DC Health Link Carrier Reference Manual

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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*[1], 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.[2]

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.[3]

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)

[1] 58 D.C. REG. 896 (May 13, 2011).
[2] 59 D.C. REG. 213 (Mar. 23, 2012).
[3] *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 2022. 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 qualified health benefit plan.

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 2022.

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 Pharmacopeial Convention (USP), or
2. The number of drugs in each USP class and category in the Essential Health Benefits package.[4]

Further guidance on the EHB benchmark package, including an itemized list of required benefits, can be found on DISB's website: http://disb.dc.gov, or by clicking here.

[4] "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).

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.

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.
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 marketplace, 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. Standard plan information for 2022 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.[5] 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.[6] Limited exceptions to the merged risk pool include student health

[5] 45 C.F.R. § 156.80(c), D.C. CODE § 31-3311.03b(c).
[6] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review," 78 FED. REG. 13406, 13423 (Feb. 27, 2013).

plans and grandfathered health plans.[7] Catastrophic plans must be developed by making plan-level adjustments to the index rate.[8]

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 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.[9]

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:

[7] 45 C.F.R. § 156.80(e).
[8] 45 C.F.R. § 156.80(d)(2)(v).
[9] 45 C.F.R. § 158.220(a).

(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.

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 Variances 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.

Beginning with the 1/1/2018 plan year, a de minimis variation of -4/+2 percentage points is used for non-CSR, non-grandfathered individual and small group market plans required to comply with the AV; however, bronze plans are allowed a greater de minimis variation of -4/+5 percentage points, subject to certain requirements.[10] CSR silver plan variations use a +/-1 percentage point.

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").[11]

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

[10] 45 C.F.R. § 156.140(c).

[11] "Revised Final 2018 Actuarial Value Calculator Methodology," published by CMS (Apr. 13, 2017)

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 addition, proposed rates must reflect risk adjustment. 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 Authority 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 Authority 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.[12] 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).[13] This requirement does not apply to catastrophic plans or HSA-compatible plans.

[12] Resolution to Determine a Separate Deductible for Pediatric Dental Benefits (May 14, 2014).
[13] 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 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 summary of benefits/benefit brochures and evidence of coverage certificates. The URL for the SBC/Benefit Brochures must be correctly loaded on the plan and benefit template, and URL's to the EOC's must be provided to the Health Benefit Exchange Authority's plan management team via the supplemental URL tracking forms found in Appendix F.

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

For plan year 2022, 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 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 carriers must submit the following information to the Authority 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 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.

B. QHP Data for DC Health Link

Each 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.
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. A 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 carriers must attach the entire Excel workbook showing their results.
    a. Plan ID Crosswalk Tool
    b. Essential Community Providers (ECP) Tool
    c. Cost Sharing 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 CCIIO'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 outlined at the beginning of this section.** Failure to meet deadlines can impact the time allotted to carriers to test plan, benefit, and rate display in DC Health Link.

C. Contracting

The ACA requires exchanges to have contracts with carriers offering QHPs. Consequently, 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 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 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 2021 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 2022 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 carriers must complete: (1) plan rate & form filings and (2) carrier certification. DISB and HBX will collaboratively review forms and rates to ensure that QDPs meet District of Columbia and federal exchange standards for rates and benefits. DISB and HBX will also collaboratively review carrier certification submissions on behalf of DC Health Link.

For plan year 2022, 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 carriers must submit the following information to DISB via SERFF:

DISB Required Dental Plan Form and Rate Submissions

Carrier Certification: All 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. Supplementary Dental Benefits Information Template (located in Appendix K)
7. The results of running CCIIO's Stand-alone Dental Plan (SADP) ECP Tool. 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 at the beginning of this section. Failure to meet this deadline can impact the time allotted to carriers to test plan, benefit, and rate display in the DC Health Link system.

C. Contracting

The ACA requires exchanges to have contracts with carriers offering QDPs. Consequently, 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 2021 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 2022 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. 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.[14] 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.[15] 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.

[14] 45 C.F.R. § 156.220(d).
[15] 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. Carriers that are not accredited at this time 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). Carrier-submitted QIPs are posted for public review on DC Health Link. 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 certain triggering events.

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 Consumer's Checkbook/Center for the Study of Services ("Checkbook"). For more than 40 years, 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 business 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 Business 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 Checkbook via 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: 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.

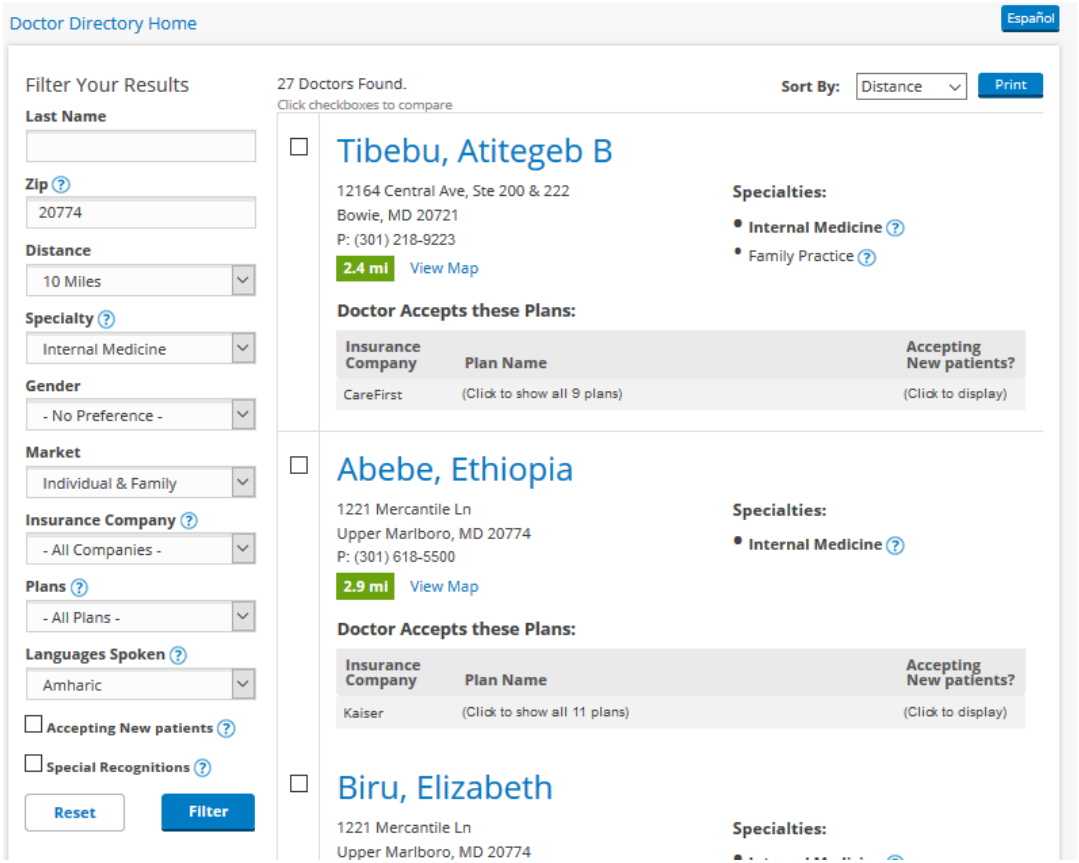
All-Plan Doctor Directory

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.

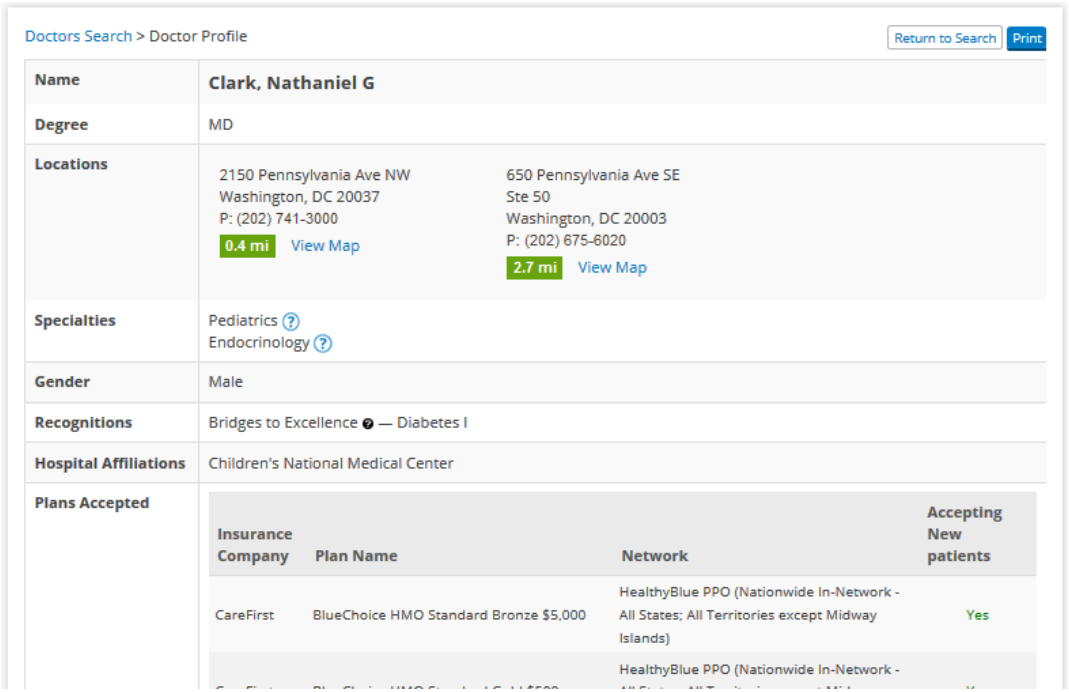
The doctor directory, which Checkbook maintains in collaboration with their data aggregation partner Zelis, allows consumers to see the plans in which their doctors participate in a single interface. The doctor directory tool only includes networks and QHPs available through the DC Health Link exchange, 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:



Provider detail page:



Doctors Search > Doctor Profile

Return to Search | Print

Name	**Clark, Nathaniel G**
Degree	MD
Locations	2150 Pennsylvania Ave NW Washington, DC 20037 P: (202) 741-3000 0.4 mi View Map 650 Pennsylvania Ave SE Ste 50 Washington, DC 20003 P: (202) 675-6020 2.7 mi View Map
Specialties	Pediatrics Endocrinology
Gender	Male
Recognitions	Bridges to Excellence — Diabetes I
Hospital Affiliations	Children's National Medical Center
Plans Accepted	

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
		HealthyBlue PPO (Nationwide In-Network -	

The primary sources of data for the doctor directory are data submitted by the carriers to 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 15th 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 Checkbook the aggregated doctor information (with plan participation based on the most up-to-date data Zelis has received from each carrier).
    b. Checkbook performs additional validation of doctor data on the updated data set, using sources such as the NPPES NPI dataset.
    c. 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 now 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, 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; 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 dchealthlink.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) and copy HBX's Plan Management team at carrier.hbxinquiries@dc.gov.

G. QHP/QDP Decertification Guidance

Federal requirements under 45 CFR §155.1080(b) require that Exchanges establish a process for the decertification of QHP/QDPs. Since 2013, the DC Health Benefit Exchange Authority's (HBX) 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 of Columbia (DC) law provides one marketplace for individual and small business coverage. (DC Code § 31–3171.09a). All individual, family, and small business policies in DC must be purchased through the individual or small business 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 CFR §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, beginning January 1, 2018, HBX will require 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 should be sent to Howard Liebers (Howard.Liebers@dc.gov) and cc: the HBX Plan Management team (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

HBX is clarifying the process for carriers to request changes to their benefit offerings after a plan has been certified. 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 and 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 staff 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 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.

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

K. Adopted Board Resolutions

Date	Board Resolution
September 05, 2012	Resolution - Establishing Working Board Committees

September 24, 2012	Resolution - Approval to Hire an Interim Executive Director
November 14, 2012	Resolution - Appointing Members of the Standing Advisory Board
December 12, 2012	Resolution - Establishing Additional Advisory Boards
February 07, 2013	Resolution - Appointments to Advisory Board
February 13, 2013	Resolution - Essential Health Benefit (EHB) Recommendations
March 07, 2013	Resolution - Appointments to Advisory Board
March 13, 2013	Resolution - Certification of Qualified Health Plan (QHP) Issuers • Recommendations of the Qualified Health Plan (QHP) Issuer Certification Process Working Group Resolution - Changes to the District of Columbia Healthcare Alliance Resolution - Market Transition Resolution - Network Adequacy Standards • Network Adequacy Working Group Report Resolution - Premium Collection Standards and Processes

	Resolution - Qualified Health Plan (QHP) Certification Standards to Promote Benefit Standardization
March 22, 2013	Resolution - Further Essential Benefit Standards and Additional Qualified Health Plan (QHP) Certification Standards
April 04, 2013	Resolution - Employee Plan Choice Resolution - Reallocated Composite Premium
April 08, 2013	Resolution - Minimum Participation - Minimum Contribution Resolution - Prohibition on Tobacco Use Rating
April 18, 2013	Resolution - To Establish an In-Person Assistor (IPA) Program • In-Person Assistor Recommendations to the DC Health Benefit Exchange Board Resolution - To Establish Certification Requirements for Qualified Dental Plans • DC Health Benefit Exchange Dental Working Group Report Resolution - To Establish a Reasonable Out-of-Pocket Maximum for Qualified Dental Plans
May 09, 2013	Resolution - To Establish Effective Dates for Eligibility Redeterminations Resulting From Changes Reported During the Benefit Year Resolution - To Establish Default Termination Rules for Individual Exchange Marketplace Enrollees Who Are Determined Eligible for Medicaid Resolution - To Establish a Default Setting for the Amount of Advanced Payment of Premium Tax Credit Displayed to Users During Plan Selection

	Resolution - To Define "Exceptional Circumstances" Permitting a Special Enrollment Period Resolution - To Require Qualified Health Plan (QHP) Issuers to Establish Polices that Address Transition of Care for Enrollees in the Midst of Active Treatment at the Time of Transition into a QHP Resolution - To Establish Outreach Strategies to Promote Tobacco Cessation Programs and Other Preventive Benefits That Are Covered Without Cost Sharing Resolution - To Establish a Minimum Threshold Under Which Individuals in the Individual Exchange Marketplace Are Not Obligated to Report Changes in Income Resolution - To Establish the Frequency of Electronic Notifications Regarding the Duty to Report Changes Relevant to Eligibility for Individual Exchange Marketplace Enrollment or Tax Credits Resolution - To Establish an Automatic Enrollment Policy for the Individual Exchange Marketplace and to Define "Exceptional Circumstances" Permitting a Special Enrollment Period Resolution - To Allow a Good Faith Extension of the Period to Resolve Eligibility Factor Inconsistencies for Eligibility or Enrollment in the Individual Exchange Marketplace
June 06, 2013	Resolution - To Establish a Financial Sustainability Plan for the Operating Costs of the DC Health Benefit Exchange • Financial Sustainability Working Group Recommendations Resolution - To Establish a Strategy for the DC Health Benefit Exchange to Improve the Quality of Care Offered by Qualified Health Care Plans • Quality Working Group Recommendations
June 17, 2013	

	Resolution - To Make a Change to the By-laws of the Authority as Permitted by Article XVI of the By-laws of the Authority Resolution - To Make Appointments to Advisory Boards, in Addition to the Standing Advisory Board, as Permitted by DC Code §31-3171.07 • Standing Advisory Board Management Recommendations
July 11, 2013	Resolution - To Establish Standards to Allow All Brokers to Sell All Qualified Health Plans in DC Health Link With Strong Consumer Protections • Producers Advisory Committee Final Report
July 22, 2013	Resolution - To Establish a Policy for Use of Credit and Debit Cards for Payment of Premiums Through DC Health Link
August 13, 2013	Resolution - To Establish Certified Application Counselor (CACs) Requirements for Participation on DC Health Link • Certified Application Counselor Recommendations From the Consumer Assistance and Outreach Advisory Committee Resolution - To Establish Requirements for Employees of Health Insurance Carriers Serving as Certified Application Counselors (CACs) on DC Health Link
September 26, 2013	Resolution - To Establish a DC Health Link Contact Center Preferred Broker Program • Producers Advisory Committee Report and Policy Recommendations on Requirements
May 14, 2014	Resolution - To Establish Employer Choice of Qualified Dental Plans

	Resolution - To Allow Health Carriers in DC Health Link to Determine Whether a Pediatric Essential Dental Benefit Is Included in a Qualified Health Plan Resolution - To Determine a Separate Deductible for Pediatric Dental Benefits Offered in QHPs
July 11, 2014	Resolution - To Define Additional "Exceptional Circumstances" Permitting a Special Enrollment Period
July 09, 2014	Resolution - To Define additional “Exceptional Circumstances” Permitting a Special Enrollment Period
July 31, 2014	Resolution - To Appoint Two (2) Members to the Standing Advisory Board to Fill Vacancies
November 12, 2014	Resolution - To Adopt a Recommendation Regarding a Separate Deductible for Pediatric Dental Benefits Offered in QHPs Resolution - To Adopt Recommendations Establishing Standard Qualified Health Plans at Each of the Four Metal Level Tiers to Promote Easier Comparison Shopping Through DC Health Link Resolution - To Appoint Two (2) Members to the Standing Advisory Board to Fill Vacancies
February 09, 2015	Resolution - To Update the Qualified Health Plan (QHP) Certification Requirements • Qualified Health Plan Certification Requirement Recommendations (1/21/2015)
March 09, 2015	Resolution - To Define Additional “Exceptional Circumstances” Permitting a Special Enrollment Period

	Resolution - To Adopt a Recommendation Revising the Standard Bronze Qualified Health Plan Offered Through DC Health Link
June 24, 2015	Resolution - To Approve an Essential Health Benefit (EHB) Benchmark Plan for 2017
September 21, 2015	Resolution - To Appoint Two (2) Members to the Standing Advisory Board to Fill Vacancies Resolution - To Define Additional "Exceptional Circumstances" Permitting a Special Enrollment Period Resolution - To Define Additional "Exceptional Circumstances" Permitting a Special Enrollment Period
December 09, 2015	Resolution - To Reappoint Three (3) Members to the Standing Advisory Board
February 26, 2016	Resolution – to define an additional time-limited "exceptional circumstance" for a Special Enrollment Period
April 06, 2016	Resolution – to adopt recommendations to modify the standard qualified health plans at each of the four metal level tiers to comply with the Plan Year 2017 federal Actuarial Value Calculator.
May 11, 2016	To appoint a new member to the Standing Advisory Board to fill a vacancy.

August 08, 2016	Resolution – to adopt recommendations that the District adopt the NAIC Model on Network Adequacy modified as necessary to meet the unique needs of the District.
November 09, 2016	Resolution - to reappoint three (3) members to the Standing Advisory Board.
February 08, 2017	Resolution – to adopt standard plans for 2018
June 14, 2017	Resolution – Past Due Premiums Resolution – Open Enrollment Plan Year 2018
July 12, 2017	Resolution – SHOP SEPs on employee and employer errors
November 08, 2017	Resolution – ACA Working Group Market Stability Recommendations
February 21, 2018	Resolution – Individual Responsibility Requirement
March 14, 2018	Resolution -- 2019 Standard Plans
March 9, 2018	Resolution – Special Enrollment Period Plan Year 2019 Resolution – Short-Term Limited Duration Health Plans

December 12, 2018	Resolution – create Ad Hoc Executive Board Committee on Legislation Resolution – to reappoint three (3) members to the Standing Advisory Board
February 13, 2019	Resolution – time-limited SEP related to DC's individual responsibility requirement Resolution – 2020 Standard Plans
May 08, 2019	Resolution – to effectively create a three month open enrollment period Resolution – to modify the previously-adopted standard bronze copay plan for 2020
September 11, 2019	Resolution – HBX cleanup legislation
November 13, 2019	Resolution - To appoint five (5) members to the Standing Advisory Board
January 08, 2020	Resolution - Individual Responsibility Requirement SEP Resolution - Auto-pay Error SEP Resolution - Pregnancy SEP Resolution - SHOP open enrollment extension for 2020
January 27, 2020	Board Chair Diane Lewis Testimony DC Council Committee on Health Hearing on B23-584, the "Pregnancy as a Qualifying Event Act of 2019"

	• Attachment A
April 1, 2020	Resolution - Standard Plan Offerings for Plan Year 2021 Resolution - SHOP COVID-19 SEP
September 9, 2020	Resolution - COVID SEPs
September 23, 2020	Resolution - Extension of SHOP Open Enrollment to 2022
November 18, 2020	Resolution Reappointing Standing Advisory Board members

Appendix A

District of Columbia Age Factors and Rating Curve

District of Columbia Age Factors and Rating Curve

Age	DC Age Factors		DISB Age Curve- 3:1 Ratio Required		Premium Ratio
0-20	0.654				
21	0.727		1.000		1.000
22	0.727		1.000		1.000
23	0.727		1.000		1.000
24	0.727		1.000		1.000
25	0.727		1.000		1.000
26	0.727		1.000		1.000
27	0.727		1.000		1.000
28	0.744		1.023		1.023
29	0.760		1.045		1.022
30	0.779		1.072		1.025
31	0.799		1.099		1.026
32	0.817		1.124		1.023
33	0.836		1.150		1.023
34	0.856		1.177		1.024
35	0.876		1.205		1.023
36	0.896		1.232		1.023
37	0.916		1.260		1.022
38	0.927		1.275		1.012
39	0.938		1.290		1.012
40	0.975		1.341		1.039
41	1.013		1.393		1.040
42	1.053		1.448		1.039
43	1.094		1.505		1.039
44	1.137		1.564		1.039
45	1.181		1.624		1.039
46	1.227		1.688		1.039
47	1.275		1.754		1.039
48	1.325		1.823		1.039
49	1.377		1.894		1.039
50	1.431		1.968		1.039
51	1.487		2.045		1.039
52	1.545		2.125		1.039
53	1.605		2.208		1.039
54	1.668		2.294		1.039
55	1.733		2.384		1.039
56	1.801		2.477		1.039

57	1.871		2.574		1.039
58	1.944		2.674		1.039
59	2.020		2.779		1.039
60	2.099		2.887		1.039
61	2.181		3.000		1.000
62	2.181		3.000		1.000
63	2.181		3.000		1.000
64+	2.181		3.000		1.000

Appendix B

DISB Health Insurance Rate & Form Filing Requirements

Health Insurance Rate Filing Requirements – ACA-Compliant Plans

The Government of the District of Columbia Department of Insurance, Securities and Banking (DISB), Actuarial Analysis Division, only accepts Health rate filings via the National Association of Insurance Commissioner's (NAIC) System for Electronic Rate and Form Filings (SERFF).

Health insurance FORM filings should be filed in SERFF separately from Health Insurance RATE filings.

Health insurance rate filings for ACA-compliant plans should include the following information as pertinent to the nature of the purpose of the filing:

1. Fill out all requested information for the rate filing in SERFF under the tabs labeled "General Information" and "Rate/Rule Schedule"

2. Create a **cover letter** on Company Letterhead that includes the following:
    a. Company Name
    b. NAIC Company Code
    c. Unique Company Filing Number (assigned by Company)
    d. Date Submitted
    e. Proposed Effective Date
    f. Type of Product
    g. Individual or Group
        Group Size
    h. Scope and Purpose of Filing
    i. Indication Whether Initial Filing or Change
    j. Indication if no DC Policyholders
    k. Overall Premium Impact of Filing on DC Policyholders
    l. Contact information, Name, Telephone, Fax, e-mail
    m. Signature and Date

3. If someone other than the insurer is submitting a filing on the insurer's behalf, then the filing must include a letter of authorization from the insurer. This letter must be on the insurer's Letterhead, dated, and signed by a person with authority. Submit this letter in the tab labeled "Supporting Documentation" in the scheduled item called **Certificate of Authority to File**.

4. Effective March 28, 2013, the Uniform Rate Review Template (URRT) replaced the Rate Summary Worksheet (Preliminary justification Part I). The URRT, a market-wide reform, is required to be completed and submitted in SERFF and in HIOS for ALL individual and small group health insurance rate filings that are not grandfathered health plan coverage or excepted benefits under the Rate Review Regulation, regardless of whether the rate action meets or exceeds the "subject to review" threshold of the Rate Review Regulation. Additionally, the Actuarial Memorandum Part III, is also required to be submitted whenever the URRT is submitted. This applies to both SERFF and HIOS.

The Draft 2021 Letter to Issuers dated January 31, 2020 states that "The approach for 2021 remains unchanged from the 2020 Letter to Issuers. Please refer to the Unified Rate Review Instructions for the

2021 plan year for more information." That information (Unified Rate Review v5.0) can be found here, dated December 20, 2019.

Please download the URRT from the HIX web page, or CMS, complete the document and attach the Excel version to the URRT Requirement under the "Supporting Documentation" tab within applicable SERFF filings. If you are submitting a rate increase that meets or exceeds the "subject to review" threshold under the Rate Review Regulation, you should attach the same version of the URRT that you prepared for upload into the HIOS system.

Please bypass this requirement on large group filings and/or filings that have grandfathered plans or excepted benefits.
Please refer to the documentation in SERFF's Online Help for instruction on completing the required PPACA fields.

The elements of the Rate Filing are as follows:
- **Part I (Unified Rate Review Template)**
    a) Worksheet 1 – Market Experience
        a. Experience Period Data
        b. Projections (Trend)
        c. Morbidity & other Adjustments
    b) Worksheet 2 – Plan / Product Info
        a. General Info
        b. Experience Period and Current Level Plan Level Info
        c. Plan Adjustment Factors
        d. Projected Plan Level Info
    c) Worksheet 3 – Rating Area; the District has only one rating area.

- **Part II (Preliminary Justification) (ONLY REQUIRED WHEN A RATE INCREASE IS GREATER THAN THE THRESHOLD FOR RATE REVIEW)** – The written description of the rate increase must include a simple and brief narrative describing the data and assumptions used to develop the rate increase, including the following:

a. Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary

b. Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios

- **Part III (Actuarial Memorandum)** – Two versions are required; an unredacted version for regulators and a redacted version for public disclosure. The Actuarial Memorandum should include the following elements:

a. Company Identifying Information
    i) Company Legal Name
    ii) State
    iii) HIOS Product ID
b. Effective date
c. Company contact information
d. Market

e. Average rate increase requested
f. Reason for rate increase
g. Risk Adjustment
h. Risk Score
i. Reinsurance
j. Non-Benefit Expenses
    i) Administrative Costs of Programs that Improve Health Care Quality
    ii) Taxes and Licensing or Regulatory Fees
k. Projected Loss Ratio
l. Index Rate
m. Market Adjusted Index Rate
n. AV Value
o. Benefit/Metal level(s)
p. Calibration
q. Consumer Adjusted Premium Rate Development
r. Past experience
s. Rating Factors
t. Credibility assumption
u. Trend assumption
v. Cost-sharing changes
w. Benefit changes
x. Claim reserve needs
y. Reliance
z. Actuarial Certification

5. Download and complete the **DISB Actuarial Memorandum Dataset** template from SERFF (located on the "Supporting Documents" tab) and upload the completed version.

6. Download and complete the **District of Columbia Plain Language Summary** template from SERFF (located on the "Supporting Documents" tab) and upload the completed version.

7. Complete the **Rate Filing Checklist** (see Appendix C)

8. Complete the CCIIO Risk Adjustment Transfer Elements Extract (RATE 'E') report and submit to DISB prior to approval of the rate filings for all QHP rate plans. This report should be submitted either by the set deadline date for QHP submissions, or no later than April 30th of the current year, whichever is first. You should receive the template and instructions for this report directly from CCIIO. You can submit this report in one of two ways (or both):

a. The report can be attached to the corresponding rate filing (marked as "confidential" if you would prefer that the report not be available for public viewing;
b. You can email the report directly to Efren Tanhehco, Supervisory Health Actuary (efren.tanhehco@dc.gov).

Please bypass this requirement on large group filings and/or filings that have grandfathered plans or excepted benefits.

9. DISB will require all issuers of Qualified Health Plans (for sale on DC HealthLink) to provide a chart containing clear and concise information on the following:

a. Any and all components of requested changes in the rates from the prior plan year, listed individually, such as trends, risk adjustment, age calibration, mapping from a different plan, etc. (this is not meant to be an exhaustive list; your list should contain all applicable components);
b. A quick summary/explanation of the change associated with each listed component; and
c. The actual percentage impact of the change to each component, such that the sum total for all components equals the total percentage change requested for the plan year.

This chart should be submitted along with the rate filing, either within the Actuarial Memorandum or as a separate supporting document.

10. The filing (and all applicable elements) should also be submitted in the Health Insurance Oversight System (HIOS) portal. Refer to the HIOS Portal User Manual published on the CMS website (https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Portal-UserManual-082014-150200.pdf) for detailed instructions on using the portal. Note that the HIOS Product ID must be included in the Actuarial Memorandum submitted with the SERFF filing.

11. The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% (85% in the large group market) of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. If they fail to meet these standards, the insurance companies are required to provide a rebate to their customers starting in 2012.

Insurers must submit a report each year to the Department of Health and Human Services (HHS) showing how much the insurer spent on health care and activities that improve care in the past year. Each year's report is due by July 31 of the following year.

Each insurer's Medical Loss Ratio information is provided separately for each state and, within each state, by market (individual, small group and large group markets). It is not provided by a particular plan, product, or policy.

Complete the **MLR Report** and submit the report to CMS by the required due date. Also send either the Excel version, or a PDF version, of the completed MLR Report for the District of Columbia to DISB via email to Efren Tanhehco, Supervisory Health Actuary (efren.tanhehco@dc.gov).

Appendix C

Rate Filing Check List
Consolidated Form Filing Check List
Prescription Guide Template

Check List

1. Consolidated form filing checklist click here.
2. Rate Filing checklist click here.
3. Prescription Guide template click here.

Note: Carriers may also reach out to HBX Plan Management team via email at carrier.hbxinquiries@dc.gov to request a copy of the checklist listed above.

Appendix D

Health Benefit Exchange Authority Attestations

DC Health Benefit Exchange Authority

DC HBX Exchange Issuer Attestations: Statement of Detailed Attestation Responses

Instructions: Please review and respond Yes or No to each of the attestations below and sign the Statement of Detailed Attestation Responses document. Please be sure to reference the specific attestation in your justification discussion. If the applicant is submitting the signed attestation document indicating Yes to all attestations, the justification section is not required.

1. Applicant attests that it will be bound by 2 CFR 376 and that no individual or entity that is a part of the Applicant's organization is excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. This attestation includes any member of the board of directors, key management or executive staff or major stockholder of the applicant and its affiliated companies, subsidiaries or subcontractors.

☐ Yes
☐ No

2. The applicant attests that, based on its best information, knowledge and belief, none of its principals, nor any of its affiliates is presently debarred, suspended, proposed for debarment, or declared ineligible to participate in Federal programs by HHS or another Federal agency under 2 CFR 180.970 or any other applicable statute or regulation, and should such actions occur, it will inform HHS within 5 working days of learning of such action.

☐ Yes
☐ No

3. Applicant attests that it either offers no stand-alone dental plans, or that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit.

☐ Yes
☐ No

4. The following attestation applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. 18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device, a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute. Applicant acknowledges the False Claims Act, 31 U.S.C., §§ 3729-3733.

☐ Yes
☐ No

5. The following applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Applicant attests to provide and promptly update when applicable changes occur in its Tax Identification Number (TIN) and associated legal entity name as registered with the Internal Revenue Service, financial institution account information, and any other information needed by CMS in order for the applicant to receive invoices, demand letters, and payments under the APTC, CSR, user fees, reinsurance, risk adjustment, and risk corridors programs, as well as, any reconciliations of the aforementioned programs.

☐ Yes
☐ No

6. The following applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Applicant attests that it will develop, operate and maintain viable systems, processes, procedures and communication protocols to accept payment-related information submitted by CMS.

☐ Yes
☐ No

_____ _____
Signature Date

_____ _____
Printed Name Title/Position

Attestation Justification: Provide a justification for any attestation for which you indicated No. Be sure to reference the specific attestation in your justification.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Appendix E

DISB Guidance on Nondiscrimination in Benefit Design

Stephen C. Taylor
Commissioner

NON-DISCRIMINATORY BENEFIT DESIGN

The intent of this guidance is to clarify non-discrimination standards and provide examples of benefit designs for Qualified Health Plans (QHP) that are potentially discriminatory under the Affordable Care Act (ACA)[1]. The ACA enacted standards that protect consumers from discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, and health condition. It prohibits issuers from designing benefits or marketing QHPs in a manner that would discourage individuals with significant health care needs from enrolling in their QHPs. In addition, the Public Health Service Act (PHS) Section 2711 generally prohibits group health plans and health insurance issuers offering group or individual coverage from imposing lifetime or annual limits on the dollar value of essential health benefits (EHB). [2] Furthermore, with respect to plans that must provide EHBs, issuers may not generally impose benefit-specific waiting periods and plan designs must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). These standards do not apply to stand-alone dental plans (SDP).

Ultimately, the Department of Insurance, Securities and Banking (DISB) and the DC Health Benefit Exchange Authority (HBX) will determine if a plan design has a discriminatory practice under applicable law after a review of the plan's forms, rates, and QHP filing templates developed by the Center for Consumer Information and Insurance Oversight (CCIIO) as submitted through SERFF, in addition to any other materials that may be requested by these agencies. In particular, DISB will conduct an in-depth review of the Prescription Drug Template, the Plans and Benefits Template, and the data captured by the CCIIO review tools (namely the Non-discrimination Tool, the Non-discrimination Formulary Outlier Tool and the Non-discrimination Clinical Appropriateness Tool).

Many benefit design features are utilized in the context of medical management, including but not limited to: exclusions; utilization management; cost-sharing; medical necessity definitions; networks; case management; and/or drug formularies. Depending on how the feature is designed and administered, each of these features has the potential to be either discriminatory or an important element in a QHP's quality and affordability. CMS has identified examples of potentially discriminatory benefit design within each of these domains, as well as best practices for minimizing the discriminatory potential of these features. These examples are not definitively discriminatory, but may be indicators of discriminatory practices. As potential discrimination is assessed internally, issuers should consider the design of singular benefits in the context of the plan as a whole, taking into account all plan features, including maximum out of pocket (MOOP) limits.

Drug Formularies

All issuers offering QHPs are required to run CCIIO tools and complete DISB's Rx Guide template. In the event a QHP imposes a utilization management requirement which unduly limits access to commonly used medications for any chronic disease in a discriminatory manner, regulators may find the requirement to be a discriminatory practice and decide not to certify the plan as meeting QHP requirements. For

[1] 45 CFR §156.125 – Prohibition on discrimination – provides as follows: "(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."
[2] 42 U.S.C. 300gg-11.

example, a plan might place all HIV/AIDs drugs in a high cost-sharing tier, which is a practice that DISB will review carefully as being discriminatory with respect to people with HIV/AIDs. By placing all medications for a single chronic disease, including generics, on the highest cost-sharing tier, and/or requiring all such medications be accessed through a mail-order pharmacy, health plans discourage people living with those chronic diseases from enrolling in those health plans – a practice which may unlawfully discriminate based on disability. This tiering structure could indicate potentially discriminatory policy.

A QHP formulary drug list URL must be easily accessible. Its information must be up-to-date, accurate, and inclusive of a complete list of all covered drugs. The information should also provide a clear description of any tiering structure that the plan has adopted and any restrictions on the way a drug can be obtained.

Behavioral Health Care

All QHP's are required to comply with the MHPAEA which states that financial requirements (e.g. co-pays and deductibles) and/or treatment limitations (e.g. visit limits) may not be more restrictive than the predominant requirements or limitations applied to medical/surgical benefits within the same benefit classification.[3] For example, an issuer who proposes a copayment on in-network, outpatient mental health/substance use disorder (MH/SUD) benefits that is more restrictive than the predominant copayment applied to substantially all in-network, outpatient medical/surgical benefits would violate MHPAEA requirements. DISB will review benefits and cost-sharing for compliance with this standard, using CCIIO tools for outlier analysis on specific QHP benefits. These benefits include inpatient mental/behavioral health stays, specialist visits, specific mental health and substance abuse disorder conditions, and prescription drugs. In addition, regulations adopted under the ACA require QHP issuers to maintain networks with sufficient numbers and types of providers, including providers specializing in the delivery of mental health and substance use disorder services, to assure all services will be accessible without unreasonable delay.[4] DISB and HBX will review provider networks to ensure sufficient access to behavioral health and substance abuse providers.

[3] 42 U.S.C. 18031(j); 42 U.S.C. 300gg-26.
[4] 45 C.F.R. 156.230(a)(2).

Domain	Benefit Example	Discriminatory Design Example	Rationale for Discriminatory Designation	Mitigation Strategies for Reducing Potential Discriminatory Practices
Behavioral Health	Mental Health Parity	Non-compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) with respect to financial requirements. For example, proposing a copayment on in-network, outpatient mental health/substance use disorder benefits that is more restrictive than the predominant copayment applied to substantially all in-network, outpatient medical/surgical benefits.	The difference in copayments appears to violate MHPAEA's substantially all medical/surgical benefits test.	Provide justification for any variance in copayments that may appear to be discriminatory.
Cost Sharing	Ancillary Costs	Requiring cost-sharing for ancillary services associated with a covered preventive service.	Requiring additional payments for ancillary services leads to surprise bills for consumers for services that should have been covered without cost-sharing.	Remove cost-sharing for ancillary services performed during or in connection with a covered preventive service.
Drug Formularies	Drug Tiering	All drugs for a specific disease, such as HIV or Multiple Sclerosis, are placed on highest cost-sharing tier	Adverse selection, encourages enrollees to select a plan from a different carrier that covers life-saving/life extending drugs.	Submit updated Rx Guide template throughout the year
Drug Formularies	Drug Exclusion	Excluded coverage of a specific drug counter to DC policy. Examples include exclusions of over-the-counter contraceptive pills, supplies, and devices. Additional exclusions to monitor include methadone maintenance treatment in form filing for proposed plans.	Inappropriate exclusions placed on benefits/services.	Remove exclusions as appropriate.
Exclusions	Cosmetic Procedures	Presumption of cosmetic procedures as being not medically necessary such as breast augmentation/nipple reconstruction, and/or tracheal shave for a person in transition with a gender dysphoria diagnosis.	Concerns with forms/riders creating environment where ALL gender dysphoria cases *must* be referred to an Ombudsman for medical necessity review, even though the World Professional Association for Transgender Health (WPATH) guidelines have already been followed and there has	Continue to ensure medical necessity criteria/guidelines are updated and consulted during filing process.

Domain	Benefit Example	Discriminatory Design Example	Rationale for Discriminatory Designation	Mitigation Strategies for Reducing Potential Discriminatory Practices
			been a doctor/behavioral health recommendation for a procedure.	
Exclusions	Age Limits	Placing an age limit on a service, such as plastic, cosmetic, and related services, that has been found to be clinically effective at all ages.	Labeling certain benefits and services proven clinically effective on all ages as "pediatric services" limits adult access to such benefits and services.	Remove the age limits from applicable benefits as appropriate. Evidence that age limits are based on accepted standards of medical practice may be considered.
Medical Necessity	Emergency Services	Restricting out-of-network emergency services based on whether the individual could have anticipated needing emergency care outside the service practice area.	As long as the individual has an emergency medical condition, as defined in 45 C.F.R. § 147.138(b)(4)(i), they may receive emergency services from an out-of-network provider under 45 C.F.R. § 147.138 without regard to whether the need for emergency services could have been anticipated prior to leaving the service area.	Remove exclusions and language from forms as appropriate.
	Reconstructive Breast Surgery	Limiting coverage of reconstructive breast surgery to mastectomies associated with breast cancer, or denying coverage based on medically necessity	WHCRA is not limited to reconstructive surgery following a mastectomy resulting from breast cancer. This service must be covered regardless of the underlying cause and medical necessity.	Remove exclusions and language from forms as appropriate.
Utilization Management	Claims Denial	DC has a mammogram mandate (§ 31–2902) that states in part: (a) Any individual or group health benefit plan, including Medicaid, shall provide health insurance benefits to cover: (1) A baseline mammogram for women; and	For women with dense breast tissue, particularly women of color, 3-D mammography is more effective at detecting cancer than the 2-D counterpart. In 2013, the breast cancer mortality rate for African American women was 39 percent higher than that for Caucasian women.	Cover 3-D mammography in appropriate cases.

Domain	Benefit Example	Discriminatory Design Example	Rationale for Discriminatory Designation	Mitigation Strategies for Reducing Potential Discriminatory Practices
		(2) An annual screening mammogram for women. A plan design that does not include this mandated benefit could be considered discriminatory.		
Utilization Management	Use of prior authorization for surgery for gender dysphoria.	Contracts that require an individual to obtain prior authorization for in-network surgery for gender dysphoria, when prior authorization is not required for in-network inpatient hospital stays, reconstructive procedures, and outpatient surgery. If prior authorization isn't obtained, the patient could be required to pay more of the allowed amount.	Limits access to necessary treatment	Consult DISB FAQs which state if prior authorization is required for a covered procedure, it will be required for both transgender and non-transgender enrollees. Revise language as needed after working with DISB/HBX.

Appendix F

Evidence of Coverage and SBC/Benefit Brochure Tracking Form

DC HEALTH LINK
Get the facts. Get covered.

Carrier Contract & SBC URL Verification Form

Carrier	Plan Name	HIOS ID	Market	SBC URL	Contract URL

Appendix G

CCIIO Quality Improvement Strategy (QIS) Implementation Plan and Progress Forms

QIS Implementation Plan

Use this form to provide the baseline details for and to describe your quality improvement strategy (QIS). Please retain a copy of this completed QIS Implementation Plan form so that it is available for future reference when reporting on activities conducted to implement the QIS. CMS will also keep each QIS Implementation Plan form on file as a reference while this particular QIS is in place.

*For any fields that do not apply, please simply leave them **blank**. There is no need to indicate "NA" or "not applicable" unless specifically instructed to do so for that criterion. For detailed instructions, please refer to the QIS Technical Guidance and User Guide for the current plan year on the Marketplace Quality Initiatives website.*

***PLEASE NOTE: For the 2022 Plan Year, all issuers will need to submit an Implementation Plan form.** If you are an issuer who:*

1. *Is continuing a current QIS (with or without modifications), select **Baseline Implementation Plan (only for the 2022 Plan Year)** and describe the QIS that will be in place for the 2022 Plan Year. Any modifications made to the QIS from the previous year should be included in this new Implementation Plan form as the new baseline data. These issuers should also report on progress achieved on the QIS during the previous year by submitting a separate QIS Progress Report form.*
2. *Is discontinuing a current QIS and implementing a new one, select **New QIS After Discontinuing a QIS Submitted During a Prior Qualified Health Plan (QHP) Application Period** and submit the Implementation Plan form to describe the QIS that will be implemented for the 2022 Plan Year. These issuers should also report on progress to close out the discontinued QIS by submitting a QIS Progress Report form.*
3. *Is participating in QIS for the first time, or implementing an additional QIS, select **New QIS with No Previous QIS submission** and submit only the Implementation Plan form.*

Beginning with the 2023 Plan Year, issuers who are reporting the prior year's progress on the QIS do not need to submit an Implementation Plan form each year. Only issuers new to QIS or issuers implementing a new QIS will need to submit an Implementation Plan form. Future modifications can be reported in a separate QIS Modification Summary Supplement that will be available for the 2023 Plan Year for issuers meeting these conditions.

For CMS Use Only | |

QIS Submission Type

Part A. New QIS Submission

These fields are required but will not be scored as part of the QIS evaluation.

1. Type of QIS Submission

Select the option that describes the type of QIS submission, and follow the instructions to complete the submission.

Type of QIS	Instructions
○ **Baseline Implementation Plan (only for the 2022 Plan Year)[1] for a Continuing QIS**	Issuers must complete 2 forms: 1. Complete the Background Information section (Parts A, B, and C) and the Implementation Plan section (Parts D and E) of the Implementation Plan form with your current QIS data. Any modifications from your 2020 Plan Year submission should be reflected in this Implementation Plan form. 2. Complete a Progress Report form to report progress on your prior year's QIS (i.e., Plan Year 2020). See instructions in the QIS Progress Report form: "Report on Progress."
○ **New QIS After Discontinuing a QIS Submitted During a Prior Qualified Health Plan (QHP) Application Period [2]**	Issuers must complete 2 forms: 1. Complete the Background Information section (Parts A, B, and C) and the Implementation Plan section (Parts D and E) of the Implementation Plan form to submit the new QIS. 2. Complete a Progress Report form to close out the discontinued QIS. See instructions in the QIS Progress Report form: "Progress Report Closeout Form."
○ **New QIS[3] with No Previous QIS Submission**	Complete the Background Information section (Parts A, B, and C) and the Implementation Plan section (Parts D and E) of the Implementation Plan form to submit the new QIS.

[1] For the 2022 Plan Year only, all issuers continuing a QIS should select this option to establish baseline Implementation Plan data
[2] A new QIS is required if an issuer: changes its QIS market-based incentive sub-type, changes its QIS topic area, the QIS is not having the expected impact, or the QIS results in negative outcomes or unintended consequences.
[3] A "new QIS" is defined as a QIS that has not been previously submitted to an Exchange.

2. Targets All QHPs and Product Types Offered Through an Exchange

2a. Indicate if this QIS is applicable to all eligible QHPs you offer or are applying to offer through the Exchanges, or to a subset of eligible QHPs.

- ○ All QHPs
- ○ Subset of QHPs[4]*

Note*: *If "Subset of QHPs" was selected above, an additional QIS Implementation Plan(s) must be submitted for eligible QHPs not covered by this QIS.*

2b. Select the relevant product types to which the QIS applies. Check all that apply.

- ☐ Health Maintenance Organization (HMO)
- ☐ Point of Service (POS)
- ☐ Preferred Provider Organization (PPO)
- ☐ Exclusive Provider Organization (EPO)
- ☐ Indemnity

[4] An issuer that previously covered all eligible QHPs with a single QIS may choose to cover a subset of QHPs with its existing QIS in subsequent years, but must submit an additional QIS form(s) to cover its remaining eligible QHPs. Similarly, an issuer that previously covered subsets of its eligible QHPs with different quality improvement strategies may discontinue one or more of its strategies by submitting a QIS form(s) to close them out. The issuer must also ensure all eligible QHPs are covered by an existing or new QIS.

Background Information

Part B. Issuer Information

These fields are required but will not be scored as part of the QIS evaluation.

3. **Issuer Legal Name**

4. **Company Legal Name**

5. **HIOS Issuer ID**

6. **Issuer State**

7. **QIS Primary Contact's First Name**

QIS Primary Contact's Last Name

8. **QIS Primary Contact's Title**

9. **QIS Primary Contact's Phone** **Ext.**

10. **QIS Primary Contact's Email**

11. **QIS Secondary Contact's First Name**

QIS Secondary Contact's Last Name

12. **QIS Secondary Contact's Title**

13. **QIS Secondary Contact's Phone** **Ext.**

14. **QIS Secondary Contact's Email**

15. **Date Issuer Began Offering Coverage Through the Exchange**

Note: *For all date fields in this form, use the down arrow key to activate the calendar and then use the mouse or arrow keys to navigate to the correct date.*

16. Current Payment Model(s) Description

Select the category(ies) of payment models that are used by the issuer across its Exchange product line. Provide the percentage of payments in each payment model category[5] used by the issuer across its Exchange product line. The total percentage of payments across all four payment model types should equal approximately 100 percent.[6]

Note: *These percentages can be estimates and do not need to be exact figures. Issuers may update this information year to year, as needed.*

Payment Model Type	Payment Model Description	Provide Percentage
☐ **Fee for Service – No Link to Quality and Value**	Payments are based on volume of services and not linked to quality or efficiency.	☐ %
☐ **Fee for Service – Linked to Quality and Value**	At least a portion of payments vary based on the quality or efficiency of health care delivery.	☐ %
☐ **Alternative Payment Models Built on Fee for Service Architecture**	Some payment is linked to the effective management of a segment of the population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or two-sided risk.	☐ %
☐ **Population-based Payment**	Payment is not directly triggered by service delivery, so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., more than one year).	☐ %
Total	Please confirm the total percentage of payments across all four payment model type categories equals approximately 100%.	0 %

[5] Categories of payment models are defined in the *Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group – Alternative Payment Model (APM) Framework Final White Paper,* available at: https://hcp-lan.org/workproducts/apm-whitepaper.pdf. See the *QIS Technical Guidance and User Guide* for the current plan year, available on the Marketplace Quality Initiatives website, for examples of payment models within each category.
[6] To calculate the percentage of payments for Fee for Service payments linked to quality or value, and/or Alternative Payment Models tied to quality or value, issuers should use the calculation methodologies defined in the *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs (APM Measurement Effort) Final Paper,* available at: https://hcp-lan.org/groups/apm-fpt/apm-report/. See Table 1 (p. 7-10) for instructions to calculate the percentage of payments for these two payment model categories.

Part C. Data Sources Used for Goal Identification and Monitoring Progress

This field is required but will not be scored as part of the QIS evaluation.

17. Data Sources

Indicate the data sources used for identifying QHP enrollee population needs and supporting the QIS rationale (Element 23). Check all that apply.

Data Sources
☐ Internal issuer enrollee data
☐ Medical records
☐ Claim files
☐ Surveys (enrollee, beneficiary satisfaction, other)
☐ Plan data (complaints, appeals, customer service, other)
☐ Registries
☐ Census data Specify Type (e.g., block, tract, ZIP Code):
☐ Area Health Resource File (AHRF)
☐ All-payer claims data
☐ State health department population data
☐ Regional collaborative health data
☐ Other: Please describe. Do not include company identifying information in your data source description. *(100 character limit)*

QIS Implementation Plan Section

Part D. QIS Summary

These fields are required but will not be scored as part of the QIS evaluation.

18. QIS Title

Provide a short title for the QIS.

(200 character limit)

19. QIS Description

19a. Provide a brief summary description of the QIS. The description must include the market-based incentive type(s) and topic area(s) selected in Elements 21 and 22.

(1,000 character limit)

19b. Is the QIS described above part of a mandatory state initiative?

○ Yes ○ No

19c. Is the QIS submission[7] a strategy that the issuer currently has in place for its Exchange product line and/or for other product lines?

○ Yes ○ No

[7] Issuers may use existing strategies employed in non-Exchange product lines (e.g., Medicaid, commercial) if the existing strategies are relevant to their QHP enrollee populations and meet the QIS requirements and criteria.

If “yes” was checked for either/both of the above, please describe the state initiative and/or current issuer strategy.

(1,000 character limit)

20. QIS Goals

Describe the overall goal(s) of the QIS (no more than two).

Note: *The topic area(s) selected in Element 22 and the measure(s) described in Element 25 should be linked to these goals.*

QIS Goal 1:

(500 character limit)

QIS Goal 2:

(500 character limit)

Part E. QIS Requirements

The Elements in Part E will be scored as part of the QIS evaluation.

21. Market-based Incentive Type(s) (Must Pass)

Select the sub-type of market-based incentive(s) the QIS includes. Check all that apply. If either "In-kind incentives," "Other provider market-based incentives," or "Other enrollee market-based incentives" is selected, provide a brief description in the space provided.

Provider Market-based Incentives:

- ☐ Increased reimbursement
- ☐ Bonus payment
- ☐ In-kind incentives (Provide a description in the space below.)

(500 character limit)

- ☐ Other provider market-based incentives (Provide a description in the space below.)

(500 character limit)

Enrollee Market-based Incentives:

- ☐ Premium credit
- ☐ Co-payment reduction or waiver
- ☐ Co-insurance reduction
- ☐ Cash or cash equivalents
- ☐ Other enrollee market-based incentives (Provide a description in the space below.)

(500 character limit)

22. Topic Area Selection (Must Pass)

Select the topic area(s) this QIS addresses, as defined in the Patient Protection and Affordable Care Act.[8] Check each topic area that applies.

QIS Topic Area	Example Activities Cited in the Patient Protection and Affordable Care Act
☐ **Improve health outcomes**	▪ Quality reporting ▪ Effective case management ▪ Care coordination ▪ Chronic disease management ▪ Medication and care compliance initiatives
☐ **Prevent hospital readmissions**	▪ Comprehensive program for hospital discharge that includes: – Patient-centered education and counseling – Comprehensive discharge planning – Post-discharge reinforcement by an appropriate health care professional
☐ **Improve patient safety and reduce medical errors**	▪ Appropriate use of best clinical practices ▪ Evidence-based medicine ▪ Health information technology
☐ **Implement wellness and health promotion activities**	▪ Smoking cessation ▪ Weight management ▪ Stress management ▪ Healthy lifestyle support ▪ Diabetes prevention
☐ **Reduce health and health care disparities**	▪ Language services ▪ Community outreach ▪ Cultural competency trainings

[8] Implementation of wellness and health promotion activities are cited in Section 2717(b) of the Patient Protection and Affordable Care Act. All other activities are cited in Section 1311(g)(1) of the Patient Protection and Affordable Care Act.

23. Rationale for QIS (Must Pass)

Provide a rationale for the QIS that describes:

- The issuer's current QHP enrollee population(s), and
- How the QIS will address the needs of the current QHP enrollee population(s).

(1,500 character limit)

24. Activity(ies) that Will Be Conducted to Implement the QIS (Must Pass)

24a. List the activities that will be implemented to achieve the goals described in Element 20.

(1,500 character limit)

24b. Describe how the activities listed in Criterion 24a relate to the market-based incentive(s) selected in Element 21.

(1,500 character limit)

24c. Describe how the activities listed in Criterion 24a relate to the topic area(s) selected in Element 22.

(1,500 character limit)

24d. If health and health care disparities is one of the topic areas selected in Element 22, please select this box ☐ and move to Element 25.

OR

If health and health care disparities is NOT one of the topic areas selected in Element 22 and health and health care disparities are not addressed elsewhere in this QIS, please select this box ☐ and move to Element 25.

OR

If health and health care disparities is NOT one of the topic areas selected in Element 22, but the QIS includes activities related to addressing health and health care disparities, describe the activities below.

(1,500 character limit)

25. Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress (Must Pass)

For Goal 1, identify at least one (but no more than two) primary measure(s) used to track progress toward meeting the goal.

Measure 1a

25a. Measure 1a Name:

Provide a narrative description of the measure numerator and denominator.

(500 character limit)

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number: [ ]

If yes, did the issuer modify the NQF-endorsed measure specification?

○ Yes ○ No

25b. Describe how Measure 1a supports the tracking of performance related to Goal 1.

(1,000 character limit)

[ ]

25c. Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator (**Note:** *The numerator and denominator should calculate to the rate provided*)*:*

Calculated Rate: [ ]

Numerator: [ ]

Denominator: [ ]

- OR -

- Indicating the data point if the measure is not a rate:

Data Point: [ ]

25d. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 25c:

[ ] – [ ]

25e. Provide the numerical value performance target for this measure *(*i.e., the target rate or data point the QIS intends to achieve):
Note: *This entry should NOT be a percentage change but a numerical value.*

Measure 1b

25f. Measure 1b Name:

Provide a narrative description of the measure numerator and denominator.

(500 character limit)

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number:

If yes, did the issuer modify the NQF-endorsed measure specification?

○ Yes ○ No

25g. Describe how Measure 1b supports the tracking of performance related to Goal 1.

(1,000 character limit)

25h. Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator (**Note:** *The numerator and denominator should calculate to the rate provided*)*:*

  Calculated Rate: ☐

  Numerator: ☐

  Denominator: ☐

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: ☐

25i. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

☐ – ☐

25j. Provide the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve*):
Note: *This entry should NOT be a percentage change but a numerical value.*

☐

QIS Goal 2:

For Goal 2, identify at least one (but no more than two) primary measure(s) used to track progress toward meeting the goal.

25k. **Measure 2a**

Measure 2a Name: ☐

Provide a narrative description of the measure numerator and denominator.

(500 character limit)

☐

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number: ☐

If yes, did the issuer modify the NQF-endorsed measure specification?

○ Yes ○ No

25l. Describe how Measure 2a supports the tracking of performance related to Goal 2.

(1,000 character limit)

25m. Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator (**Note:** *The numerator and denominator should calculate to the rate provided*):

  Calculated Rate:

  Numerator:

  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

25n. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

–

25o. Provide the numerical value performance target for this measure (i.e., the target rate or data point the QIS intends to achieve):
Note: *This entry should NOT be a percentage change but a numerical value.*

25p. **Measure 2b**

Measure 2b Name:

Provide a narrative description of the measure numerator and denominator.

(500 character limit)

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number:

If yes, did the issuer modify the NQF-endorsed measure specification?

○ Yes ○ No

25q. Describe how Measure 2b supports the tracking of performance related to Goal 2.

(1,000 character limit)

25r. Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator (**Note:** *The numerator and denominator should calculate to the rate provided*):

Calculated Rate:

Numerator:

Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: [ ]

25s. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

[ ] – [ ]

25t. Provide the numerical value performance target for this measure (i.e., the target rate or data point the QIS intends to achieve):

Note: *This entry should NOT be a percentage change but a numerical value.*

[ ]

26. Timeline for Implementing the QIS

26a. QIS Initiation/Start Date: [ ]

26b. Describe the milestone(s) and provide the date(s) for each milestone (i.e., when activities described in Element 24 will be implemented). At least one milestone is required.

(100 character limit per milestone)

	Milestone(s)	**Date for Milestone(s)**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

27. Risk Assessment

27a. List all known or anticipated barriers to implementing QIS activities.

(750 character limit)

If no barriers were identified, describe how you assessed risk in the box below. If barriers were identified above, this box should be left blank.

(750 character limit)

27b. Describe the mitigation activities that will be incorporated to address **each** barrier identified in Criterion 27a. If there were no barriers identified, this box should be left blank.

(1,500 character limit)

Optional: *If there is any additional information you would like to provide regarding your QIS Implementation Plan, please do so in the box below.*

(1,500 character limit)

QIS Progress Report Form

Use this form to report on progress made during the previous year of your quality improvement strategy (QIS). Please refer to your most recent QIS Implementation Plan and any subsequent modifications for baseline data.

☐ *Confirm you have reviewed your most recent QIS Implementation Plan in preparing this submission.*

For detailed instructions, please refer to the QIS Technical Guidance and User Guide for the current plan year on the Marketplace Quality Initiatives website*.*

PLEASE NOTE: Only issuers who are continuing a QIS[1] need to submit a Progress Report form. *There are two scenarios for issuers:*

1. ***Progress Report:*** *Issuers who are continuing their current QIS (with or without modifications) should select Report on Progress and report progress on their prior year's QIS (i.e., the 2020 Plan Year Implementation Plan form). These issuers should also describe the QIS that will be in place for the 2022 Plan Year by submitting a QIS Implementation Plan.*
2. ***Progress Report Closeout Form:*** *Issuers discontinuing their current QIS and implementing a new one should select Progress Report Closeout Form and submit the Progress Report form to close out the discontinued QIS. These issuers should also describe the QIS that will be in place for the 2022 Plan Year by submitting a QIS Implementation Plan for the new QIS.*

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[1] This includes issuers who selected 1) Baseline Implementation Plan (only for the 2022 Plan Year) or 2) New QIS After Discontinuing a QIS in the QIS Implementation Plan Form for the 2022 Plan Year.

QIS Submission Type

Part A. Progress Report or Closeout QIS Submission

These fields are required, but will not be scored as part of the QIS evaluation.

1. Type of QIS Submission

Select the option that describes the type of QIS submission, and follow the instructions to complete the submission.

Type of QIS	Instructions
◯ **Progress Report**	Issuers must complete 2 forms: 1. Complete the Background Information section (Parts A and B), and the Progress Report Summary section (Part C) of the Progress Report form to report progress on your prior year's QIS (i.e., 2020 Plan Year Implementation Plan form). 2. Complete an Implementation Plan form to submit the baseline Implementation Plan. See instructions in the QIS Implementation Plan form: "Baseline Implementation Plan (only for the 2022 Plan Year)".
◯ **Progress Report Closeout Form**	Issuers must complete 2 forms: 1. Complete the Background Information section (Parts A and B) and the Progress Report Summary section (Part C) of the Progress Report form to close out the discontinued QIS, reporting on progress up until the strategy was discontinued. 2. Complete a new Implementation Plan form. See instructions in the QIS Implementation Plan form: New QIS after Discontinuing a QIS Submitted During a Prior QHP Application Period".

Background Information

Part B. Issuer Information

These fields are required, but will not be scored as part of the QIS evaluation. Issuers may update the information in Part B from year to year, as needed.

2. Issuer Legal Name

3. Company Legal Name

4. HIOS Issuer ID

5. Issuer State

6. QIS Primary Contact's First Name

QIS Primary Contact's Last Name

7. QIS Primary Contact's Title

8. QIS Primary Contact's Phone **Ext.**

9. QIS Primary Contact's Email

10. QIS Secondary Contact's First Name

QIS Secondary Contact's Last Name

11. QIS Secondary Contact's Title

12. QIS Secondary Contact's Phone **Ext.**

13. QIS Secondary Contact's Email

14. Date Issuer Began Offering Coverage Through the Exchange

Note: *For all date fields in this form, use the down arrow key to activate the calendar and then use the mouse or arrow keys to navigate to the correct date.*

15. Current Payment Model(s) Description

Select the category(ies) of payment models that are used by the issuer across its Exchange product line. Provide the percentage of payments in each payment model category[2] used by the issuer across its Exchange product line. The total percentage of payments across all four payment model types should equal approximately 100 percent.[3]

Note: *These percentages can be estimates and do not need to be exact figures. Issuers may update this information year to year, as needed.*

Payment Model Type	Payment Model Description	Provide Percentage
☐ **Fee for Service – No Link to Quality and Value**	Payments are based on volume of services and not linked to quality or efficiency.	☐ %
☐ **Fee for Service – Linked to Quality and Value**	At least a portion of payments vary based on the quality or efficiency of health care delivery.	☐ %
☐ **Alternative Payment Models Built on Fee for Service Architecture**	Some payment is linked to the effective management of a segment of the population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or two-sided risk.	☐ %
☐ **Population-based Payment**	Payment is not directly triggered by service delivery, so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., more than one year).	☐ %
Total	Please confirm the total percentage of payments across all four payment model type categories equals approximately 100%.	0 %

[2] Categories of payment models are defined in the *Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group – Alternative Payment Model (APM) Framework Final White Paper,* available at: https://hcp-lan.org/workproducts/apm-whitepaper.pdf. See the *QIS Technical Guidance and User Guide* for the current plan year, available on the Marketplace Quality Initiatives website, for examples of payment models within each category.
[3] To calculate the percentage of payments for Fee for Service payments linked to quality or value, and/or Alternative Payment Models tied to quality or value, issuers should use the calculation methodologies defined in the *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs (APM Measurement Effort) Final Paper,* available at: https://hcp-lan.org/groups/apm-fpt/apm-report/. See Table 1 (p. 7-10) for instructions to calculate the percentage of payments for these two payment model categories.

QIS Progress Report Section

Part C. QIS Progress Report Summary

The Elements in Part C will be scored as part of the QIS evaluation.

Note: *The Goal(s) and Measure(s) identified in this section (Part C: Progress Report Summary) are the Goal(s) and Measure(s) from the Implementation Plan form on file against which QIS progress is measured.*

Note: *All references to Implementation Plan form elements and criteria in this form refer to the 2020 Plan Year Implementation Plan.*

16. Analyze Progress Using Baseline Data, as Documented in the Implementation Plan (Must Pass)

Restate Goal 1 identified in Element 24 of the Implementation Plan on file.

QIS Goal 1:

(500 character limit)

Measure 1a:

16a. Restate Measure 1a name from Criterion 24a of the Implementation Plan on file:

16b. Baseline Assessment: Restate the baseline results from Criterion 24c of the Implementation Plan on file by **either**:

- Calculating the rate and providing the associated numerator and denominator *(**Note:** The numerator and denominator should calculate to the rate provided):*

  Calculated Rate:

  Numerator:

  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

16c. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 24c:

[ ] – [ ]

16d. Provide the Progress Report results by either:

- Calculating the rate and providing the associated numerator and denominator (**Note:** *The numerator and denominator should calculate to the rate provided):*

  Calculated Rate: [ ]

  Numerator: [ ]

  Denominator: [ ]

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: [ ]

16e. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

[ ] – [ ]

16f. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve*)
Note: *This entry should NOT be a percentage change but a numerical value.*

[ ]

16g. Was the performance target achieved?

◯ Yes ◯ No

Measure 1b:

16h. Restate Measure 1b name from Criterion 24f of the Implementation Plan on file:

[ ]

16i. Baseline Assessment: Restate the baseline results from Criterion 24h of the Implementation Plan on file by **either**:

- Calculating the rate and providing the associated numerator and denominator (***Note:*** *The numerator and denominator should calculate to the rate provided*):

  Calculated Rate: ☐

  Numerator: ☐

  Denominator: ☐

- OR -

- Indicating the data point, if the measure is not a rate:

  Data Point: ☐

16j. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 24h:

☐ – ☐

16k. Provide the Progress Report results by **either:**

- Calculating the rate and providing the associated numerator and denominator (***Note:*** *The numerator and denominator should calculate to the rate provided*):

  Calculated Rate: ☐

  Numerator: ☐

  Denominator: ☐

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: ☐

16l. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

☐ – ☐

16m. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve*)
Note: *This entry should NOT be a percentage change but a numerical value.*

☐

16n. Was the performance target achieved?

◯ Yes ◯ No

QIS Goal 2

Restate Goal 2 identified in Element 24 of the Implementation Plan on file.

QIS Goal 2:

(500 character limit)

Measure 2a:

16o. Restate Measure 2a name from Criterion 24k of the Implementation Plan on file:

16p. Baseline Assessment: Restate the baseline results from Criterion 24m of the Implementation Plan on file by **either**:

- Calculating the rate and providing the associated numerator and denominator (***Note:*** *The numerator and denominator should calculate to the rate provided*):

  Calculated Rate:

  Numerator:

  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

16q. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 24h:

–

16r. Provide the Progress Report results by **either:**

- Calculating the rate and providing the associated numerator and denominator (***Note:*** *The numerator and denominator should calculate to the rate provided*):

  Calculated Rate: ☐

  Numerator: ☐

  Denominator: ☐

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: ☐

16s. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

☐ – ☐

16t. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve*)
Note: *This entry should NOT be a percentage change but a numerical value.*

☐

16u. Was the performance target achieved?

◯ Yes ◯ No

Measure 2b:

16v. Restate Measure 2b name from Criterion 24p of the Implementation Plan on file:

☐

16w. Baseline Assessment: Restate the baseline results from Criterion 24r of the Implementation Plan on file by **either**:

- Calculating the rate and providing the associated numerator and denominator (Note: the numerator and denominator should calculate to the rate provided),

  Calculated Rate: ☐

  Numerator: ☐

  Denominator: ☐

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: ☐

16x. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 24h:

[ ] – [ ]

16y. Provide the Progress Report results by **either:**

- Calculating the rate and providing the associated numerator and denominator (***Note:*** *The numerator and denominator should calculate to the rate provided):*

  Calculated Rate: [ ]

  Numerator: [ ]

  Denominator: [ ]

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: [ ]

16z. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

[ ] – [ ]

16aa. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve*)
Note: *This entry should NOT be a percentage change but a numerical value.*

[ ]

16bb. Was the performance target achieved?

◯ Yes ◯ No

17. Summary of Progress (Must Pass)

17a. Please provide a summary of progress covering the following details:

- Indicate why progress was or was not made toward the performance target(s) documented in Element 24 of your QIS Implementation Plan on file, and
- Include a description of activities that led to the outcome.

(1,000 character limit)

17b. If the issuer selected **"Progress Report Closeout Form"** in Element 1 of *this* Progress Report form, provide the rationale for discontinuing the QIS.

(1,000 character limit)

17c. If the issuer received an **"Interim Meets"** determination during the previous Post-certification Assessment (PCA) period and was instructed to address the deficiencies in their subsequent Plan Year submission, please indicate which elements and/or criteria you updated based on PCA Notices and describe the changes.

(1,000 character limit)

18. Barriers and Mitigation Activities

18a. Were barriers encountered in implementing the QIS?

○ Yes ○ No

If "Yes," describe:

- The barriers, and
- The mitigation activities implemented to address **each** barrier.

(1,500 character limit)

18b. Were there problems meeting timelines as indicated in Element 25 of the QIS Implementation Plan on file?

○ Yes ○ No

If "Yes," describe:

- The problems in meeting timelines, and
- The mitigation activities implemented to address **each** problem in meeting the timeline.

(1,500 character limit)

Optional: *If there is any additional information you would like to provide regarding your QIS Progress Report, please do so in the box below.*

(1,500 character limit)

Appendix H

Stand-Alone Dental Supplemental Benefits Form

Dental Benefits Template

1. Dental Benefits Template, click here.

Note: Carriers may also reach out to HBX Plan Management team via email at carrier.hbxinquiries@dc.gov to request a copy of the checklist listed above.

Dental Benefits Template

Guidance for Dental Benefit Supplemental Form

To make for a smooth portal rollout and minimize the need to request clarification, carrier teams completing the Dental Benefit Supplemental Form (Appendix H) should note the following:

1. Do NOT merge the cells (e.g., when annual maximum is $1000 in both in-network and out-of-network, do NOT merge the cells; fill out in each cell.)
2. Do NOT enter just numbers; use $ or % as appropriate (e.g., entering just “50” leaves it unclear whether it should be “$50” or “50%”).
3. Do NOT enter off-exchange plans.
4. Under the Waiting Period columns, do NOT use “Not Applicable”. Use “None” or describe waiting period at each service class level, e.g. “No waiting for Class I, 6-month for Class II, 12-month for Class III, IV & V”.
5. When a benefit is not covered, use “Not a Covered Benefit”. Do NOT use “NA”, “Not Covered”, “Not a benefit”, “Not Applicable”, or “100%”.
6. Enter “No Charge” instead of “$0” or “0%”.
7. Ensure that data is entered correctly. In the past, there have been discrepancies between the benefit brochures and Dental Benefit Supplemental Form.
8. Coinsurance values should always reflect the percentage the member pays, not what the carrier pays.
9. For each benefit, carriers should explicitly state if the coinsurance/copay is subject to the deductible (similar to SERFF benefit filings).

DC HEALTH LINK
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Issuer ID	HIOS ID (Standard Component + Variant)	Plan Marketing Name	Plan Type (PPO/HMO)	High/Low

Maximum Out-of-pocket			
Individual		Family	
Pediatric In-Network	Pediatric Out-of-Network	Pediatric In-Network	Pediatric Out-of-Network

Deductible							
Individual				Family			
Pediatric In-Network	Adult In-Network	Pediatric Out-of-Network	Adult Out-of-Network	Pediatric In-Network	Adult In-Network	Pediatric Out-of-Network	Adult Out-of-Network

Annual Maximum Benefit					
Individual		Family		Waiting Period	
Adult In-Network	Adult Out-of-Network	Adult In-Network	Adult Out-of-Network	Pediatric	Adult

Preventative and Diagnostic Services (Class I)

Oral Exams			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Prophylaxis (cleanings)			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Bitewing X-Rays			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Flouride Treatments			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Full Mouth X-Rays			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Sealants on permanent molars

Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Space Maintainers			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Palliative Treatments			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Preventative and Diagnostic Services (Class I)

Emergency Oral Exam

Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Basic Services (Class II)			
Direct placement Fillings			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Basic Services (Class II)			
Simple Extractions			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Basic Services (Class II)			
Periodontal scaling and root planing			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Surgical (Class III)			
Surgical periodontic services			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Surgical (Class III)			
Endodontics			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Surgical (Class III)			
Oral Surgery			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Surgical (Class III)			
General anesthesia			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Restorative (Class IV)			
Full and/or partial dentures			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Restorative (Class IV)			
Crowns, inlays, and onlays			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Restorative (Class IV)			
Replacement of crows, inlays, and/or bridges			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Restorative (Class IV)			
Denture Adjustments and relining			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Restorative (Class IV)			
Repair of prosthetic appliances			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Major Services - Restorative (Class IV)			
Dental implants, fixed bridges			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Orthodontic Services (Class V)			
Orthodontia			
Pediatric In-Network	Adult In-Network	Pediatric Out-Of-Network	Adult Out-of-Network

Appendix I

Supplemental Template for Formulary and Network URLs

Supplemental Formulary/ URL Template

1. For a fillable copy of the template, click here.