs for approval.

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<sup>4</sup> "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," 78 FED. REG. 12834, 12845-12846 (Feb. 25, 2013).

A carrier must submit provider data at regular intervals and in an agreed-to format for use to populate DC Health Link's single provider directory search tool.

Pursuant to federal requirements, each carrier must make its provider directory for a QHP available on its website. It must also make the directory available to DC Health Link for publication online and to enrollees or potential enrollees in hard copy upon request. The QHP provider directory must provide an up-to-date listing of providers and clearly designate providers that are not accepting new patients.

Carriers must 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.

Carriers are required to take steps to maintain a high level of accuracy in their provider directories. Annually, a carrier is required to take at least one of the following steps and report such steps to DISB:

1. Perform regular audits reviewing provider directory information, including review required under the No Surprises Act.
2. Validate provider information where a provider has not filed a claim with a carrier in two years (or a shorter period of time).
3. Take other innovative and effective actions approved by DISB to maintain accurate provider directories. For example, an innovative and effective action is validating provider information based on provider demographic factors such as an age where retirement is likely.

## **V. Nondiscrimination**

Carriers must comply with all federal and District nondiscrimination requirements. Carriers must submit to HBX a copy of the insurance contract also known as a certificate of coverage/evidence of coverage for each certified qualified health plan. Submission to HBX must be consistent with the timing requirements under federal law for required disclosure.



## VI. Standard Plans

In the individual and SHOP marketplaces, carriers are required to offer one standard QHP plan for each metal level of QHPs it offers, except for bronze, which has one “regular” standard plan and one HSA-compatible standard plan. The Executive Board adopted a Resolution on November 10, 2021, providing that the same standard plans that are available in the individual market be made available in SHOP starting in plan year 2023. Standard plan information for the current plan year as well as past plan years can be found [here](#).

If a benefit is not listed on the standard plan template, carriers must follow the DC Benchmark Plan for non-listed benefits. In this context, “carrier” means each licensed entity with its own NAIC Company Code.

## VII. Rating Rules and Rate Review

### A. Merged Risk Pool

The individual and small group market shall be merged into a single risk pool for rating purposes in the District.<sup>5</sup> 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.<sup>6</sup> Limited exceptions to the merged risk pool include student health plans and grandfathered health plans.<sup>7</sup> Catastrophic plans must be developed by making plan-level adjustments to the index rate.<sup>8</sup>

The index rate for federal reporting must be the same for individual and small group markets. Carriers should merge claims experience for the individual and small group markets into a single risk pool in order to calculate this single index rate prior to applying separate modifiers for risk adjustment. Carriers should then apply the separate modifiers and, therefore, create separate “market-adjusted index rates” for individual and small group markets, i.e., the market-level adjustments made to

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<sup>5</sup> 45 C.F.R. § 156.80(c), D.C. CODE § 31-3311.03b(c).

<sup>6</sup> “Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review,” 78 FED. REG. 13406, 13423 (Feb. 27, 2013).

<sup>7</sup> 45 C.F.R. § 156.80(e).

<sup>8</sup> 45 C.F.R. § 156.80(d)(2)(v).

the index rate to produce the market adjusted index rate, and the plan-level adjustments that are applied to produce the plan adjusted index rates.

The District has been approved to use a hybrid approach to the merging of its markets which requires issuers to utilize a single risk pool of individual and small group claims in the development of the index rate; however, all other aspects of rate development are separate for each market. All assumptions used in producing the index rate, market adjusted index rate, plan adjusted index rates, and consumer-level premiums are reviewed by DISB for reasonableness and consistency with federal and District law.

For federal reporting purposes, medical loss ratios should also be calculated separately for each market.<sup>9</sup>

In addition, filing for the small group market can include a quarterly adjustment to the index rate as authorized by federal regulations. Rates may only be submitted once per year for both markets.

Carriers should follow the approach below for 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 as described under section B below:

- (a) 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.

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<sup>9</sup> 45 C.F.R. § 158.220(a).

## **B. 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.

Before separating the experience into two separate lines of business (individual and small group), the following adjustment factors are allowed to arrive at the ACA EHB single risk pool of “allowed costs” (i.e., the index rate);

- An adjustment to remove non-EHB benefits that are included in the base period and/or manual experience
- An adjustment to include additional EHB’s (including pediatric dental) which are not reflected in the base period experience
- A utilization adjustment (i.e., induced demand) to reflect differences between the average benefit utilization underlying the base period experience and the average benefit utilization underlying the projection period
- A demographic adjustment to reflect the average demographics anticipated in the projection period
- A product/network to reflect the average product/network mix in the projection period
- A morbidity adjustment to reflect the average morbidity anticipated in the projection period
- Trend to account for anticipated changes in provider contracts and utilization
- Pent up demand adjustment
- Other applicable carrier-specific adjustments

Please note that the result after application of the above adjustment factors is the combined/merged single risk pool (projected period) index rate prior to applying the separate modifiers for each separate (individual and small group) line of business.

After separating into two separate lines of business for individual and small group, the following market-level adjustment factors are allowed and must be applied equally to all plans:

- An adjustment for risk adjustment including anticipated risk transfer payments and the risk adjustment user fee and Exchange fee fixed cost adjustment

Five plan-level adjustments are then allowed by regulation and may vary for each plan, as actuarially supported:

- The impact of benefits and actuarial value, including an induced demand adjustment to account for differences between the average induced demand underlying the index rate and the anticipated induced demand of each plan
- Product/network adjustment
- Non-EHB items adjustment
- Administrative retention expenses
- Catastrophic adjustment factor (applied only to catastrophic plans)

The following calibration factors must then be applied:

- Average age calibration factor (based on the average age underlying the index rate)
- A calibration adjustment to account for a billable member limit of no more than three children under the age of 21 for qualified health plans.
- A calibration adjustment to account for a billable member limit of no more than four children under the age of 21 for stand-alone dental plans.

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. HBX will use an age curve developed by DISB. See Appendix A for more information about the age rating curve.

### **C. Plans Using the AVC**

The Plans & Benefits Template uses the Actuarial Value Calculator (AVC) to calculate Actuarial Values (AV) for all standard, non-catastrophic plans, all silver plan CSR variations, and all limited cost sharing plan variations. If AVs cannot be calculated, the *AV Calculator Output Number* remains blank. If *Unique Plan Design?* equals “Yes” on the Benefits Package worksheet of the Plans & Benefits Template, the AV from the AVC is not used during validation; instead, the *Issuer Actuarial Value* entered by the carrier into the Cost Share Variance worksheet is used to validate that the plan’s AV falls within the relevant de minimis range.

If the Cost Share Variance worksheet contains both unique plan designs and non-unique plan designs, the Check AV Calculator procedure attempts to calculate an AV for the unique as well as the non-unique plan designs. If the stand-alone AVC returns an error for a unique plan design, resulting in a blank *AV Calculator Output Number*, the carrier does not need to

address the error to validate the template; so long as the *Issuer Actuarial Value* falls within the relevant de minimis range for unique plan designs, the template validates. While not required, the Centers for Medicare & Medicaid Services (CMS) recommends that issuers run the Check AV Calculator procedure on Cost Share Variance worksheets that contain only unique plan designs so that the issuer's submission includes the *AV Calculator Output Number* for plans that do not generate an error in the stand-alone AVC.

For plan year 2023, the final Notice of Benefit and Payment Parameters sets out a de minimis variation of +2/-2 percentage points for all standard bronze plans, gold plans, platinum plans, individual market off-Exchange silver plans, and all small group market silver plans (on- and off-Exchange). In addition, the de minimis range for standard bronze plans is +5/-2, and individual market silver QHPs have a de minimis range of +2/0 percentage points and a de minimis range of +1/0 percentage points for income-based silver CSR plan variations.

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### **Calculation of Employer Contribution for Health Reimbursement Arrangement (HRA) and Health Savings Account (HSA) Plans Offered in SHOP**

The AVC also incorporates health savings accounts (HSAs) and health reimbursement arrangements (HRAs) that are integrated with group health plans if the amount may only be used for cost sharing; to use this option the user must include an annual amount contributed by the employer or in the case of HRAs, the amount first made available (sometimes referred to in this document as "HRA contributions").<sup>11</sup>

### **D. Rate Development and Review**

DISB will review all rates, including rates for DC Health Link 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 requested 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

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<sup>10</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. , (May , 2022).

<sup>11</sup> "Revised Final 2018 Actuarial Value Calculator Methodology," published by CMS (Apr. 13, 2017).

addition, proposed rates must reflect risk adjustment, reinsurance, and risk corridors. If the company's data does not fully support a requested rate, DISB will ask for more information, approve a lesser rate, or reject the requested rate increase.

HBX will have a carrier's rate and form filings as filed with DISB. Carriers are required to respond to requests for additional information from consulting actuaries for HBX. Consulting actuarial review of the primary assumptions in carrier rate filings and any actuarial reports will be published on an HBX webpage. Published reports will not contain confidential information provided by carriers.

HBX will not negotiate rates with carriers. Each QHP offered through DC Health Link must have a prior approved rate by DISB.

DISB shall make all rate filings, including all supporting documentation, amended filings, and reports, available for public inspection on its website. DISB will consider comments received on any rate filings during the review of the rates.

Any new entrants to DC Health Link will be afforded some flexibility in HBX submission deadlines.

## **E. Dental-Specific Rating Rules**

Dental carriers are required to follow QHP rating rules, including the filing of age-based rates utilizing the Federal Rate Data Table template.

QHPs with an embedded EHB pediatric dental benefit must have a separate deductible for that pediatric dental benefit.<sup>12</sup> The maximum deductible in embedded pediatric dental plans shall be \$50/\$100 (individual in & out-of-network) and \$100/\$200 (family in & out-of-network).<sup>13</sup> This requirement does not apply to catastrophic plans or HSA-compatible plans.

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<sup>12</sup> Resolution to Determine a Separate Deductible for Pediatric Dental Benefits (May 14, 2014).

<sup>13</sup> Resolution to Adopt a Recommendation Regarding Separate Deductible for Pediatric Dental Benefits Offered in QHPs (Nov. 12, 2014).

## VIII. Summary of Benefits and Coverage (SBC) / Benefit Summaries and Evidence of Coverage (EOC) Guidelines

HBX requires carriers to use the standard federal format for Summary of Benefits and Coverage (SBCs) submitted by QHPs and carrier-specific Benefit Summaries for QDPs. HBX further requires that all QHPs provide Evidence of Coverage Certificates (EOCs) to be submitted at the time of SBC submissions.

### A. Format and File Name Conventions

Prior to submission to HBX, SBCs (QHP) and Benefit Summaries (QDP) must be created and saved in the PDF file format (.pdf). In addition to the PDF file format, the carrier must establish an accurate plan-specific unique URL for SBCs/benefit brochures and EOCs. The URL for the SBC/Benefit Brochures must be correctly loaded on the Plans and Benefits template, and URLs to the EOCs must be provided to the Health Benefit Exchange Authority's Plan Management team via the supplemental URL tracking forms found in Appendix F, DC Health Link Decision Support Tools.

SBC and Benefit Summary plan names must be identical to the QHP and QDP marketing name, and SBC/Benefit Brochures (.pdf) file name must be identical to the QHP or QDP marketing name.

#### Examples of Correct Naming Conventions for SBC (only) PDF files

1. **SHOP**

Marketing name: Carrier PPO Bronze 6500

SBC Title name: Carrier PPO Bronze 6500

SBC File name (inbound to HBX): Carrier PPO Bronze 6500\_SHOP.pdf

2. **Individual Marketplace**

Marketing name: Carrier POS Silver 2500

SBC Title name: Carrier POS Silver 2500

SBC File name (inbound to HBX): Carrier\_POSSilver2500\_50CSR\_IVL.pdf carrier\_POSSilver2500\_75CSR\_IVL.pdf, Carrier\_POSSilver2500\_0CSR\_IVL.pdf

Note: **DO NOT** use special characters (e.g., \*, #) in the SBC file extension. The only acceptable special character is an underscore (\_).

## **B. Deadlines for Submission**

The deadline for SBCs/Benefit Summaries and EOCs will be provided by the Plan Management team via a “Carrier Blast” once finalized.

## **IX. Carrier Submission Process for Qualified Health Plans**

There are two categories of forms that health carriers must complete: (1) plan rate and form filings and (2) carrier certification. DISB and HBX will collaboratively review forms and rates to ensure that QHPs meet District and federal exchange standards for rates and benefits. DISB and HBX will also collaboratively review health carrier certification submissions on behalf of DC Health Link.

For plan year 2023, federal template submissions will not be required until the conclusion of the plan forms review by DISB and HBX. All required federal templates will be submitted through SERFF and passed to DC Health Link.

### **A. QHP Rate, Form Filings, and Carrier Certification**

**Form Filings:** All health carriers must submit the following information to DISB via SERFF:

1. DISB Required Form Submissions – See Appendix B
2. DISB Required Form Review Check List – See Appendix C
3. Prescription Guide Template – See Appendix C

**Carrier Certification:** All health carriers must submit the following information to HBX via SERFF:

1. DC HBX Exchange Issuer Attestations: Statement of Detailed Attestation Responses
2. Quality Improvement Plan – Existing Carrier Quality Improvement Plan
3. Quality Improvement Strategy

**Rate Filings:** All health carriers must submit the following information to DISB via SERFF:



1. [Federal Uniform Rate Review Template](#) – Data for market-wide review.
2. DISB Actuarial Value Input Template – Collects plan actuarial value data (available on SERFF).
3. DISB Rate Requirements – See Appendix C, DISB Rate Filing and Form Filing Checklists, Prescription Guide Template.

## **B. QHP Data for DC Health Link**

Each health carrier must submit the following [federal QHP templates](#) through SERFF for certification to offer QHPs through DC Health Link:

1. [Essential Community Providers \(ECP\) / Network Adequacy Template](#) - Collects identifying information for Essential Community Providers and detailed provider network information.
2. [Plans & Benefits Template](#) - Collects plan and benefit data for medical and dental; basis of plan display in DC Health Link. NOTE: the Standardized Options Add-In is for federal standardized options and do not apply to DC HBX standard plan designs.
3. [Prescription Drug Template](#) - Collects formulary data for plans.
4. [Network ID Template](#) - Information identifying a plan's provider network.
5. [Rate Data Template](#) - Rating tables; basis of premium display in DC Health Link.
6. [Business Rules Template](#) - Supporting carrier business rules.
7. [Plan Crosswalk Template](#)
8. [Service Area Template](#)
9. A screenshot of your Data Integrity Tool (DIT) results (available [here](#)). A health carrier must provide justification for each error shown in its DIT results.
10. The results of running the following [CCIIO review tools](#). Please note that health carriers must attach the entire Excel workbook showing their results.
  - a. Plan ID Crosswalk Tool
  - b. Essential Community Providers (ECP) Tool
  - c. Non-Discrimination Cost Sharing Review Tool
  - d. Category & Class Drug Count Tool
  - e. Non-Discrimination Clinical Appropriateness Review Tool

11. Justifications for any failures within the Category & Class Drug Count Tool and Non-Discrimination Clinical Appropriateness Review Tool using CCIO's combined prescription drug supporting documentation and justification form, available [here](#).

All federal templates listed above must be submitted to HBX via SERFF **according to the timeline announced in Carrier Blast 2022.0001**. Failure to meet deadlines can impact the time allotted to health carriers to test plan, benefit, and rate display in DC Health Link.

### **C. Contracting**

The ACA requires exchanges to have contracts with health carriers offering QHPs. Consequently, health carriers that offer coverage through DC Health Link will be required to enter into a contract with HBX. A standard contract will be used. HBX does not intend to negotiate contract terms with each health carrier individually. When applicable, a draft standard contract will be provided and there will be a 15-day period for feedback from health carriers. The terms and conditions of the contract will include requirements for health carriers to comply with federal and District laws and regulations, and HBX rules and policies.

### **D. Trading Partner Agreement**

All health carriers that are offering plans/products on DC Health Link in plan year 2022 have the DC Health Benefit Exchange Authority Trading Partner Agreements (TPA) in effect. Any health carrier that wants to offer plans/products on DC Health Link for the first time in plan year 2023 must sign and submit the TPA in order to begin technical on-boarding, electronic data interchange (EDI) connectivity, and scenario testing.

## **X. Carrier Submission Process for Qualified Dental Plans**

There are two categories of forms that dental carriers must complete: (1) plan rate and form filings and (2) carrier certification. DISB and HBX will collaboratively review forms and rates to ensure that QDPs meet District and federal exchange standards for rates and benefits. DISB and HBX will also collaboratively review dental carrier certification submissions on behalf of DC Health Link.

For plan year 2023, federal template submissions will not be required until the conclusion of the plan forms review by DISB and HBX. All required federal templates will be submitted through SERFF and passed to DC Health Link.

## A. QDP Rate, Form Filings, and Carrier Certification

**Form and Rate Filings:** All dental carriers must submit the following information to DISB via SERFF:

DISB Required Dental Plan Form and Rate Submissions

**Carrier Certification:** All dental carriers must submit the following information to HBX via SERFF:

DC HBX Exchange Issuer Attestations: Statement of Detailed Attestation Responses

## B. QDP Data for DC Health Link

All dental carriers must submit the following [federal templates](#) through SERFF for certification to offer QDPs on the DC Health Link insurance marketplace:

1. [Network ID Template](#) - Information identifying a plan's provider network.
2. [Plans & Benefits Template](#) - Collects plan and benefit data for medical and dental; basis of plan display in DC Health Link.
3. [Rate Data Template](#) - Rating tables; basis of premium display in DC Health Link.
4. [Business Rules Template](#) - Supporting carrier business rules.
5. [Plan Crosswalk Template](#)
6. Dental Benefit Supplemental Form (located in Appendix H)
7. The results of running CCIIO's Stand-alone Dental Plan (SADP) ECP Tool. Dental carriers must submit the entire Excel workbook showing their results.

Like QHPs, all Federal and District templates listed above must be submitted to HBX via SERFF according to the schedule listed in **Carrier Blast 2022.0001**. Failure to meet this deadline can impact the time allotted to dental carriers to test plan, benefit, and rate display in the DC Health Link system.

## **C. Contracting**

The ACA requires exchanges to have contracts with dental carriers offering QDPs. Consequently, dental carriers that offer coverage through the DC Health Link will be required to enter into a contract with HBX. A standard contract will be used. HBX does not intend to negotiate contract terms with each carrier individually. When applicable, a draft standard contract will be provided and 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 regulations, and HBX rules and policies.

## **D. Trading Partner Agreement**

All dental carriers that are offering plans/products on DC Health Link in plan year 2023 have the DC Health Benefit Exchange Authority Trading Partner Agreements (TPA) in effect. Any dental carrier that wants to offer plans/products on DC Health Link for the first time in plan year 2023 must sign and submit the TPA in order to begin technical on-boarding, electronic data interchange connectivity, and scenario testing.

# **XI. Additional Information and Requirements**

## **A. Transparency**

The ACA requires that all health plans and health insurance policies provide enrollees and applicants with a uniform summary of benefits and coverage (SBC). The SBC provides consumers consistent information about what health plans cover and what limits, exclusions, and cost-sharing apply. It must be written in plain language. The SBC must include three illustrations of typical patient out-of-pocket costs for common medical events: routine maternity care, management of type 2 diabetes, and a simple fracture.

Health carriers must provide the SBC as part of the QHP certification process for participation in DC Health Link. An SBC template and sample completed SBCs are posted at <http://cciio.cms.gov>.

Federal regulations implementing the ACA require carriers to make available the amount of enrollee cost-sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely

manner upon the request of the individual.<sup>14</sup> At a minimum, such information must be made available to individuals through a website and through other convenient means for individuals without access to the Internet.

Carriers also must disclose other information that would help consumers understand how reliably each QHP reimburses claims for covered services, whether the provider network is adequate to assure access to covered services, and other practical information.<sup>15</sup> The required information must be provided to HBX, HHS, and DISB in plain language that the intended audience, including individuals with limited English proficiency, can readily understand and use. HBX will make accurate and timely disclosure to the public of the following information:

- Claims payment policies and practices
- Financial disclosures
- Information on enrollee rights
- Data on rating practices
- Data on enrollment/disenrollment
- Data on number of claims that are denied
  - Information on cost-sharing and payments with respect to out-of-network coverage
  - Upon request of an individual, information on cost-sharing with respect to a specific item/service

## **B. Quality Data**

The ACA requires carriers to implement quality improvement strategies, enhance patient safety, case management, chronic disease management, readmission prevention, wellness and health promotion activities, activities to reduce healthcare disparities, and publicly report quality data for each of their QHPs. HHS has indicated that they are working on measuring the quality of qualified health plans by:

- (1) Developing and testing a quality reporting system;
- (2) Developing a quality improvement strategy;
- (3) Implementing a consumer experience survey; and
- (4) Requiring carriers to work with patient safety organizations.

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<sup>14</sup> 45 C.F.R. § 156.220(d).

<sup>15</sup> 45 C.F.R. § 156.220(a).

In accordance with 45 C.F.R. § 156.275, HBX will accept carrier accreditation based on local performance of its QHPs by the three accrediting agencies currently recognized by HHS: the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC) and URAC. New carriers that are not accredited will be provided a grace period for accreditation, pursuant to 45 C.F.R. § 155.1045.

Carriers are required to attest to meeting the federal quality standards. HBX will continue to collect information from carriers on their existing quality improvement plans (QIPs). HBX will continue to coordinate with public and private payers and other stakeholders to update QIP requirements and public reporting thereof based on stakeholder input, continuing federal guidance, and the District's public health priorities.

### **C. Marketing Guidelines**

Carriers must comply with all applicable federal and District laws and regulations governing marketing of health benefit plans. Carriers must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

### **D. Enrollment**

Carriers must abide by enrollment periods established by HBX and coverage effective dates consistent with District and federal laws and regulations. Carriers shall process enrollment in accordance with standards set forth in 45 C.F.R. § 156.265, applicable District laws and regulations, and eligibility information supplied by HBX. Carriers shall be responsible for notifying enrollees of their coverage effective dates in accordance with 45 C.F.R. § 156.260. Carriers must provide each new enrollee with an enrollment information package that is written in plain language, is accessible, and is in compliance with the requirements of 45 C.F.R. § 155.220.

As required by 45 C.F.R. § 155.400, HBX will accept QHP selections from applicants eligible for enrollment, notify carriers of QHP selections, and transmit necessary eligibility and enrollment information promptly to carriers and to HHS. Accordingly, on a monthly basis, carriers are required to acknowledge the receipt of enrollment information and to reconcile such information with HBX and HHS. Carriers must assist HBX in its obligation to produce timely and accurate annual federal tax forms and to report IRS-related data on a monthly basis.

Carriers and HBX will observe the federal requirements for initial, annual, and special open enrollment periods established by HHS in 45 C.F.R. § 155.420. Special enrollment periods must be provided for qualified individuals experiencing triggering events outlined in 45 C.F.R. § 155.420(d), as well as those triggering events adopted by the Executive Board.

Individuals generally will have 60 days from the triggering event to modify their QHP selection.

### **E. QHP/QDP Certification**

Pursuant to 45 C.F.R. § 1080, HBX may decertify any QHP/QDP that fails to meet the required certification standards or the requirements for recertification.

### **F. DC Health Link Decision Support Tools**

HBX offers consumers access to a variety of decision support tools that are hosted and maintained by the Center for the Study of Services (“Consumers’ CHECKBOOK”). For more than 40 years, Consumers’ CHECKBOOK, an independent non-profit consumer organization, has been a leading innovator in providing information to help consumers make well-informed choices. These tools include “Plan Match”—which incorporates an out-of-pocket cost estimator, a prescription drug look-up tool, and a doctor search tool—and an all-plan doctor directory. The tools are available in both English and Spanish.

It’s now easier than ever for HBX consumers to use Plan Match. Following the rollout of API integration, both individual market and small group consumers who have logged into their DC Health Link accounts can now shop with their personal household information and coverage effective dates pre-populated in Plan Match. SHOP enrollees will also have their employer’s reference plan and contribution levels pre-populated in the tool. Once users select the health plan that’s right for them, they will be able complete enrollment.

## **Plan Match Tool**

HBX provides consumers with a Plan Match tool to help them compare available health plans. Consumers use Plan Match to compare plans on estimates of total cost (premium & actuarial out of pocket estimates), provider participation, coverage of prescription drugs, plan benefits, QRS quality ratings, and more. The tool is available to both individual market and small group market consumers.

The Plan Match tool allows consumers to see key comparisons of available health plans in a single interface. The tool displays QHPs available to consumers and reflects known or estimated financial assistance to consumers (e.g., Advanced Premium Tax Credits, Cost Sharing Reduction plan variants, Employer Premium Contribution).

The primary sources of plan data for the Plan Match tool are the SERFF/CCIIO template data submitted by the carriers to HBX. The provider participation data is submitted by the carriers to Consumers' CHECKBOOK via Consumers' CHECKBOOK's data aggregation partner, Zelis (formerly Strenuus).

In 2018, HBX launched a new Plan Match tool that gives Individual & Family market consumers the ability to compare dental insurance plans. In 2019, this feature was enhanced to allow the comparison of dental plan benefits for children age 18 or younger.

\*\*\*QHP Formulary Updates: Consumers' CHECKBOOK uses the SERFF/CCIIO Prescription Drug template data to populate the formulary component of Plan Match. Updated formulary data files must be submitted in the SERFF/CCIIO format, or in the CMS Machine Readable Drugs.json format. See the "RX Template Quarterly Updates Requirements" section for further guidance on the formulary update process.

## **All-Plan Doctor Directory**

HBX also provides consumers with an all-plan doctor directory tool to help them understand which doctors are in-network in the different plans being offered through the exchange. Consumers use this tool both to compare doctor participation across plans and to find in-network doctors for the plan in which they have enrolled.

The doctor directory, which Consumers' CHECKBOOK maintains in collaboration with their data aggregation partner Zelis, allows consumers to see the plans in which their doctors participate in a single interface. The doctor directory tool only includes networks and QHPs available through the DC Health Link exchange, which simplifies the look-up process for consumers.



Consumers are able to see details about individual doctors, including practice addresses & office phone numbers, specialties (along with easy to understand specialty descriptions), hospital affiliations, whether the doctor is accepting new patients, and if the doctors have received special recognitions, including the Bridges to Excellence clinical recognitions programs.

Example of Doctor Directory search results:

Doctor Directory Home
Español

**Filter Your Results**

**Last Name**

**Zip** ?

**Distance**

**Specialty** ?

**Gender**

**Market**

**Insurance Company** ?

**Plans** ?

**Languages Spoken** ?

**Accepting New patients** ?

**Special Recognitions** ?

Reset
Filter

27 Doctors Found. Sort By:  Print

Click checkboxes to compare

**Tibebu, Atitegeb B**  

12164 Central Ave, Ste 200 & 222  
Bowie, MD 20721  
P: (301) 218-9223  
2.4 mi [View Map](#)

**Specialties:**

- [Internal Medicine](#) ?
- [Family Practice](#) ?

**Doctor Accepts these Plans:**

Insurance Company	Plan Name	Accepting New patients?
CareFirst	(Click to show all 9 plans)	(Click to display)

**Abebe, Ethiopia**  

1221 Mercantile Ln  
Upper Marlboro, MD 20774  
P: (301) 618-5500  
2.9 mi [View Map](#)

**Specialties:**

- [Internal Medicine](#) ?

**Doctor Accepts these Plans:**

Insurance Company	Plan Name	Accepting New patients?
Kaiser	(Click to show all 11 plans)	(Click to display)

**Biru, Elizabeth**  

1221 Mercantile Ln  
Upper Marlboro, MD 20774

**Specialties:**

25 | Page

Provider detail page:

Doctors Search > Doctor Profile [Return to Search](#) [Print](#)

<b>Name</b>	<b>Clark, Nathaniel G</b>														
<b>Degree</b>	MD														
<b>Locations</b>	2150 Pennsylvania Ave NW Washington, DC 20037 P: (202) 741-3000 <span style="background-color: #90EE90;">0.4 mi</span> <a href="#">View Map</a>	650 Pennsylvania Ave SE Ste 50 Washington, DC 20003 P: (202) 675-6020 <span style="background-color: #90EE90;">2.7 mi</span> <a href="#">View Map</a>													
<b>Specialties</b>	Pediatrics <a href="#">?</a> Endocrinology <a href="#">?</a>														
<b>Gender</b>	Male														
<b>Recognitions</b>	Bridges to Excellence <a href="#">?</a> — Diabetes I														
<b>Hospital Affiliations</b>	Children's National Medical Center														
<b>Plans Accepted</b>	<table border="1"> <thead> <tr> <th>Insurance Company</th> <th>Plan Name</th> <th>Network</th> <th>Accepting New patients</th> </tr> </thead> <tbody> <tr> <td>CareFirst</td> <td>BlueChoice HMO Standard Bronze \$5,000</td> <td>HealthyBlue PPO (Nationwide In-Network - All States; All Territories except Midway Islands)</td> <td>Yes</td> </tr> <tr> <td>CareFirst</td> <td>BlueChoice HMO Standard Bronze \$5,000</td> <td>HealthyBlue PPO (Nationwide In-Network - All States; All Territories except Midway Islands)</td> <td>Yes</td> </tr> </tbody> </table>			Insurance Company	Plan Name	Network	Accepting New patients	CareFirst	BlueChoice HMO Standard Bronze \$5,000	HealthyBlue PPO (Nationwide In-Network - All States; All Territories except Midway Islands)	Yes	CareFirst	BlueChoice HMO Standard Bronze \$5,000	HealthyBlue PPO (Nationwide In-Network - All States; All Territories except Midway Islands)	Yes
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The primary sources of data for the doctor directory are data submitted by the carriers to Consumers’ CHECKBOOK (via Zelis). The monthly data update process is described below:

1. Carriers submit their provider data to Zelis on a regular basis (the target is for each carrier to provide updated data monthly by the 15<sup>th</sup> of each month; some provide more frequent updates, some provider less frequent updates). Note, for several of the DC Carriers, the data that Zelis receives is provided via data feeds from the carrier’s national office.

2. On a monthly basis:
  - a. Zelis submits to Consumers' CHECKBOOK the aggregated doctor information (with plan participation based on the most up-to-date data Zelis has received from each carrier).
  - b. Consumers' CHECKBOOK performs additional validation of doctor data on the updated data set, using sources such as the NPPES NPI dataset.
  - c. Consumers' CHECKBOOK then pushes the refreshed doctor data in the DC Health Link all-plan doctor directory.

### **HRAs and "SmartChoice for Business" Tool**

As of January 2020, there are two types of Health Reimbursement Arrangements (HRAs) that DC Health Link employers can offer to help their employees pay health plan premiums. In partnership with HBX, Consumers' CHECKBOOK has developed an employer-facing tool called "SmartChoice for Business" that allows DC small businesses to weigh their options when it comes to providing a health benefit. Specifically, the tool estimates and compares the costs of 1) offering health coverage through the DC Health Link Small Business marketplace (SHOP); 2) offering an HRA that employees can use to buy insurance on the DC Health Link Individual & Family marketplace; and 3) raising wages. The tool provides employer users with estimates of the employer's contribution costs and the employees' health insurance premium costs under the three benefit options. In addition to this resource, employees have access to a separate HRA Affordability Tool on [dhealthlink.com](http://dhealthlink.com) to determine if an HRA offered to them would be considered affordable.

For questions regarding the logistics of submitting provider data, Plan Match, or how to submit updated formulary data, please contact Andy Duff ([aduff@cssresearch.org](mailto:aduff@cssresearch.org)) and copy HBX's Plan Management team at [carrier.hbxinquiries@dc.gov](mailto:carrier.hbxinquiries@dc.gov).

### **G. QHP/QDP Decertification Guidance**

Federal requirements under 45 C.F.R. § 155.1080(b) require that Exchanges establish a process for the decertification of QHP/QDPs. Since 2013, HBX's decertification process has leveraged the existing mechanism for suspending a carrier's authority to operate in the District. In November 2016, the Plan Management Advisory Committee met to discuss the decertification of plans and HBX reiterated reliance on the District of Columbia's Department of Insurance, Securities and Banking's (DISB) certification process to meet federal requirements. This update memorializes such practice.

District law provides one marketplace for individual and small group coverage. (DC Code § 31–3171.09a). All individual, family, and small business policies in DC must be purchased through the individual or small group marketplaces available through DC Health Link. Certification or decertification to offer coverage through DC Health Link is concurrent with the process for being certified to offer coverage under DC law. As such, DISB participates in the certification process of plans, checking that they meet the requirements to

offer coverage under DC law and the certification requirements under 45 C.F.R. § 155.1000. Thus, if an issue were to arise that could lead to the removal of a health plan from the marketplace, specifically that a plan no longer met certification requirements, DISB could make that determination and administer the decertification process. The authority to be removed from the DC market pre-existed the ACA and can be found at D.C. Code § 31-4305 (revocation and appeal language for life insurance) and § 31-5111 (applying § 31-4305 to health insurance).

## **H. RX Template Quarterly Updates Requirements**

In order to maintain the highest level of data integrity within our decision support tool known as “Plan Match” powered by Consumers’ CHECKBOOK, HBX requires all QHP carriers to update their Prescription Drug Templates in SERFF throughout the year when making any changes to the information provided in the Prescription Drug Templates submitted at certification.

- The changes include but are not limited to the following: Removal of covered drugs;
- Addition of covered drugs;
- Placement of a covered drug into a higher cost-sharing tier; and
- Addition of any new requirements for prior authorization, step therapy, or other limitations.

The intent of this document is not to limit how often carriers make changes to a formulary, but to streamline the process by which those updates flow from the carrier database to the DC Health Link database. All changes should continue to be submitted via SERFF. If a carrier determines that its binders are closed in SERFF at the time of submission, a formal request to reopen the binder and make changes should be sent to Howard Liebers ([Howard.Liebers@dc.gov](mailto:Howard.Liebers@dc.gov)) and cc: the HBX Plan Management team ([carrier.hbxinquiries@dc.gov](mailto:carrier.hbxinquiries@dc.gov)). The formal request to reopen a binder for submission should be made on company letterhead and describe the changes to the template.

## **I. Post-Certification Template Changes**

Please note that post-certification changes that reduce benefits are discouraged, and HBX will work with DISB and carriers to ensure that customers are not adversely affected by any such changes that may be approved.

Carriers wishing to make changes to benefits included in certified plans must adhere to the following process to request a change.

1. Notify HBX’s Plan Management team and DISB via an email sent to [carrier.hbxinquiries@dc.gov](mailto:carrier.hbxinquiries@dc.gov) and [Howard.Liebers@dc.gov](mailto:Howard.Liebers@dc.gov) to provide details of the requested change.
2. Provide to HBX and DISB the plan name, HIOS ID, and impacted document(s).
3. Provide to HBX and DISB the benefit as filed originally and the requested change.
4. Provide the number of plans and customers affected by the requested change. “Customers” includes policy holders and dependents, as well as the number of groups if small group plans are affected.

Upon receipt, the HBX Plan Management team will review the online plan details display to determine visibility impact of the requested change. If, after initial review, it is determined the requested change in benefit is visible in the plan detail page, the carrier must also provide a copy of the notice it will send to impacted enrollees. Once all documentation has been reviewed, HBX will consult with the DISB on the requested benefit change and will notify the carrier of DISB’s decision.

For all approved changes, the carrier must upload the corrected document(s) into SERFF and conduct rate and benefit testing in the impacted systems. Upon release into production, the carrier must also issue notice to affected customers.

## J. Operational Carrier Blast Summary

Blast Doc. No.	Issue Date	Title	Summary
2015.0001	3-Jun-15	QHP Terminations	Establishment of minimal voluntary termination guidelines and processes in the SHOP and Individual Markets
2015.0002	11-Jun-15	Small Group Market (SHOP) Conversion Process Timeline	SHOP Conversion process timeline (original)
2015.0003	12-Jun-15	Individual Market Renewal Timeline	2015 Renewal Certification Timeline
2015.0004	22-Jun-15	Religious Accommodations	DC Health Link Operational Process on Groups Requesting Religious Accommodations
2015.0005	22-Jul-15	SHOP Conversion	SHOP Conversion Operational Plan (Original)
2015.0006	6-Aug-15	SHOP Conversion #2	SHOP Conversion Operational Plan (Amended)
2015.0007	6-Aug-15	Stand Alone SHOP Dental Onboarding Timeline	Document submission requirements for all approved dental carriers requesting to sell stand-alone dental plans on the DC Health Link platform.

2016.0007	13-Apr-16	Guidance for Individual Market Payment	Binder Payment operational policy for the individual market
2016.0008	5-Jul-16	Adult Dependents Aging Off a Policy	Operational Policy for dependent Age-Offs
2016.0008 (Amendment)	30-Aug-16	Adult Dependents Aging Off a Policy (Amendment)	Operational Policy for dependent Age-Offs Amendments
2016.0009	1-Jul-16	Eligibility of District Resident Temporarily Absent from DC Health Link Service Area	Establishment of eligibility for residents whom are temporary displaced from residency inside the District of Columbia service area or city geographical borders.
2016.0010	1-Jun-17	Guidance for Carriers on SHOP Groups Qualifying for Religious Objection Accommodation	Operational process for small market employers that qualify for religious exemption/accommodation health plans.
2017.0001	1-Mar-17	31 Day Claims Grace Period (SHOP)	Operational policy for implementation of the 31 day claims grace period on SHOP non-pay terminations
2017.0002	1-Jun-17	Establishment of the Carrier Member Level Reports	Operational Policy and Process on member level reports required by all carrier partners
2017.0003	29-Aug-17	IVL Voluntary Enrollee-Initiated Terminations	Operational policy and process around voluntary terminations in the individual market, prospectively and retroactively.
2017.0004	21-Jul-17	Prescription Drug Template Update Requirement	Operational requirement and process for carriers to submit quarterly updated Rx formulary templates (included in manual)
2017.0005	21-Jul-17	Employer FEIN Changes vs. Correction Operational Policy	Establishment of the operational process around SHOP Employer EIN changes and corrections.
2017.0006	7-May-18	SHOP Voluntary Termination Policy	Establishment of the operational policy for SHOP Consumers to termination of employer sponsored coverage on DC Health Link
2017.0007	28-Sep-17	Decertification of Qualified Health Plans	Establishment of the Decertification Process Qualified Health Plans (included in manual)
2017.0008	7-May-18	Anti-Duplication and Medicare Eligibility	Guidance on anti-duplication and Medicare eligible enrollees

2018.0001	20-Apr-18	Adjustment to SHOP Proration Calculation Formula	Operational process on calculating premiums in the SHOP market for coverages that are not equal to 30 days.
2018.0002	27-Apr-18	Cessation of Invoicing for the SHOP Market	Operational process to establish invoice cessation after SHOP employers have passed the eligibility window for reinstatement
2018.0003	20-Apr-18	Pediatric Dental Deductible Indicator on the Plan and Benefit Template (Individual and SHOP)	Operational process for carriers to highlight the required separate pediatric deductible for all Qualified Health and Dental Plans.
2018.0004	18-Apr-18	Carrier Changes to Benefits Following Plan Certification (Individual and SHOP markets)	Establishment of processes for carriers to make changes to filed documents post certification (included in manual)
2020.0001	1-Apr-20	2021 Recertification Deadline	Final issuance of the 2021 recertification dates.
2020.0002	18-May-20	Quality Data Requirements Suspended for Plan Year 2021	In line with CMS guidance, submission of the QIS Plan and Progress Report and Quality Improvement Plan is not required for PY2021 recertification.
2020.0003	19-Jun-20	Supplemental Template for Formulary and Network URL Submission	Due to a change in SERFF templates, DCHBX has created a new template to collect formulary and network URLs.
2021.0001	9-Apr-21	2022 Recertification Deadlines	Final 2022 recertification deadlines.
2022.0001	8-Apr-22	2023 Recertification Deadlines	Final 2023 recertification deadlines.

Note: To request a copy of any document referenced above please send your request via email to [carrier.hbxinquiries@dc.gov](mailto:carrier.hbxinquiries@dc.gov).