DC Health Link Carrier Reference Manual

2019

May 2018
V.1

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I. Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. A key provision of the law 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*, effective March 3, 2012.[1]

The *Health Benefit Exchange Authority Establishment Act of 2011* 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.[2]

The DC Health Benefit Exchange Authority (the "Authority") 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)
- 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 the Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. This manual and appendices document the rules and policies that have been adopted by the Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2019. Health and dental carriers offering coverage in the individual and/or small group

[1] 58 D.C. REG. 213 (Mar. 23, 2012).
[2] *Id.*

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 the Authority. The Authority willcontract 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.

The Authority 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 2019.

Pediatric vision and dental benefits in the Federal Employees Dental and Vision Insurance Program (FEDVIP) with the largest national enrollment have been defined as the pediatric vision and pediatric dental essential health benefits.

Habilitative services have been defined as services that help a person keep, learn, or improve skills, and functioning for daily living, including, but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder.

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

1. District-required Benefits
2. EHB Benchmark Plan Information

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

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

Further guidance on the EHB benchmark package, including an itemized list of required benefits, can be found on the website of the District of Columbia Department of Insurance, Securities and Banking (DISB): http://disb.dc.gov, or by clicking here.

IV. Network Adequacy

A carrier is required to submit the Center for Consumer Information and 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 on-line 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 the Authority 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.

[3] "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).

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 the Authority a copy of the insurance contract also known as a certificate of coverage/evidence of coverage for each certified qualified health plan. Submission to the Authority 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 2019 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.[4] The index rate must be developed by pooling individual and small group market experience at the licensed entity level. The merged risk pool does not change how carriers may choose to offer plans in the individual or small group markets. For federal reporting purposes, carriers shall use unmerged market standards.[5]

[4] 45 C.F.R. § 156.80(c), D.C. CODE § 31-3311.03b(c).
[5] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review," 78 FED. REG. 13406, 13423 (Feb. 27, 2013).

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

The index rate for federal reporting must be the same for individual and small group markets. 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.[8]

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:

[6] 45 C.F.R. § 156.80(e).
[7] 45 C.F.R. § 156.80(d)(2)(v).
[8] 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. The Authority 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.[9] 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 AV Calculator also incorporates health savings accounts (HSAs) and health reimbursement arrangements (HRAs) that are integrated with group health plans if the amounts 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").[10]

D. Rate Development and Review

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

The Authority 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 the Authority. Consulting actuarial review of the assumptions in carrier rate filings and the actuarial reports will be published on an Authority webpage and submitted to DISB for consideration. Published reports will not contain confidential information provided by carriers.

[9] 45 C.F.R. § 156.140(c).
[10] "Revised Final 2018 Actuarial Value Calculator Methodology," published by CMS (Apr. 13, 2017)

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

If a carrier voluntarily provides its rate filing to the Authority and works with the Authority's consulting actuaries, the Authority will provide a special on-line designation to the carrier's QHPs. The Authority will also provide a written recommendation to DISB for approval of the rate by DISB. Additional information on the rate submission process and timeline is included below.

DISB shall, after the May 1, 2018 due date, 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.[11] 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).[12] This requirement does not apply to catastrophic plans or HSA-compatible plans.

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

The Authority requires carriers to use the standard federal format for SBCs submitted QHPs and carrier specific Benefit Summaries for QDPs.

A. Format and File Name Conventions

Prior to submission to the Authority, SBCs (QHP) and Benefit Summaries (QDP) must be created and saved in the PDF file format (.pdf). Failure to use this format (and the associated file extension) will result in delays in processing.

[11] Resolution to Determine a Separate Deductible for Pediatric Dental Benefits (May 14, 2014).
[12] Resolution to Adopt a Recommendation Regarding Separate Deductible for Pediatric Dental Benefits Offered in QHPs (Nov. 12, 2014).

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

Examples of Correct Naming Conventions

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: Please **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 is **August 17, 2018**, and will be loaded into DC Health Link by the Authority's Plan Management staff in advance of scheduled carrier plan and rate benefit testing.

The deadline for corrected SBCs is **September 19, 2018**.

IX. Carrier Submission Process for Qualified Health Plans

The Authority, in coordination with DISB, has set forth the following timeline for QHP certification and re-certification for 2019:

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

For plan year 2019, federal template submissions will not be required until the conclusion of the plan forms review by DISB and the Authority. All required federal templates will be submitted through SERFF and passed to DC Health Link.

Plan Form Filing Deadline May 1, 2018

Rate Filing Deadline June 1, 2018

Federal Templates Filing Deadline July 30, 2018

QHP SBC Submission Deadline August 17, 2018

Final SBC Revision Deadline September 19, 2018[13]

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

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

DISB and the Authority will notify carriers of form approval no later than July 17, 2018 and rate approval no later than September 14, 2018. DC Health Link Certification will also be concluded no later than September 30, 2018.

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:

[13] No SBC corrections, unless previously authorized by the Authority, will be accepted beyond this date.

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 DC Health Link via SERFF no later than **July 30, 2018**. Failure to meet this deadline 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 the Authority. A standard contract will be used. The Authority 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 DC Health Link rules and policies.

D. Trading Partner Agreement

Any health carrier that has not offered plans/products on DC Health Link for the first time in plan year 2019 must sign and submit the DC Health Benefit Exchange Authority Trading Partner Agreement (TPA) in order to begin technical on-boarding, electronic data interchange (EDI) connectivity, and scenario testing.

X. Carrier Submission Process for Qualified Dental Plans

The process for QDP submissions is similar to the process for QHPs.

The Authority, in coordination with DISB, has set forth the following timeline for QDP renewal, recertification, and any new plan offerings for 2019:

Plan Form Filing Deadline May 1, 2018

Rate Filing Deadline June 1, 2018

Federal Template Filing Deadline July 30, 2018

QDP Benefit Summary Submission Deadline August 17, 2018

Final QDP Benefit Summary Revision Deadline September 19, 2018

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 the Authority 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 DC Health Link via SERFF no later than **July 30, 2018**. Failure to meet this deadline 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 QDPs. Consequently, carriers that offer coverage through the DC Health Link will be required to enter into a contract with the Authority. A standard contract will be used. The Authority 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 DC Health Link rules and policies.

D. Trading Partner Agreement

Any dental carrier that has not offered plans/products on DC Health Link for the first time in plan year 2019 must sign and submit the DC Health Benefit Exchange Authority Trading Partner Agreement 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 qualified plan certification process for participation in DC Health Link. A 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 DC Health Link, HHS, and DISB in plain language that the intended audience, including individuals with limited English proficiency, can readily understand and use. DC Health Link 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

[14] 45 C.F.R. § 156.220(d).
[15] 45 C.F.R. § 156.220(a).

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.

In accordance with 45 C.F.R. § 156.275, DC Health Link 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. The Authority 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, https://dchealthlink.com/individuals/plan-info/health-plans). The Authority 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 the Authority 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 the Authority. 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, the Authority 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 the Authority and HHS. Carriers must assist the Authority in its obligation to produce timely and accurate annual federal tax forms and to report IRS-related data on a monthly basis.

Carriers and the Authority 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 Certification

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

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 For 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.

Please download the URRT from the HIX web page, 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.

The completed URRT must be downloaded from the HIX page, completed, and included on every applicable health insurance rate filing beginning March 28, 2013.

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 URRT are as follows:
- **Part I (Unified Rate Review Template)**
    a. Historical and projected claims experience
    b. Trend projections related to utilization, and service or unit cost
    c. Any claims assumptions related to benefit changes
    d. Allocation of the overall rate increase to claims and non-claims costs
    e. Per enrollee per month allocation of current and projected premium
    f. Three year history of rate increases for the product associated with the rate increase

- **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. Non-Benefit Expenses
        i) Administrative Costs of Programs that Improve Health Care Quality
        ii) Taxes and Licensing or Regulatory Fees
    i. Projected Loss Ratio
    j. Index Rate

k. Market Adjusted Index Rate
l. AV Value
m. Benefit/Metal level(s)
n. Calibration
o. Consumer Adjusted Premium Rate Development
p. Past experience
q. Rating Factors
r. Credibility assumption
s. Trend assumption
t. Cost-sharing changes
u. Benefit changes
v. Claim reserve needs
w. Reliance
x. 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 ***)

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

DISB Rate Filing & Form Filing Checklists

Form Review Checklist

V3_Created April 20, 2018

Company Name:	
Product Type:	
Product Name:	
Plan:	
SERFF Tracking Number:	
Plan Form Number:	
Market	☐ Individual ☐ Small Group

☐	60% AV (Bronze)
☐	70% AV (Silver)
☐	80% AV (Gold)
☐	90% AV (Platinum)
☐	Catastrophic

Instructions

1. Issuers are requested to complete the checklist for Plan Year 2019. While not required, the Department of Insurance, Banking, and Securities (DISB) and DC Health Benefit Exchange Authority (HBX) strongly prefer issuers complete the checklist to facilitate a more effective and efficient form filing review process. At a minimum, providing the page number and/or confirmation for applicable requirements will allow DISB and HBX to streamline the review and issuer communication processes. In the future, the checklist is to be submitted along with form filing, however for the 2019 plan year we will accept submission along with binder templates.
2. Only one checklist must be completed for all plan variations that are included in the filing submission.
3. In the applicable column, identify the form and page number where the provision is located. If a provision is applicable but is not required to be a policy provision, please confirm compliance with the requirement by writing 'Yes.'
4. Any exceptions to compliance with the checklist requirements must be noted on the checklist and explained in a separate document referencing the specific form numbers.
5. The completed checklist and any accompanying explanation must be submitted under the SERFF Supporting Documentation tab.

6. This checklist is intended only as a guide to be used for the preparation of Marketplace form filings. The checklist identifies and summarizes relevant statutes, rules and bulletins but is not an exhaustive or complete statement of all applicable requirements and provisions.
7. To fill out the checklist below:
   YES: Check this box if all contract provisions in the section meet minimum requirements.
   NO: Check this box if any of the contract provisions do not meet minimum requirements, restrict coverage in a way not allowed by law, or for any other reason are inconsistent with the law.
   N/A: Check this box if a contract does not have to meet this requirement (e.g., does not use Primary Care Physicians and therefore does not have to include designation of PCP option).

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Guaranteed availability of coverage Carriers that offer coverage in a state must accept every individual or employer in that state that applies for coverage, subject to certain exceptions **Federal & DC Law** • PHS Act § 2702 (42 U.S.C. § 300gg-1) • 45 C.F.R. § 147.104: Guaranteed availability of coverage • 45 C.F.R. § 155.420 Special enrollment periods • Patient Protection and Affordable Care Act; Market Stabilization, 82 FED. REG. 18346, 18351-18353 (Apr. 18, 2017) • D.C. Code § 31-3302.01: guaranteed availability	Exceptions to guaranteed availability • Enrollment may be restricted to open or special enrollment periods (SEPs)		✓	✓			
Guaranteed renewability of coverage Issuers must renew or continue in force coverage at the option of the plan sponsor or individual with six exceptions: • Nonpayment of premiums • Fraud • Violation of participation or contribution rules (SHOP) • Termination of product • Enrollees' movement outside service area • Association membership ceases	Uniform modification of coverage exception: issuers can modify an individual or group health plan's coverage only at the time of renewal. For individual and SHOP, the modification must be consistent with state law and effective uniformly for all individuals with that product. • **Notice requirement:** if a carrier makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the carrier must provide notice of the modification not later than 60 days prior to the date on which the modification will become effective.		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Federal & DC Law • PHS Act § 2703 (42 U.S.C. § 300gg-2) • PHS Act § 2715 (42 U.S.C. § 300gg-15) • 45 C.F.R. § 147.106: Guaranteed renewability of coverage • 45 C.F.R. § 147.200(b): Summary of benefits and coverage and uniform glossary • Patient Protection and Affordable Care Act; Market Stabilization, 82 FED. REG. 18346, 18351-18353 (Apr. 18, 2017) • D.C. Code § 31-3302.05: Individual renewability • D.C. Code § 31-3303.03: Small group renewability • 26A DCMR 3513.4: Renewability for HMOs							
Preexisting condition exclusions Carriers of group and individual health insurance coverage may not apply pre-existing condition exclusions to any individual or enrollee. **Federal & DC Law** • PHS Act § 2704 (42 U.S.C. § 300gg-3) • 45 C.F.R. § 144.103: Definition of preexisting condition exclusion • 45 C.F.R. § 146.111: Preexisting condition exclusions (group) • 45 C.F.R. § 147.108: Prohibition of preexisting condition exclusions (IVL and group) • D.C. Code § 31-3303.07: Limits on pre-existing condition period (group) • D.C. Code § 33-3303.12 and 33-3303.13: Affiliation period (HMOs) • D.C. Code § 31-3302.01-.02: Individual - health insurer cannot discriminate based on health status) • D.C. Code § 31-3303.06: Small employer - no exclusions based on health status) • D.C. Code § 31-3303.09: Group plan may not establish rules for eligibility of any individual to enroll based on health status-related factors.			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Essential Health Benefits (EHB): Coverage of EHB Issuers must provide benefits that are substantially equal to the EHB-benchmark plan, including covered benefits and limitations on coverage, for the following categories: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance use disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care **<u>Federal & DC Law</u>** • PHS Act § 2707 (42 U.S.C. § 300gg-6) • PHSA §2711 • 45 C.F.R. § 147.150: Coverage of essential health benefits • 45 C.F.R. § 156.115: Provision of EHB • 45 C.F.R. § 156.125: Prohibition on discrimination • 45 C.F.R. § 156.200(e): QHP issuer participation standards • D.C. Code § 31-3171.09: QHP certification requires providing EHB per federal law • D.C. Code § 31-3272: Habilitative services for children under 21. • See DC benchmark plan information: https://www.cms.gov/cciio/resources/data-resources/ehb.html#District%20of%20Columbia	**DC does not permit benefit substitutions.** Excluded from EHB even though an EHB benchmark plan may cover them: • Adult dental, adult vision, long-term/custodial nursing home care benefits, non-medically necessary orthodontia • Abortion services **Carriers cannot exclude or limit these benefits that are in the DC benchmark:** • Reversal of voluntary sterilization o Benchmark: surgical reversal of voluntary sterilization is covered in the benchmark plan for all members (male and female). Description of covered services, p.[B][5] and [B][6]. • Surgical treatment for temporomandibular joint syndrome o Benchmark: covered benefit under oral surgery: "Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness." Description of Covered Services, p.[B][12] • Hospice – family and bereavement counseling o Benchmark – family counseling: "Family Counseling will be provided for the Immediate Family and the Family Caregiver before the death of the terminally ill Member, when authorized or approved by CareFirst[.]" Description of Covered Services, p.[B][28]. o Benchmark – bereavement counseling: "Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first." Description of Covered Services, p.[B][28].		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
	Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply.						
☐ **No annual limits on the dollar value of EHB:** ☐ Ambulatory patient services ☐ Emergency services ☐ Hospitalization ☐ Maternity and newborn care ☐ Mental health and substance use disorder services, including behavioral health treatment ☐ Prescription drugs ☐ Rehabilitative and habilitative services and devices ☐ Laboratory services ☐ Preventive and wellness services and chronic disease management ☐ Pediatric services, including oral and vision care Federal & DC Law • PHSA §2711 • 75 Fed Reg 37188 • 45 CFR §147.126 • D.C. Code § 31-3272: Habilitative services for children under 21.			✓	✓			
EHB: Prescription Drug Benefits To provide EHB, a plan must: 1. Provide benefits that cover at least the greater of one drug in every U.S. Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB-benchmark plan, and	**Carriers cannot exclude or limit these benefits that are in the DC benchmark:** • Methadone maintenance treatment o Benchmark: "methadone maintenance treatment" is a covered benefit. Description of covered services, p.[B][31].		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
2. Have procedures in place to allow an enrollee to request an exception and gain access to clinically appropriate drugs not covered by the health plan. **Federal & DC Law** • 45 C.F.R. § 156.122: Prescription drug benefits o **Note:** exceptions process for non-formulary drugs is described in 45 C.F.R. § 156.122(c) • D.C. Code § 31-3171.09	• Insurers, HMOs and Pre-paid Health Services Plans (PHSPs) are required to provide a standard and expedited formulary exception process for the insured or the insured's designee and the insured's prescribing health care professional to request a formulary exception for a clinically-appropriate prescription drug that is not on the formulary. For standard formulary exception requests, the insurer, HMO or PHSP is required to make a decision and notify the insured or the insured's designee and the prescribing health care professional no later than 72 hours after receipt of the request. For expedited requests, the insurer, HMO or PHSP is required to make a decision and notify the insured or the insured's designee and the prescribing health care professional no later than 24 hours after receipt of the request. An internal appeal of a formulary exception denial is only permitted if the initial review of the request and the appeal are both completed within the initial review time frames (24 hours for expedited, 72 hours for standard). **Model language** "If a prescription drug is not on our formulary, you, your designee or your prescribing health care professional may request a formulary exception for a clinically-appropriate prescription drug in writing, electronically or telephonically."						
Maternity coverage (see EHB) and required benefits for hospital stays in connection with childbirth: • Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. EXCEPTION: this does not apply if the provider, in • Consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. • No prior authorization required for 48/96 hour hospital stay. • Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital.			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
The issuer is not allowed to: • Deny the mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements; • Provide monetary payments/rebates to encourage mothers to accept less than the minimum requirements; • Penalize an attending provider who provides services in accordance with these requirements; • Provide incentives to an attending provider to induce the provider to provide care inconsistent with these requirements; • Restrict benefits for any portion of a period within the 48/96-hour stay in a manner less favorable than the benefits provided for any preceding portion of such stay; • Require the mother to give birth in a hospital; and • Require the mother to stay in the hospital for a fixed period of time following the birth of her child. *An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother.* Federal & DC Law • PHSA §2725 • 45 CFR §146.130 • D.C. Code § 31-3802 – Coverage for postpartum care							
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) A carrier that provides mental health or substance use disorder (MH/SUD) benefits and medical/surgical (med/surg) benefits must comply with parity requirements for:	Common issues • Prior authorization requirements that are not imposed on medical/surgical services • Treatment plan requirements • Benefits restricted for failure to follow a course of treatment		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• Lifetime and annual dollar limits, • Financial requirements • Quantitative treatment limits, • Cumulative financial requirements and quantitative treatment limits, and • Non-quantitative treatment limits (NQTLs) The processes, strategies, evidentiary standards, or other factors used in applying a NQTL to MH/SUD benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to med/surg benefits in the same classification. ☐ **Completed Mental Health Parity and Addiction Equity Act Checklist and Certification is included with filing.** **Federal & DC Law** • PHS Act § 2726 (42 U.S.C. § 300gg-26) • 45 C.F.R. § 146.136: Parity in mental health and substance use disorder benefits (small group) • 45 C.F.R. § 147.160: Applies 45 C.F.R. § 146.136 to IVL • 45 C.F.R. § 156.115(a)(3): Applies 45 C.F.R. § 146.136 to IVL and SHOP QHPs	• Uneven application of medical necessity criteria to behavioral health benefits relative to med/surg benefits • Higher cost sharing amounts for mental health or substance use disorder benefits than for med/surg MHPAEA applies to benefits for Medication Assisted Treatment (MAT) for opioid use disorder: • Q11, CCIIO FAQs set 31 (4/20/16) • Q6-Q9, CCIIO FAQs set 34 (10/27/16)						
D.C. Code §31-3101 (DC Law 16-242) Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage/Expansion of Substance Abuse and Mental Illness Insurance Coverage Amendment Act of 2006 Amended D.C. Code§ 31-3102 to state each health insurer that offers individual or group health plans or certificates issued or delivered in the District to an employer or individual shall provide coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness.							
Drug Abuse, Alcohol Abuse, Mental Illness Act of 1986 (D.C.) D.C. Code § 31-3102: Except as otherwise provided, each health insurer shall provide coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness.			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Covered benefits for drug abuse, alcohol abuse, and mental illness shall be limited to inpatient, residential, and outpatient services certified as necessary by a physician, psychologist, advanced practice registered nurse, or social worker. All drug abuse, alcohol abuse, and mental illness treatment or services eligible for health insurance coverage shall be subject to peer review procedures. These procedures may be initiated by a health insurer in the course of reviewing claims for payment. All individual health benefit plans or certificates shall offer coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness. **Drug Abuse, Alcohol Abuse** D.C. Code §§ 31-3102, 3103, 3110: • Treatment covered minimum 12 days annually • Additional treatment, minimum 60 days per year at a minimum rate of 75% for first 40 outpatient visits/year and 60% for an outpatient visits thereafter • Does not alter terms and conditions of HMO membership contract relating to prior approval **Mental Illness** D.C. Code § 31-3104: • Covered benefits limited to coverage of treatment of clinically significant mental illnesses identified in the most recent edition of the International Classification of Diseases or of the Diagnostic and Statistical Manual of the American Psychiatric Association. • Treatment shall be covered for a minimum of 60 days per year for inpatient or residential care in a hospital or nonhospital residential facility, and at a minimum rate of 75% for the first 40 outpatient visits per year and at a minimum rate of 60% for any outpatient visits thereafter for that year. • Does not alter terms and conditions of HMO membership contract relating to prior approval							

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Exemptions D.C. Code § 31-3105: • Methods of determining levels of payment or reimbursement for services, or for the type of facility charge eligible for payment or reimbursement under this chapter, shall be consistent with those for physical illnesses in general and shall take into consideration usual, customary, and reasonable charges for those services.							
Prohibition on excessive waiting periods* *applies to group coverage, not individual A carrier may not apply any waiting period that exceeds 90 days. A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective. Being otherwise eligible to enroll means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). **Federal & DC Law** • PHS Act §§ 2704(b)(4), 2706 (42 U.S.C. §§ 300gg-3(b)(4), 300gg-7) • 45 C.F.R. § 147.116: Prohibition on waiting periods that exceed 90 days	• **Exception:** Carriers may not impose a waiting period on pediatric orthodontia. CCIIO FAQ 5/26/16.			✓			
Coverage of clinical trials Carriers that cover a "qualified individual" may not: • Deny the individual from participating in an approved clinical trial; • Deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection to the individual's participation in the trial; or • Discriminate against the individual on the basis of the individual's participation in the trial.	**DC & FEDERAL LAW:** a QHP must cover routine patient costs for clinical trials for the prevention, detection, treatment, or monitoring of cancer, life-threatening disease or condition, or chronic disease. Routine patient costs for items and services to diagnose or treat complications or adverse events arising from participation in an approved clinical trial = items and services furnished in connection with participation in a clinical trial and must be covered if the carrier typically covers the items or services for a qualified individual who is not enrolled in a clinical trial. (Q5, Q6, CCIIO FAQs set 31 (4/20/16))		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
If an in-network provider is participating in a clinical trial, the issuer may require participation in the trial through the participating provider if the provider will accept the individual as a participant. • An individual may participate in an approved clinical trial conducted outside the state in which the individual resides. • "Qualified individual" means an individual that is eligible to participate according to trial protocol and referring health care professional/ medical information establishing appropriateness. • "Approved clinical trial" means a phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. **Federal & DC Law** • PHS Act § 2709 (42 U.S.C. § 300gg-8) • D.C. Code § 31-2993.01: definitions • D.C. Code § 31-2993.02: covered trials • D.C. Code § 31-2993.03: right to file grievance							
No lifetime or annual dollar limits on EHB Carriers may not establish any lifetime or annual dollar limits on EHBs. Any dollar limits imposed by the EHB-benchmark plan may be converted to actuarially-equivalent non-dollar limits (such as day or visit limits). **Federal & DC Law** • PHS Act § 2711 (42 U.S.C. § 300gg-11) • 45 C.F.R. § 147.126(a)(2): No lifetime or annual limits • D.C. Bulletin 10-IB-02-08/10			✓	✓			
Rescissions	FAQs: Q7, CCIIO FAQs set 2 (10/8/10); Q3, CCIIO FAQs set 31 (4/20/16)		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid. Carriers may not rescind coverage unless the covered individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. Prior to rescinding coverage, a carrier must provide at least **30 days** advance written notice to each participant who would be affected. **Federal & DC Law** • PHS Act § 2712 (42 U.S.C. § 300gg-12) • 45 C.F.R. § 147.106: Guaranteed renewability of coverage • 45 C.F.R. § 147.128: Rules regarding rescissions • D.C. Code § 31-3302.05: IVL renewability • D.C. Code § 31-3303.03: Small group renewability • D.C. Code § 31-3311.06: Post-claims underwriting and prior approval for rescission, cancellation, or limitation							
Dependent coverage until 26 years of age A carrier that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age. **In DC, dependent child is removed from plan at end of calendar year in which s/he turns 26.** Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: • Financial dependency on primary subscriber, • Residency, • Student status, • Employment,	Eligible if under age 26: - Biological children - Stepchildren - Legally adopted children - Foster children, including any children placed with primary subscriber for adoption - Any children the primary subscriber is responsible for under a qualified medical support order or court-order (whether or not the child resides with the primary subscriber) - Grandchildren in the primary subscriber's court-ordered custody - A grandchild when his/her parent is a covered dependent under this plan - Any other child with whom the primary subscriber has a parent-child relationship - Any children approved by the Exchange		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• Eligibility for other coverage, • Marital status. ☐ Terms of the policy for dependent coverage cannot vary based on the age of a child. **Federal & DC Law** • PHS Act § 2714 (42 U.S.C. § 300gg-14) • 45 C.F.R. § 147.120: Eligibility of children until at least age 26 • D.C. Code § 31-4712(b)(1)(J) • D.C. Code § 31-2996.02: Same health benefits to dependent child – up to age 26 – as any other covered dependent • D.C. Code § 31-4724: - coverage of minor children in group policies.	Impermissible restriction example: Adult child can stay on parent's coverage only if child spends at least 6 months in the state. Issuers are not required to cover the child of a child dependent.						
Internal claims and appeals, external review processes Carriers must implement an effective internal claims and appeals process, which includes, but is not limited to: • Providing notice of available internal and external appeals processes; • Providing notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established to assist such enrollees with the appeals processes; and • Allowing an enrollee to review the claim file and present evidence and testimony as part of the internal claims and appeals process. **Federal & DC Law** • PHS Act § 2719 (42 U.S.C. § 300gg-19) • 45 C.F.R. § 147.136: Internal claims and appeals and external review processes • 29 CFR § 2560.503-1 • D.C. Code 44-301.03: Grievance system • D.C. Code § 44-301.06: Formal internal appeals process • D.C. Code § 44-301.07: Formal external appeals process for matters other than rescissions	Enrollees have: • Right to info about why a claim or coverage was denied, including how you can appeal the denial decision • Right to appeal to the insurance company (internal appeals process) • Right to an independent review (external review)		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• D.C. Code § 44-301.08: Independent review organizations							
Claims procedures, including applicable time frames **General requirements:** Required to include a description of: • Claims procedures; • Procedures for obtaining prior approval; • Preauthorization procedures; • Utilization review procedures; and • Applicable time frames. The claims procedure cannot unduly inhibit the initiation or processing of claims. A "claim for benefits" is a request for benefits made by a claimant in accordance with an issuer's reasonable procedure for filing benefit claims, including pre-service and post-service claims. A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations— (A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; except that any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" that meets either (A) or (B) above shall be treated as a claim involving urgent care.			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Time and process for urgent care (pre-service, post-service): • Determination for urgent care made within 72 hours. • Notice of the determination within 72 hours of receipt of the claim. • Notice of urgent care decisions include a description of the expedited review process applicable to such claim. • No extension of the determination time-frame is permitted. • If the claimant fails to provide sufficient information, issuer must notify the claimant within 24 hours and must include specific information necessary to complete the claim. • The claimant must have at least 48 hours to provide the specified information. • A determination must be made within 48 hours of receiving specified information or expiration of time afforded to the claimant to provide the specified information (whichever is earlier). **Time and process for concurrent urgent care (at the request of the claimant):** • Claim for concurrent urgent care: if a claimant requests to extend the course of treatment beyond time/number of treatments. • Claim must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. • Determination must be made within 24 hours. • Notification is required within 24 hours of the claim's request. **Time and process for pre-service claim:** • Determination for a pre-service claim must be made within 15 days of the request of the claim. • Notice of the determination within 15 days of the claim. • Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. • Notice required of the extension prior to the expiration of the initial 15-day period, • The issuer must identify for the claimant the circumstances requiring the extension and date by which the issuer expects to render a decision.							

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• If the claimant fails to provide sufficient information, the issuer must notify the claimant and specifically describe the required information needed to render a decision. • Claimant has 45 days from receipt of notice of insufficient information to provide specified information. **Time and process for on-going services/treatment (concurrent care decisions):** • Reduction/termination of benefits of ongoing courses of treatment (concurrent care) before the end of the time/treatments is considered an adverse benefit determination. • Determination for concurrent care must be made sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. • Notice of the determination sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. **Time and process for post-service claim:** • Determination for post-service claim must be made within 30 days of receipt of claim. • Notice of the determination within 30 days of receipt of the claim. • Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer: • Notice of the extension must be provided to the claimant prior to expiration of the initial 30-day period. • The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision. • If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information necessary to render a decision. • The claimant has at least 45 days from the receipt of notice to provide the specified information.							

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Standards for all required notices: • Issuer must provide the claimant with written electronic notification of any adverse benefit determination for pre-service, post-service, and concurrent treatment claims. • All notices of adverse benefit determination (including final internal adverse benefit determinations) must be provided in a culturally and linguistically appropriate manner and must include: • Information sufficient to identify the claim involved • including: date of service, health care provider, and, upon request, diagnosis/treatment codes and their meanings; • Specific reason for the adverse determination, including the denial code and its corresponding meaning and a description of the issuer's standard that was used in denying the claim. • A final internal adverse benefit decision must include: o A discussion of the decision; o A description of available internal appeals and external review processes; and o A description of how to initiate an appeal. • An adverse benefit determination must describe: o Applicable expedited review process; and o Availability of and contact information for health insurance consumer assistance or ombudsman. Federal Laws 45 CFR §147.136 29 CFR §2560.503-1							
Internal appeals of adverse benefit determinations - processes, rights and required notices: • Enrollees have a right to appeal an adverse benefit determination. • Enrollees may review the claim file and present evidence and testimony as part of the internal appeals process.			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• Enrollees have at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal. • Enrollees must have access to an expedited review process. • Requests for expedited review must be allowed to be submitted orally or in writing. Pre-service claim: • Determination must be made within 30 days after receipt of the claimant's request. • Notice of the determination within 30 days after receipt of the claimant's request. Post-service claim: • Determination must be made within 60 days after receipt of the claimant's request. • Notice of the determination within 60 days after receipt of the claimant's request. Urgent claim: • Determination must be made within 72 hours after receipt of the claimant's request. • Notice of the determination within 72 hours after receipt of the claimant's request. • If claimant fails to provide sufficient information to determine covered/payable benefits for an urgent claim, the issuer must: o Notify the claimant within 24 hours of the information necessary to complete the claim. o Give the claimant at least 48 hours to provide the specified information. o Provide notice of the determination within 48 hours of the earlier of receiving the specified information and the end of the time period provided to return the specified information. • The issuer must provide the claimant with written or electronic notice of the determination in a culturally and linguistically appropriate manner.							

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In the case of an adverse benefit determination, the notification shall include: • Information sufficient to identify the claim involved (including date of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning); • Diagnosis/treatment codes and meanings must be provided as soon as practicable. Requests for this information cannot be considered a request for an internal appeal or external review; • Specific reason(s) for the determination, including the denial code and corresponding meaning, as well as a description of issuer's standard that was used in denying the claim (including a discussion of the decision in final internal adverse benefit determination); • Description of available internal appeals and external review processes • Information on how to initiate an appeal; • Information about the availability of, and contact information for, office of health insurance consumer assistance or ombudsman; and • A statement that the claimant is entitled to receive reasonable access to/copies of all documents, records, and other information relevant to the claim. An "*adverse benefit determination*" means a denial, reductions, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage must be treated as an adverse benefit determination.							

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If an issuer fails to adhere to all of the requirements listed with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate an external review or any remedies available under state law. • The internal claims and appeals process will not be deemed exhausted if the violation did not cause harm to the claimant so long as the issuer demonstrates that the violation was for good cause or due to matters beyond the control of the issuer, and • That the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the claimant. <u>Ongoing (concurrent care) decisions</u>: • Issuer is required to provide continued coverage pending the outcome of an appeal; • Must provide benefits for an ongoing course of treatment; and • Cannot reduce or terminate benefits. • Provide advance notice and an opportunity for a review in advance of reducing or terminating benefits. <u>Federal Laws</u> PHSA §2719 75 Fed Reg 43330 76 Fed Reg 37208 45 CFR §147.136							
External review processes rights and required notices: • External review of an adverse benefit determination for: o Medical necessity; o Appropriateness; o Health care setting; o Level of care; o Effectiveness of a covered benefit; and o Rescission.			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A

• External review of adverse benefit determinations for experimental or investigational treatments or services.
  o Have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
• Issuers must provide effective written notice to claimants of external review rights in plan materials, and in each notice of adverse benefit determination.
 	
• If exhaustion of internal appeals is required prior to external review, requirement to exhaust does not apply if:
  o Issuer did not meet internal appeal process timelines (with limited exceptions); or
  o In cases of urgent care.
• Cost of an external review must be borne by the issuer.
• Claimant cannot be charted a filing fee greater than $25.
• Restriction on the minimum dollar amount of a claim is not allowed.
• Claimant must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination (including final internal adverse benefit determination).
• IRO decision is binding on the issuer.
• For standard reviews (not urgent), the IRO must inform the issuer and the claimant in writing of its decision within 60 days from receipt of the request for review.
 	
Urgent care:
• The process must provide for expedited external review of urgent care claims.
• The IRO must inform the issuer and the claimant of an urgent care decision within 4 business days from receipt of the request for review.
• If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification.
 	
Federal Laws
PHSA §2719							

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
75 Fed Reg 43330 76 Fed Reg 37208 45 CFR §147.136							
Choice of health care professional If a carrier requires or provides for a participating primary care provider (PCP), then the carrier must permit each participant to designate <u>any</u> participating PCP who is available to accept the participant. **<u>Federal & DC Law</u>** • PHS Act § 2719A (42 U.S.C. § 300gg-19a) • 45 C.F.R. § 147.138(a)(1): Patient protections	**Notice requirement:** if group health plan or health insurance issuer requires the designation by a participant, beneficiary, or enrollee of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding: 1. Designation of a primary care provider **and** 2. The enrollee's right to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. **<u>Model language from regulation</u>** "[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information]."		✓	✓			
Choice of pediatrician as PCP If a carrier of group or individual health insurance coverage requires or allows for designation of a PCP for a child, a person shall be permitted to designate a physician who specializes in pediatrics (allopathic or osteopathic) as a child's primary care provider, if such provider participates in the network of the plan or issuer and is available to accept the child.	**Notice requirement:** if group health plan or health insurance issuer requires the designation by a participant, beneficiary, or enrollee of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding: • The enrollee's right to designate any participating physician who specializes in pediatrics as the primary care provider.		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
Federal & DC Law • PHS Act § 2719A (42 U.S.C. § 300gg-19a) • 45 C.F.R. § 147.138(a)(2): Patient protections • D.C. Bulletin 10-IB-02-08/10	**Model language from regulation** "For children, you may designate a pediatrician as the primary care provider."						
Patient access to obstetrical and gynecological (OB/GYN) care Carriers of group and individual health insurance coverage that provide coverage for OB/GYN care and requires the designation of a PCP: • May not require prior authorization or a referral for a female patient to see a participating provider specializing in OB/GYN care; and • Must permit OB/GYN providers to directly refer for or order OB/GYN-related items and services without prior authorization or approval of another provider, including a PCP. **Federal & DC Law** • PHS Act § 2719A (42 U.S.C. § 300gg-19a) • 45 C.F.R. § 147.138(a)(3): Patient protections • D.C. Code § 44-302.03: Direct access to OB/GYN	**Notice requirement:** if group health plan or health insurance issuer requires the designation by a participant, beneficiary, or enrollee of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding: • The plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. **Model language from regulation** "You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information]."		✓	✓			
Coverage of emergency services Carriers of group and individual health insurance coverage must cover emergency services benefits in a hospital must cover those services: • Without the need for a prior authorization determination; • Without regard to whether the provider furnishing such services is a participating provider with respect to such services; and	**NOTE:** SHOP plan participants may request documentation and data that the carrier used to calculate each of the minimum payment standards (including the UCR amount) for out-of-network emergency services. This information must be given within 30 days of request. (Q4, CCIIO FAQs set 31 (4/20/16)) **NOTE:** DC law requires coverage of one annual HIV screening test performed while enrollee is receiving emergency medical services at a hospital emergency department.		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• If such services are provided by an out of network provider, without imposing administrative requirements or coverage limitations that are more restrictive than or cost sharing requirements that exceed those that would apply if such services were provided in-network. **Federal & DC Law** • PHS Act § 2719A (42 U.S.C. § 300gg-19a) • 45 C.F.R. § 147.138(b): Patient protections • D.C. Code § 31-2802: Access to emergency medical services • D.C. Code § 31-2803: DC HIV screening in emergency room							

Coverage of preventive health services (general)
 	
Carriers of group and individual health insurance coverage must provide coverage of the following items and services without imposing any cost-sharing requirements:
• United States Preventive Services Task Force (USPSTF): A or B rated items or services with respect to the individual involved
• Immunizations for routine use in children, adolescents, and adults recommended by ACIP of the CDC (Q8, CCIIO FAQs set 12 (2/20/13))
• For infants, children, and adolescents, evidence-informed preventive care screenings supported by HRSA guidelines
• For women, evidence-informed preventive care screenings recommended by HRSA and not already included in recommendations by the USPSTF
 	
DC Mandates
• Colorectal cancer screenings: must be in compliance with American Cancer Society (ACS) recommendations (which are broader than USPSTF). DC law permits carriers to require cost-sharing for ACS recommended screenings.
• Prostate cancer screenings: must be in compliance with ACS recommendations , which say prostate-specific antigen (PSA) screening must be covered
	• **Reasonable medical management techniques OK:** to the extent the recommendation or guideline doesn't specify the frequency, method, treatment, or setting. 45 C.F.R. § 147.130(a)(4); Q8, CCIIO FAQs set 2 (10/8/10).
	  • OK to cover preventive service performed at in-network ambulatory surgical center without cost-sharing but impose cost-sharing if performed at in-network outpatient hospital, so long as plan accommodates anyone for whom it'd be medically inappropriate to have the preventive service at an ambulatory surgical center (to be covered without cost-sharing) Q1, CCIIO FAQs set 5 (12/22/10).
	
	• **Preventive services must be in-network:** carriers may impose cost-sharing if receive preventive services out-of-network. 45 C.F.R. § 147.130(a)(3)(i).
	  • Exception: no cost-sharing for a preventive service from an out-of-network provider if no in-network provider who can perform the preventive service. 45 C.F.R. § 147.130(a)(3)(ii); Q3, CCIIO FAQs set 12 (2/20/13).
			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
o Coverage shall not be more restrictive than or separate from coverage provided for any other illness, condition, or disorder • One annual HIV screening test while receiving emergency medical services in hospital emergency department **Federal & DC Law** • PHS Act § 2713 (42 U.S.C. § 300gg-13) • 45 C.F.R. § 147.130: Coverage of preventive health services • 45 CFR §156.155(b) • D.C. Code § 31-2803: DC HIV screening • D.C. Code § 31-2931: DC colorectal cancer screening • D.C. Code § 31-2952: DC prostate cancer screening	• **May get charged for office visit if:** • Preventive service is billed separately (or is tracked as individual encounter data separately) from the office visit. • If not tracked separately (or tracked as individual encounter data separately), but primary purpose of office visit wasn't to get the preventive service. 45 C.F.R. § 147.130(a)(2). • **Must cover preventive services for all enrollees, including dependent children** • If carrier covers dependent children, they must be provided full range of recommended preventive services applicable to them, such as preconception and prenatal care. Q6, CCIIO FAQs set 26 (5/11/15). • **Carriers cannot limit sex-specific preventive services based on an individual's sex assigned at birth, gender identity or recorded gender** • For example, must cover a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix, when the individual otherwise satisfies the criteria in the relevant recommendation or guideline as well as all applicable coverage requirements. Q5, CCIIO FAQs set 26 (5/11/15). • **Services ancillary to the preventive service must also be covered without cost-sharing** • For example, benefits in connection with screening colonoscopy that must be covered: o Polyp removal (Q5, CCIIO FAQs set 12 (2/20/13)) o Anesthesia (Q7, CCIIO FAQs set 26 (5/11/15)) o Specialist consultation prior to exam (Q7, CCIIO FAQs set 29 (10/23/15)) o Pathology exam on polyp biopsy (Q8, CCIIO FAQs set 29 (10/23/15))						

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
	o Bowel preparation medications (Q1, CCIIO FAQs set 31 (4/20/16)) • **Must cover weight management services for obesity:** screening for obesity in adults, and for adults with BMI of 30kg/m2 or higher, "intensive, multicomponent behavioral interventions." For example: • Group and individual sessions of high intensity (12 to 26 sessions in a year) • Behavioral management activities, such as weight loss goals • Improving diet or nutrition and increasing physical activity • Addressing barriers to change • Self-monitoring • Strategizing how to maintain lifestyle changes *Important: carriers may use reasonable medical management techniques to determine frequency, method, treatment, or setting for recommended preventive services, but cannot impose general exclusions that would include recommended preventive services. Q6, CCIIO FAQs set 29 (10/23/15). • **Updated recommendation on tobacco cessation for non-pregnant adults** • Must cover both behavioral interventions and FDA-approved pharmacotherapy for cessation to adults who use tobacco (USPSTF clinical summary, full recommendation statement). Q1, CCIIO FAQs set 34 (10/27/16). o Behavioral interventions: individual, group, and over the phone o Pharmacotherapy • Over-the-counter nicotine replacement products (3): transdermal nicotine patches, nicotine lozenges, and nicotine gum • Prescription-only nicotine replacement products (2): nicotine inhaler or nasal spray (Nicotrol®)						

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
	• Prescription-only bupropion hydrochloride sustained release (2): Zyban® or generic and varenicline tartrate (Chantix®), which do not contain nicotine.						
Coverage of women's preventive services (excluding contraception) **HRSA recommendations** **Federal & DC Law** • PHS Act § 2713 (42 U.S.C. § 300gg-13) • 45 C.F.R. § 147.130: Coverage of preventive health services • D.C. Code §§ 31-2901-2903: coverage of mammograms and cervical cytologic screenings for women • D.C. Code § 31-3802.01 Inpatient postpartum treatment; at-home post-delivery care	DC Mandates • Mammograms for women: must cover a baseline mammogram and an annual screening mammogram for women without cost-sharing when received in-network. "Baseline mammogram" means a screening mammogram that is used as a comparison for future examinations. "Screening mammogram" means a low dose x-ray used to visualize the internal structure of the breast. • Cervical cytologic screening for women: must cover an annual cervical cytologic screening and additional cervical cytologic screenings upon certification by an attending physician that the test is medically necessary without cost-sharing when received in-network. "Cytologic screening" means a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix. Notes • **BRCA genetic testing** (USPSTF recommendation): includes both genetic counseling and BRCA testing, if appropriate. Includes women who have not been diagnosed with BRCA-related cancer but have previously had breast cancer, ovarian cancer, or other cancer. Q6, CCIIO FAQs set 12 (2/20/13); Q1, CCIIO FAQs set 26 (5/11/15). • **Breastfeeding support, counseling, and equipment**: comprehensive prenatal and postnatal lactation support, counseling, and costs of renting or purchasing breastfeeding equipment in connection with each birth. Q18 and Q20, CCIIO FAQs set 12 (2/20/13) o Lactation counseling cannot be limited to inpatient setting (Q4, CCIIO FAQs set 29 (10/23/15)) o Must cover out-of-network lactation counseling providers if none in-network (Q2 and Q3, CCIIO FAQs set 29 (10/23/15)		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
	o Must cover rental or purchase of breastfeeding equipment for duration of breastfeeding, provided the individual remains continuously enrolled in the plan or coverage (Q5, CCIIO FAQs set 29 (10/23/15)) o DC law: for women discharged earlier than 48 hours after a vaginal delivery or earlier than 96 hours after a Caesarian delivery, carriers must cover post-delivery care in the patient's home or in a provider's office that includes, among other services, assistance and training in breast or bottle feeding.						
Coverage of women's preventive services: contraception **HRSA recommendations** **Federal & DC Law** • PHS Act § 2713 (42 U.S.C. § 300gg-13) • 45 C.F.R. § 147.130: Coverage of preventive health services • 45 C.F.R. § 147.131: Accommodations in connection with coverage of certain preventive health services • Defending Access to Women's Health Care Services Amendment Act of 2018 o Allows pharmacists to prescribe and dispense certain contraceptives pursuant to established protocols; to amend the Women's Health and Cancer Rights Federal Law Conformity Act of 2000 to require insurers to cover certain health care services without cost-sharing, to require that insurers authorize dispensing of up to a 12-month supply of a self-administered hormonal contraceptive prescribed and dispensed by a licensed pharmacist, to provide to certain employers a religious exemption from, or accommodation for, the coverage of contraceptive products and services, and to require insurers to provide information regarding coverage to enrollees and potential enrollees. o	Must cover without cost-sharing at least one form of contraception in each method identified by the FDA. The FDA currently has identified 18 distinct methods of contraception for women. **New for PY2019** HHS now provides an exemption from the contraceptive coverage mandate to entities and individuals that object to contraceptive coverage on the basis of sincerely held religious beliefs. Fact Sheet: Religious and Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act DC law: must allow for the dispensing of up to a 12-month supply of a covered prescription contraceptive at one time. Tips • Includes methods generally available over-the-counter such as contraceptive sponges, female condoms, and spermicides. Q15, CCIIO FAQs set 12 (2/20/13). • Services related to follow-up and management of side effects, counseling for continued adherence, and for device removal also		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• D.C. Code § 31-3834.01: Full-year coverage for contraception The Department will provide carriers with an annual notice of their obligation to provide women's preventive services.	must be covered without cost-sharing. Q15, CCIIO FAQs set 12 (2/20/13). • May cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs. **However**, must accommodate any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version. Q14, CCIIO FAQs set 12 (2/20/13); Q3, CCIIO FAQs set 26 (5/11/15); Q2, CCIIO FAQs set 31 (4/20/16).						
Contraception: Religious exemption/accommodation Carriers must provide coverage of preventive health services identified in 45 C.F.R. § 147.130(a)(1) without imposing cost-sharing requirements, including coverage of all FDA approved contraceptive services for women with child-bearing capacity, as prescribed by a provider. However, group health plans established or maintained by a religious employer may be exempt from having to provide coverage for contraceptives, and other employers that are eligible organizations may be eligible for an accommodation. **Federal & DC Law** • 45 C.F.R. § 147.131(a) and (b): Accommodations in connection with coverage of certain preventive health services • 45 C.F.R. § 147.132: Religious exemptions in connection with coverage of certain preventive health services • D.C. Code § 31-3831	An employer that is a qualifying non-profit or closely held for-profit corporation that sponsors an ERISA-covered self-insured plan and has a sincerely held religious objection to providing coverage of contraceptive services may effectuate a religious accommodation to relieve it of any obligation to contract, arrange, pay or refer for that coverage in one of two ways: 1. Complete EBSA Form 700 or 2. Provide appropriate notice of the objection to HHS. Q1, CCIIO FAQs set 20 (7/17/14); Q9, CCIIO FAQs set 29 (10/23/15); Q1, CCIIO FAQs set 36 (1/9/17). The regulations exempt entities only from providing an otherwise mandated item to which they object on the basis of their religious beliefs or moral conviction. The entities include: • Churches, integrated auxiliaries, and religious orders with religious objections; • Nonprofit organizations with religious or moral objections; • For-profit entities that are not publicly traded with religious or moral objections; • For-profit entities that are publicly traded with religious objections;			✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
	• Other non-governmental employers with religious objections; • Institutions of higher education with religious or moral objections; • Individuals with religious or moral objections, with employer sponsored or individual market coverage, where the plan sponsor and issuer (as applicable) are willing to offer them a plan omitting contraceptive coverage to which they object; • Issuers with religious or moral objections, to the extent they provide coverage to a plan sponsor or individual that is also exempt. Fact Sheet: Religious and Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act						
Women's Health and Cancer Rights Act (WHCRA) A carrier that provides medical and surgical benefits with respect to a mastectomy must provide, in a case of a participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: • All stages of reconstruction of the breast on which the mastectomy has been performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient at all stages of mastectomy. • This benefit can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the coverage. • The issuer is prohibited from denying a patient eligibility to enroll or renew coverage solely to avoid these requirements; penalizing or offering incentives	This includes nipple and areola reconstruction, including nipple and areola repigmentation to restore the physical appearance of the breast. (Q12, CCIIO FAQs set 31 (4/20/16)) **Important!** The mastectomy does not have to have been related to breast cancer, so excluding eligibility of WHCRA's benefits based on the reason for the mastectomy is strictly prohibited. (See U.S. Department of Labor's "Your Rights After A Mastectomy").		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
to an attending provider to induce the provider to furnish care inconsistent with these requirements. • Notice about the availability of mastectomy-related benefits must be given at issue and annually. **Federal & DC Law** • 42 U.S.C. § 300gg-27 • D.C. Code § 31-3832: Coverage may be subject to annual deductibles and coinsurance provisions as are consistent with those established for other benefits • D.C. Code § 31-3835: Coverage for reconstructive surgery following mastectomies							
Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) A carrier that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. **Federal & DC Law** • 42 U.S.C. § 300gg-25 • 45 C.F.R. § 146.130: Standards relating to benefits for mothers and newborns (group) • 45 C.F.R. § 148.170: Standards relating to benefits for mothers and newborns (IVL)	• Carrier may not require a provider to obtain authorization for the hospital length of stay (48 hours/96 hours) • Early discharge of mother and/or newborn is OK: if decision to discharge is made by an attending provider in consultation with the mother (or the newborn's authorized representative) • Benefit available even if childbirth outside of a hospital: hospital length of stay begins when mother or newborn is admitted as hospital inpatient in connection with childbirth		✓	✓			
Newborn and Maternity Benefits under DC Law • D.C. Code § 31-3801: Health benefits payable for newborn of subscriber/insured from moment of birth • D.C. Code § 31-3802.01: Postpartum inpatient and at-home care			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• D.C. Code § 7-875.04: Coverage for health screenings (benefits plan shall include the uniform, age-appropriate health screening requirements for children from birth to age 21 years who are DC residents, DC wards, or children with special needs who reside or are receiving services in another state) • D.C. Bulletin 06-IB-001-4/14: Limited maternity benefit bulletin (requiring companies submitting individual and group accident and health forms that provide limited maximum maternity benefits to disclose such limitation in bold 10-point type)							
Maximum out-of-pocket (proposed) The maximum out-of-pocket (MOOP) cost for plan year 2019 may not exceed $7,900 for self-only coverage and $15,800 for coverage other than self-only coverage. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for EHB. This limit is not require to include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-EHBs. **Federal & DC Law** • 45 C.F.R. § 156.130(a): Cost-sharing requirements	For PY2019, the MOOP* cannot exceed: $7,900 for individual $15,800 for family Proposed as of April 5, 2018		✓	✓			
Coverage for dependent student on medically necessary leave of absence ("Michelle's Law") Issuer cannot terminate coverage due to a medically necessary leave of absence before: • The date that is 1 year after the first day of the leave; or • The date on which coverage would otherwise terminate under the terms of the coverage. Change in benefits prohibited – A child on medically necessary leave of absence is entitled to the same benefits as if the child continued to be a covered student who was not on a medically necessary leave of absence; however, if there is a change in			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
the manner in which the beneficiary/parent is covered and continues to cover the dependent, the changed coverage will apply for the remainder of the period of the medically necessary leave of absence. Eligibility for protections: A dependent child under the terms of the coverage of the beneficiary, enrolled in the coverage on the basis of being a student immediately before the first day of the medically necessary leave of absence involved. "Medically necessary leave of absence" means a leave of absence or change of enrollment of a dependent child from a post-secondary education institution that: • Commences while the child is suffering from a serious illness or injury • Is medically necessary; and • Causes the child to lose student status for purposes of coverage under the terms of coverage. Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the terms for continued coverage during medically necessary leaves of absence. Federal Law • PHSA § 2728 • 45 C.F.R. § 147.145 • 42 U.S.C. § 300gg-28							
Coverage is not based on genetic information (GINA) An issuer is not allowed to: • Adjust premiums based on genetic information; • Request /require genetic testing; or • Collect genetic information from an individual prior to/in connection with enrollment in a plan, or at any time for underwriting purposes. EXCEPTION FOR MEDICAL APPROPRIATENESS (only if the individual seeks a benefit under the plan):			✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• If an individual seeks a benefit under a plan, the issuer may limit or exclude the benefit based on whether the benefit is medically appropriate and the determination of whether the benefit is medically appropriate is not for underwriting purposes. • If a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information (the issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness). • The incidental collection of genetic information is permitted, as long as it is not used for underwriting purposes. EXCEPTIONS: • A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. • An issuer can obtain and use results of a genetic test for making a determination regarding payment (minimum amount of information necessary to make the determination). • An issuer may request but not require that a beneficiary undergo a genetic test if the request is pursuant to research and the following conditions are met: o Research must be in accordance with Federal regulations and applicable state/local law or regulations; o The issuer makes a written request, and the request clearly indicates that compliance is voluntary, and noncompliance will have no effect on eligibility for benefits; o No information collected can be used for underwriting purposes; and o The issuer completes a copy of the "Notice of Research Exception under the Genetic Information Nondiscrimination Act." Federal Law • PHSA § 2753							

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• 74 Fed Reg 51664 • 45 C.F.R. § 146.122 (group), 45 C.F.R. § 148.180 (individual)							
Providers operating within their scope of practice and authorized by the issuer to provide services cannot be discriminated against. Issuers may not discriminate against any provider contracted with the issuer to provide services and operating within the provider's scope of practice. Federal Law • PHSA § 2706 • CCIIO ACA Implementation FAQs - Set 15			✓	✓			
Issuers must provide applicants and enrollees information in plain language and in a manner that is accessible and timely (QHPs only). Required notices must meet the following standards: • For individuals living with disabilities: o Accessible Web sites and o The provision of auxiliary aids and services o At no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. • For individuals who are limited English proficient (at no cost to the individual), language services, including: o Oral interpretation, including telephonic interpreter services in at least 150 languages; o Written translations; and o Taglines in non-English languages indicating the availability of language services. Issuers must inform individuals of the availability of these services and how to access them. Federal Law • 45 CFR §155.205	District's top 15 languages: 1. Spanish 2. Amharic 3. Chinese 4. French 5. Tagalog 6. Russian 7. Portuguese 8. Italian 9. Vietnamese 10.-12. Kru, Ibo, and Yoruba 13. Bengali 14. Japanese 15. Korean		✓	✓			

Category	Reminders	Page # or Confir-mation	Individual	Small Group	Yes	No	N/A
• D.C. Code § 31-3171.09 • CCIIO Technical Guidance: Guidance and Population Data for Exchanges, Qualified Health Plan Issuers, and Web-Brokers to Ensure Meaningful Access by Limited-English Proficient Speakers Under 45 CFR §155.205(c) and §156.20 (Mar. 30, 2016) • CCIIO: Sample translated taglines							
Minimum 60% actuarial value is required Health plans must meet the AVs in the metal tiers. *Reviewer check: included printout of AV calculator and methodology.* *Reviewer check: included disclosure of how benefits were defined and entered into AV calculator* Federal Law 42 USC §18021	AV is measured as a percentage of expected health care costs a health plan will cover; calculated based on the cost-sharing provisions for a set of benefits		✓	✓			

Other DC Health Insurance Mandates	Page # or Confir-mation	Individual	Small Group	Yes	No	NA
D.C. Code §44-302.01 (2001 ed.) **Access to Specialists as Primary Care Providers** *(applicable to HMOs only)* Right to choose specialist as PCP if member has chronic disabling or life threatening condition) §44-302.02: member's right to more than one visit with specialist		✓	✓			
D.C. Code §31-4712 (2011 ed.) Accident and Sickness Policies		✓	✓			
D.C. Code §16-4403 Applicability of Arbitration Act of 2007 • Any provision in an insurance policy with a consumer that requires binding arbitration is void and unenforceable; • An insurance policy may permit resolution through arbitration if decision to arbitrate is made by the parties at the time a dispute arises and decision whether to arbitrate is not a condition for continued policy coverage under same terms		✓	✓			
D.C. Code §31-2995.01 Chemotherapy Pill Coverage Act of 2009 (Individual and group) A plan or insurance policy that covers prescription drugs shall cover prescribed, orally administered anticancer medication and the person receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy; the coverage shall be on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications		✓	✓			
26 DCMR 4403 Child-Only Policies A carrier issuing child-only policies shall accept applications for coverage twice a year: Jan 1 thru Jan 31 each year and July 1 thru July 31 each year. • During the open enrollment periods, any applicant for a child-only policy shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on medical condition or health status. • 4403.4 Notice of the open enrollment period and instructions on how to apply during the open enrollment period shall be displayed prominently on the carrier's website for the duration of the open enrollment period. 4403.5 During open enrollment, a carrier may request from an applicant information to determine whether the proposed insured has substantially similar coverage available and may obtain an attestation from an applicant that the proposed insured does not have substantially similar coverage available.		✓				
D.C. Code §32-732 Continuation of Health Coverage ("Baby COBRA") Employee's right to continued health benefits coverage (3 months or the period of time during which employee is eligible for premium assistance under federal law, if applicable) D.C. Bulletin 09-IB-01-05/11: Extending DC employees' continuation of coverage to 9 months under certain circumstances D.C. Bulletin 01-LG-004-12/18: Extending health benefits for covered members of a small employer with fewer than 20 employees for 3 months beyond termination of coverage D.C. Bulletin 09-IB-02-05/11: Extension of coverage for DC employees under certain circumstances			✓			
D.C. Code § 44-301 et seq. (2001 ed.) Notification of health care provider termination; continuance of coverage *(applicable to HMOs only)*						
D.C. Code § 44-303.01 Continuity of Coverage (HMO)		✓	✓			

Other DC Health Insurance Mandates	Page # or Confir-mation	Individual	Small Group	Yes	No	NA
Member notification, transition period where provider contract is terminated during course of treatment • When medically necessary, persons with serious illness undergoing a course of treatment or who are in the second trimester of a pregnancy shall be permitted to continue to receive medically necessary covered services, with respect to the cause of treatment, by the physician or nurse midwife during a transitional period of at least 90 days from the date of the notice under the same terms and conditions as specified under the provider contract.						
D.C. Code § 31-3002 Diabetes Health Insurance Coverage Expansion Act of 2000: A health benefit plan shall provide coverage for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.		✓	✓			
D.C. Code § 31-3011 Discontinuance of Class of Health Insurance Policies Insurer must provide written notice to each policyholder of class in market and to all participants and beneficiaries covered under the coverage: • Request to Commissioner for discontinuance; • The earliest possible date that the Commissioner might approve the request; • The earliest possible date that the coverage could be discontinued; and • A statement written in plain English of the obligations of the insurer and the rights of policyholders; Upon approval, insurer must provide: • Written notice to each policyholder, participant, and beneficiary of discontinuance at least 90 days prior to date of discontinuance; Offer to each policyholder the option to purchase all other hospital, surgical, and medical expense coverage currently offered by insurer in group market.			✓			
D.C. Act 18-0084 Domestic Partnership Judicial Determination of Parentage Amendment Act of 2009 D.C. Bulletin 09-IB-01-07/02: applicable to insurers and HMOs - Insurance products that cover the domestic partner of a primary insurance policyholder, or in the case of group policies, the domestic partner of an employee covered under a group policy, shall cover the domestic partner of an insured in a relationship recognized as a domestic partnership pursuant to the law; and provides date for qualifying event.		✓	✓			
D.C. Code §32-701 Domestic Partnership Registration Procedures and Fees Approval Resolution of 2002 & Domestic Partnership Notice Update		✓	✓			
D.C. Code §31-3101 (DC Law 16-242) Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage/Expansion of Substance Abuse and Mental Illness Insurance Coverage Amendment Act of 2006		✓	✓			
D.C. Code §31-3105 Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage Amendment Act of 2000 (Mental Parity Provisions)		✓	✓			
D.C. Code §46-401 Equal Access to Marriage		✓	✓			
D.C. Code §22-3225.09 et seq. FRAUD WARNING: Compliance with the Insurance Fraud Prevention and Detection Amendment Act of 1998		✓	✓			
D.C. Code §31-3201 Health Insurance Claim Forms – Uniformity The HCFA 1500 and UB 92 claims forms shall serve as the official health insurance claims forms of the District of Columbia for hospitals and other medical providers and governmental agencies, and such forms shall be used and exclusively accepted by all insurers, including HMOs and other forms of managed care that require insurance claim forms for their records.		✓	✓			
D.C. Code §31-3301.1 Health Insurance Portability and Accountability • Guaranteed DC HIPAA individual health benefit plans for eligible individuals		✓	✓			

Other DC Health Insurance Mandates	Page # or Confir-mation	Individual	Small Group	Yes	No	NA
• Renewability of current health benefit plans Availability of health benefit plans by small employers						
D.C. Code §31-3401 Health Maintenance Organizations HMOs are required to "…provide or arrange for basic healthcare services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments of deductibles, or both…" Basic health care services include the following benefits: • Preventive care • Emergency care • Inpatient and outpatient hospital and physician care • Diagnostic laboratory and diagnostic and therapeutic radiological services, and Services mandated under the statutes listed in items 1 through 3.		✓	✓			
D.C. Code §31-3501 Hospital and Medical Services Corporation Regulation • § 31-3508 – Filing of subscriber contract forms and rates § 31-3512 Group subscriber contract standard provisions		✓	✓			
D.C. Code § 31-3407 HMO Form Requirements Group or individual contracts shall contain a clear statement of the following: • Name and address of the health maintenance organization; • Eligibility requirements; • Covered services within the service area; • Covered emergency care benefits and services; • Out of area covered benefits and services, if any; • Copayments, deductibles, or other out-of-pocket expenses; • Limitations and exclusions; • Enrollee termination; • Enrollee reinstatement, if any; • Claims procedures; • Continuation of coverage, if any; • Conversion; • Extension of benefits, if any; • Coordination of benefits, if applicable; • Subrogation, if any; • Description of the service area;		✓	✓			

Other DC Health Insurance Mandates	Page # or Confir-mation	Individual	Small Group	Yes	No	NA
• Entire contract provision; • Term of coverage; • Cancellation of group or individual contract holder; • Renewal; • Reinstatement of group or individual contract holder, if any; • Grace period; • Conformity with District of Columbia law; and Payment provisions.						
D.C. Code §31-3834 Hormone Replacement Therapy Requires an individual or group health plan, and a health insurer offering health care coverage that provides coverage for prescription drugs, shall provide benefits which cover any hormone replacement therapy prescribed for menopause)		✓	✓			
Bulletin No 09-IB-01-07/02 Implementation of the Domestic Partnership Judicial Determination of Parentage Amendment Act of 2009 & the Jury and Marriage Amendment Act (applicable to insurers and HMOs) • Recognizes same-sex marriages legally entered into in another jurisdiction to be a recognized marriage in DC • Insurance products that cover the spouse of the primary policyholder or spouse of employee covered under group policy, shall cover same-sex spouse; and provides date for qualifying event;		✓	✓			
D.C. Act 18-0070 Jury and Marriage Amendment		✓	✓			
Bulletin 06-IB-001-4/14 Limited Maternity Health Benefit Companies submitting individual and group accident and health forms that provide limited maternity benefits are required to include the following language: "Maternity Benefits may contain a limited maximum benefit under the policy. Please reference the schedule of benefits in the group or individual plan contract" The typeface should be in bold print and at least 10 point-type set. This language should appear in the policy and any certificate issued therefrom.		✓	✓			
Medical Necessity/Medically Necessary Definition – June 2003 Notice ***Add the following to the definition:*** The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Group Policy			✓			
D.C. Code § 31-1603 Prohibition of Discrimination Prohibition of discrimination in the provision of insurance on basis of age, marital status, geographic area of residence, occupation, sex, sexual orientation, gender identity or expression, or any similar factor or combination of factors for the purpose of seeking to predict whether any individual may in the future develop AIDS or ARC		✓	✓			

Other DC Health Insurance Mandates	Page # or Confir-mation	Individual	Small Group	Yes	No	NA
• No health or disability insurance policy or contract shall contain any exclusion, reduction, other limitation of coverage, deductibles, or coinsurance provisions related to the care and treatment of AIDS, ARC, HIV infection, or any illness or disease arising from these medical conditions, unless the provisions apply generally to all benefits under the policy or contract.						
D.C. Code §31-1610 & D.C. Law 17-0177 Prohibition of Discrimination in the Provision of Insurance on Basis of HIV/AIDS Test (Prohibition of Discrimination on the Basis of Gender Identity and Expression Amendment Act of 2008) No insurer shall inquire about the sexual orientation or gender identity or expression of an applicant in an application for health, life, or disability income insurance coverage or in an investigation conducted by an insurer or insurance support organization on behalf of an insurer in connection with an application for the coverage. • Sexual orientation or gender identity or expression, shall not be used as a factor in the underwriting process or in the determination of insurability. • An insurance company shall not use sexual orientation, gender identity or expression, lifestyle, living arrangements, occupation, gender, or beneficiary designation to determine whether to test an individual D.C. Bulletin 13-IB-01-30/15 (Revised): Prohibition of discrimination in health insurance based on gender identity or expression		✓	✓			
D.C. Code §31-4724 Psychologists or Optometrists – Access to psychologists or optometrists under group and individual health insurance policy. Choice of practitioner: No policy of group health insurance shall restrict access to psychologists or optometrists. When a policy relating to group health insurance requires payment or reimbursement for services which may be performed by a duly licensed psychologist or optometrist, any person covered by the policy shall be free to select and have direct access to such psychologist or optometrist without supervision or referral by a practitioner of the healing art and shall be entitled under the policy to have payment or reimbursement made for services performed.		✓	✓			
D.C. Code § 31-3862 Telehealth Reimbursement Health insurer may not deny coverage for healthcare service on the basis that service is provided through telehealth if same service would be covered in person)		✓	✓			

RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP

PLANS SOLD ON DC HEALTH LINK

CHECK-LIST

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.		
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.		
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.		
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2017 and later, follow filing due date requirements.		
5	Market	Indicate whether the products are sold in the individual or small employer group market.		
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non-grandfathered, or a mixture of both.		
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.		
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. **In the small group market, please also provide weighted average rate increase requested for 2016Q1 over 2015Q1; etc.**		
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)		
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)		
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.		
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.		
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for District of Columbia and the nationwide average rate history.		
14	Exposure	Current number of policies, certificates and covered lives.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.		
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.		
17	Index Rate	Provide the index rate.		
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.		
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.		
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.		
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.		
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders. For initial filings, provide the derivation of any new plan factors.		
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.		
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.		
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.		
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.		
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation . Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.		

Number	Data Element	Requirement Description	Individual/and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.		
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in District of Columbia, the loss ratio meets the minimum.		
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative support for the amount.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.		
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
32	Past and Prospective Expenses	Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change. Provide the assumed administrative costs in the following categories: • Salaries, wages, employment taxes, and other employee benefits • Commissions • Taxes, licenses, and other regulatory fees • Cost containment programs / quality improvement activities • All other administrative expenses • Total		
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.		
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.		
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of the District of Columbia and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet --- Provide this document with all Grandfathered plan filings. **Provide in Excel and PDF format.**		
36.1	Unified Rate Review Template (Non-Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. **Provide in Excel and PDF format.**		
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for *all* individual and small employer group filings (whether or not they are "subject to review" as defined by HHS).		
38	DISB Actuarial Memorandum Dataset	Summarizes data elements contained in Actuarial Memorandum. Provide this document with all Non-Grandfathered plan filings. **Provide in Excel format only**.		
39	District of Columbia Plain Language Summary	Similar to the Part II Preliminary Justification, this is a written description of the rate increase as specified by 45 CFR § 154.215, but as a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. Provide this document for all individual and small employer group filings.		
40	Summary of Components for Requested Rate Change	DISB will require that issuers provide a chart listing a) any and all components of requested rate changes from the prior year; b) a quick summary/explanation of the change; and c) the actual percentage impact of the change for each component, such that the total for all components listed equals the total percentage change requested for the plan year.		

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
41	CCIIO Risk Adjustment Transfer Elements Extract (RATE 'E')	Received directly from CCIIO; this report should be completed and submitted by the set deadline for QHP submissions, or by April 30th of the current year, whichever is first.		
42	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: • Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule; • Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and • Demonstration that the plan has a reasonable annual limitation on cost-sharing.		

CERTIFYING SIGNATURE

The undersigned representative of the organization submitting this rate filing attests that all items contained in the above checklist have been included in the filing to the best of the company's ability.

_____	_____
(Print Name)	**(Signature)**

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.

_____
_____
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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, the 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. The 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] The 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

DCHBX Authority Executive Board Resolutions

DC HBX Authority Board QHP & QDP Certification Resolutions

The following resolutions enacted by the DC HBX Authority Executive Board are required for QHP and QDP carriers offering plans on the DC Health Link insurance market place. This memo provides a short summary of the resolution and hyperlink to the full text and additional materials (if applicable). For access to all resolutions enacted by the Board, please visit http://hbx.dc.gov/page/adopted-resolutions

Resolution to Approve an Essential Health Benefit (EHB) Benchmark Plan for 2017 (6/24/2015)

- Pursuant to Department of Insurance, Securities and Banking statute §31-3311.03(a), the HBX Executive Board approves GHMSI Blue Preferred PPO $1,000 – 100%/80% as the EHB benchmark for plan year 2017.
- Plan Contract and SBC
- DISB announcement (6/30/2015)

Resolution- To Update the Qualified Health Plan (QHP) Certification Requirements (2/9/2015)

Updated QHP Certification Requirements Working Group Report (1/21/2015)

- Network Adequacy
    - For plan year 2016 and beyond, in addition to submitting the CCIIO Federal Network Template, carriers must also submit the CCIIO Network Adequacy Template for QHP certification
    - DISB will track complaints related to network adequacy and will update their tracking mechanism as necessary

- Provider Directory
    - For plan year 2016 and beyond, carriers must submit provider data at intervals and in formats as determined by HBX for use to populate DC Health Link's provider directory search tool. Carriers participating in the individual market have already begun providing provider information to populate a DC Health Link individual market provider directory search tool, which is scheduled to "go live" in Spring 2015. Timing of developing and implementing a DC Health Link provider directory for the small group marketplace will be determined based on experience and consumer use of individual marketplace provider directory tool.
    - In time for the 2016 plan year open enrollment (beginning October 1, 2015), Carriers will be required to prominently post a phone number or email address on their on-line 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 will be required to take steps to maintain a high level of accuracy in their provider directories. Beginning in calendar year 2015 and annually, a carrier is required to take at least one of the following steps and report such steps to DISB;
  - Perform regular provider directory information
  - Validate provider information where a provider has not filed a claim with a carrier in 2 years (or a shorter period of time).
  - Take other innovative and effective actions approved by DISB to maintain accurate provider directories.

- Review of Rates
  - For plan year 2016 and beyond, similar to reviews that occurred in 2013 and 2014, HBX is clarifying that for 2015 (plan year 2016 rates): 1) HBX will have a carrier's rate and form filings as filed with DISB, 2) Carriers are required to respond to requests for additional information from consulting actuaries for HBX, and 3) Consulting actuarial review of the assumptions in carrier rate filings and the actuarial reports will be published on HBX webpage and submitted to DISB for consideration. Published reports will not contain confidential information provided by carriers.
  - In this work, HBX will coordinate with DISB to minimize duplication of effort and maintain confidentiality of submissions consistent with current practice.
  - In addition to these steps, HBX will develop an enhanced process under its legal authority. HBX will coordinate with DISB and will work with carriers, consumers, and other stakeholders to develop an enhanced process.

- Quality of Health Plans
  - For plan year 2016 DCHBX will use the federal standards and approach to make data on plan quality available to consumers and the DCHBX will establish on dchealthlink.com a link to the NCQA public report cards for health plans

- Non-Discrimination
  - Carriers must submit to DCHBX a copy of the insurance contract- also known as the certificate of coverage/evidence of coverage- for each certified QHP. Submission to HBX shall be at the health plan level and shall be made at the same time federal law requires disclosure to consumers.

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 (11/12/2014)

Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefits Exchange Authority (10/6/2014)

Addendum to Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority (11/5/2014)

Metal tier by metal tier Benefit Design example

- Beginning in plan year 2016, the Executive Board has adopted standard plans for DCHL at all four metal tiers in the Individual health insurance marketplace and carriers are required to offer one standardized plan at each metal level.

Resolution - To Adopt a Recommendation Regarding a Separate Deductible for Pediatric Dental Benefits Offered in QHPs (11/12/2014)

- The maximum deductible in embedded pediatric dental plans shall be $50/$100 (individual in and out-of-network) and $100/$200 (family in and out-of-network).

Resolution to Establish Employer Choice of Qualified Dental Plans (5/14/2014)

- Enables employers, purchasing coverage through DC Health Link, to offer their employees any number of qualified dental plans available through the DCHL insurance marketplace.
- Employers are not required to have a minimum contribution amount toward standalone qualified dental plan coverage.
- If an employer chooses to offer a contribution for stand-alone qualified dental plan coverage, the employer contribution methodology shall be the employer contribution methodology shall be the employer contributing a percentage of the member-level age rate within a reference plan selected by the employer; this is the same methodology used for contributions for a qualified health plan.
- DC Health Link shall provide greater transparency (more information) about pediatric dental benefits.

Resolution to Allow Health Carriers in DC Health Link to Determine Whether a Pediatric Essential Dental Benefit is Included in a Qualified Health Plan (5/14/2014)

- QHP carriers offering coverage on DC Health Link have the choice to embed, or not embed, the pediatric essential health benefits in the qualified health plans being offered.

Resolution to Determine a Separate Deductible for Pediatric Dental Benefits Offered in QHPs (5/14/2014)

- QHP's with an embedded essential pediatric dental benefit being offered in DC Health Link must have a separate deductible beginning in plan year 2016 for its pediatric dental benefit.
- There shall be maximum amounts for the deductible to be informed by the Dental Working Group, or other group to which the Executive Board may assign the issue. A QHP carrier can choose to have lower or zero deductibles for pediatric dental benefit.

Resolution to Require Qualified Health Plan (QHP) Carriers to Establish Policies that Address Transition of Care for Enrollees in the Midst of Active Treatment in the Time of Transition into a QHP (5/9/2013)

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

Resolution to Establish an Automatic Enrollment Policy for the Individual Exchange Marketplace and to Define "Exceptional Circumstances" Permitting a Special Enrollment Period (5/9/2013)

- The District of Columbia Health Benefit Exchange (DCHBX) will enable an individual to be automatically enrolled if he or she does not select a new plan, and does not terminate such coverage when their existing plan is no longer offered in a subsequent plan year, into a similar plan, if available. A similar plan is defined as same carrier, metal tier, and provider network.
- Additionally, a new 60-day SEP is established. The triggering date is the effective date for the plan in which the individual has been automatically enrolled. This provides the individual an additional opportunity to change plans.
- There is no automatic enrollment if there is no similar plan available.

Resolution - To Establish Outreach Strategies to Promote Tobacco Cessation Programs and Other Preventive Benefits That Are Covered Without Cost Sharing (5/9/2013)

1. As part of the general information on the DC HBX website, provide descriptive information on the ACA covered preventive services including tobacco cessation and, when feasible, link to carrier websites which describe the availability of their tobacco cessation/preventive benefits.
2. Recognizing that carriers now communicate with new enrollees, ensure that carriers include information about tobacco cessation and other preventive services in their new member communication. Note: this recommendation is not intended to duplicate existing communication or add to costs.
3. Recognizing that carriers now communicate with providers, ensure that carrier communications to their providers include up to date information on the preventive benefits and tobacco cessation programs to be provided with no cost sharing. Note: this recommendation is not intended to duplicate existing communication or add to costs.
4. As part of training for navigators, in-person assistors (IPAs), and certified application counselors (CACs), the DC HBX should provide descriptive materials on the availability of no cost preventive services including tobacco cessation for use in enrollment counseling sessions. These counselors should stress the importance of enrollees speaking directly with their carrier to obtain more information on these benefits.
5. Utilize alternative vehicles for communication, other than carriers, including providing educational materials to small business owners and benefit administrators on the availability of preventive services including tobacco cessation
6. Maintain ongoing discussions with key stakeholder groups to identify additional opportunities to increase the use of preventive services including tobacco cessation. Stakeholder groups should include at least carriers, providers, and community organizations.

Appendix G

DCHBX Plan Management Policy Bulletins

DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

April 20, 2018 | 2018.0001

Adjustment to SHOP Proration Calculation Formula

The DC Health Benefit Exchange Authority is making an adjustment to the way it calculates prorated premiums due for partial months of coverage in the small business marketplace. This adjustment will result in more precise calculations.

The current small business marketplace calculation uses an estimate of 30 days in the month to determine the daily premium and does not adjust in the months that have more or fewer than 30 days. Going forward, the proration calculation will be based on the actual number of days in the month, yielding a more precise result. Both the current and new formulas can be found below.

Current proration calculation formula:

(Monthly_Premium / 30) x
#_of_Days_of_Coverage_in_Partial_Month

= Partial_Month_Premium

Revised proration calculation formula:

(Monthly_Premium / # of days in month) *
#_of_Days_of_Coverage_in_Partial_Month

= Partial_Month_Premium

This change is effective on April 19, 2018.

KEY DATES for Plan Year 2019

Activity		Dates
Release of 2019 Carrier Reference Manual v. 1		4/30/2018
Rate & Form Filing Deadline		5/1/2018
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	7/30/2018
	SBCs Due	8/17/2018

ANNOUNCEMENTS

Plan Management Advisory Committee to be refreshed in 2018

CARRIER WORKING GROUP CALENDAR
Q2 Meeting: May 30, 2018

Introducing assigned Plan Management team members:

Andre Dixon (andre.dixon2@dc.gov)
Kaiser & Delta Dental

Brian Schwartz (brian.schwartz@dc.gov)
Aetna & Dominion Dental

Olufunmilayo Hall Olufunmilayo.Hall@dc.gov
CareFirst (Plan Management/Individual Market)

Rober Hooker robert.hooker@dc.gov
CareFirst (Broker/SHOP)

TBD:
UnitedHealthcare & Bestlife

This update has been developed to keep all issuers of qualified health, including qualified dental plans, current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2019 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

April 27, 2018 | 2018.0002

Cessation of Invoicing for the SHOP market

After termination for non-payment, groups will continue to be invoiced for the 31 day claims grace period. The balance due will stay on the group's account until it is paid.

Hence, the DC Health Benefit Exchange Authority will cease invoicing for the 31 day claims grace period after the reinstatement window has closed and an additonal two billing cycles have passed.

At the end of the second billing cycle after the reinstatement period ends, the employer will be issued a final notice informing them that the DC Health Benefit Exchange Authority has ceased invoicing for the 31 day claims grace period but that this does not remove their responsibility for payment to the carrier(s).

Example of ceasation of invoicing timeline:

May 1, 2018: Group terminated for non-payment with coverage end date of 3/31/2018 (paid through date will be 2/28/2018) and termination notice issued.

June 1, 2018: Group reinstatement window closes and 1st invoice with premiums due for 31 day claims grace period (3/1/2018 to 3/31/2018) is issued.

July 1, 2018: 2nd invoice with premiums due for 31 day claims grace period (3/1/2018 to 3/31/2018) issued .

August 1, 2018: Final notice issued to the employer notifying them that DC Health Link has ceased invoicing for the 31 day claims grace period.

KEY DATES for Plan Year 2019

Activity		Dates
Release of 2019 Carrier Reference Manual v. 1		4/30/2018
Rate & Form Filing Deadline		5/1/2018
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	7/30/2018
	SBCs Due	8/17/2018

ANNOUNCEMENTS

Plan Management Advisory Committee to be refreshed in 2018

CARRIER WORKING GROUP CALENDAR
Q2 Meeting: May 30, 2018

Introducing assigned Plan Management team members:

Andre Dixon (andre.dixon2@dc.gov)
Kaiser & Delta Dental

Brian Schwartz (brian.schwartz@dc.gov)
Aetna & Dominion Dental

Olufunmilayo Hall (Olufunmilayo.Hall@dc.gov)
CareFirst (Plan Management/Individual Market)

Rober Hooker (Robert.Hooker@dc.gov)
CareFirst (Broker/SHOP)

Julie Harris (Julie.Harris@dc.gov)
UnitedHealthcare & Bestlife

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DC Health Benefit Exchange Authority

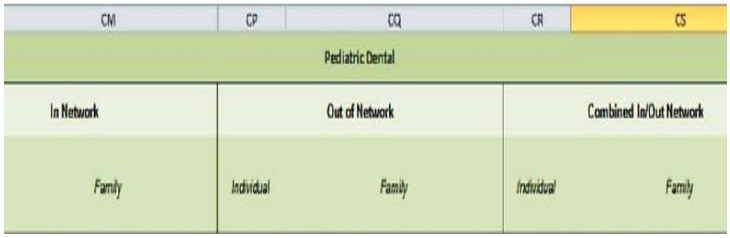
Carrier Reference Manual

UPDATE

April 20, 2018 | 2018.0003

Pediatric Dental Deductible Indicator on the Plan and Benefit Template (Individual and SHOP markets)

The DC Health Benefit Exchange Authority is clarifying its expectations with respect to how pediatric dental deductibles are to be reflected on the plan and benefit template. Effective for the 2019 plan year, carriers must indicate the pediatric dental deductible on the "cost share variance tab" of the plan and benefit template. The deductible amount must be shown along with the plan medical deductibles (see screen shot below)



CM	CP	CQ		CR	CS
Pediatric Dental					
In Network		Out of Network		Combined In/Out Network	
Family	Individual		Family	Individual	Family

Non-Compliant plans will be flagged for being out of compliance and may not be loaded into the DC Heathlink system..

Please also note that the separate pediatric dental deductible requirement is not applicable to catastrophic plans sold in the individual market.

KEY DATES for Plan Year 2019

Activity		Dates
Release of 2019 Carrier Reference Manual v. 1		4/30/2018
Rate & Form Filing Deadline		5/1/2018
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	7/30/2018
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TBD:
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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

April 18, 2018 | 2018.0004

Carrier Changes to Benefits Following Plan Certification (Individual and SHOP markets)

The DC Health Benefit Exchange Authority 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.

Effective immediately, carriers wishing to make changes to benefits included in certified plans must adhere to the following process to request a change.

1. Notify the Health Benefit Exchange Authority (HBX) Plan Management team and Department of Insurance, Securities and Banking (DISB) via an email sent to carrier.hbxinquiries@dc.gov and Howard.Leibers@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's 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 copy of the notice it will send to impacted enrollees. Once all documentation has been reviewed, HBX will consult with the Department of Insurance, Security, and Banking 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.

KEY DATES for Plan Year 2019

Activity		Dates
Release of 2019 Carrier Reference Manual v. 1		4/30/2018
Rate & Form Filing Deadline		5/1/2018
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	7/30/2018
	SBCs Due	8/17/2018

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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

March 1, 2017 | 2017.0001

31 Day Claims Grace Period (SHOP)

Effective immediately, pursuant to DC Official Code §31-4712, SHOP employers who have failed to make sufficient payment within the 60 day payment grace period will be terminated retroactive to the last date of the month for which premiums have been paid in full, plus 31 calendar days.

Under applicable District law, carriers must provide all small business policyholders terminated for non-payment of premiums with a 31 day claims grace period after the paid through date. The last date of the claims grace period will be transmitted as the date of termination for the carrier installation.

Example: Employer is terminated due to non-payment of premiums after exhausting the 60 day payment grace period. Employer has paid premiums through February 28, 2017. The date of termination transmitted by DCHBX to the carrier is March 31, 2017 (31 calendar days after February 28, 2017 paid through date).

KEY DATES for Plan Year 2018

Activity		Dates
Release of 2018 Carrier Reference Manual v. 1		Coming Soon
Rate & Form Filing Deadline		TBD
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	TBD
	Final Deadline for submission of all plan data	TBD
	SBCs Due	TBD
	Deadline to submit all plan corrections	TBD

ANNOUNCEMENTS

CARRIER WORKING GROUP CALENDER

Quarter 1 Carrier Working Group Tenatively Scheduled for March 15, 2017

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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

June 1, 2017 | 2017.0002

Establishment of the Carrier Member Level Reports

Pursuant to 45 CFR 155.400(d) and the DC Exchange Benefit Enrollment Companion Guide, enrollment reconciliation is conducted with each carrier on a monthly basis. In support of this process, carriers are now required to provide a twice weekly full member level report containing the enrollment details of every DCHBX member. These reports will inform DCHBX's daily case work and dispute resolution processes, and will improve the efficiency and speed with which DCHBX can resolve enrollment discrepancies identified by carriers on their reconciliation discrepancy templates.

Carriers should submit one file for the individual (IVL) market and another for the small group (SHOP) market. The member level report should be a flat excel file containing one row for every member (including dependents). The report must include one column for each of the following data points:

- Exchange Member ID
- Carrier ID (optional)
- Carrier Assigned Group Number
- First Name
- Last Name
- DOB
- Relationship (primary, spouse, child, etc.)
- Carrier Assigned Group Number
- Address 1
- Address 2
- City
- State
- Zip
- HIOS ID
- HBX Policy ID
- Policy Start date
- End date
- Status

The file should be delivered every Monday and Thursday and placed in the carrier reconcile/outbound folder.

KEY DATES for Plan Year 2018

Activity		Dates
Release of 2018 Carrier Reference Manual v. 1		Coming Soon
Rate & Form Filing Deadline		TBD
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	TBD
	Final Deadline for submission of all plan data	TBD
	SBCs Due	TBD
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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

August 29, 2017 | 2017.0003

IVL Voluntary Enrollee-Initiated Terminations

Pursuant to 45 C.F.R. § 155.430(b)(1), the District of Columbia Health Benefit Exchange Authority (HBX) is required to permit an enrollee to cancel or terminate coverage in a Qualified Health Plan (QHP) following appropriate notice to the Exchange or the QHP issuer. This applies exclusively to the individual marketplace.

When issuers transmit these cases to the Exchange through electronic data interchange (EDI), issuers are advised to use termination code 14 to indicate an enrollee-initated voluntary termination.

To further support this termination policy, HBX will implement the following workaround beginning Plan Year 2018 if a carrier does not transmit voluntary terminations to HBX :

1. HBX will waive the 14 day termination notice policy,which states that a consumer wanting to terminate coverage must request the termination 14 days prior to the requested termination date. Consumers will be granted a terimination date as early as the date of the request.

2. Consumers' requests for a retroactive termination date will continue to be processed via the established tracker process.

KEY DATES for Plan Year 2018

Activity		Dates
QHP Application Submission & Review	Finalized SBCs Due	9/1/2017
	Deadline to submit all plan corrections	10/1/2017

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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

July 21, 2017 | 2017.0004

Prescription Drug Template Update Requirement

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, DC Health Link 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
- 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 Leibers (Howard.Liebers@dc.gov) and cc: the HBX Plan Management team (carrier.hbxinquiries@dc.gov). The formal request to reopen for submission should be made on company letterhead and describe the changes to the template.

KEY DATES for Plan Year 2018

Activity		Dates
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	7/31/2017
	Final Deadline for submission of all plan data	8/15/2017
	SBCs Due	9/1/2017
	Deadline to submit all plan corrections	10/1/2017

ANNOUNCEMENTS

Plan Management Certification Calendar

Coming Soon

CARRIER WORKING GROUP CALENDAR

Q3 Meeting Scheduled for August 30, 2017

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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

July 21, 2017 | 2017.0007

Employer FEIN Changes vs. Correction Operational Policy

This policy statement is to distinguish between FEIN corrections versus FEIN changes and to outline the DC Health Benefit Exchange Authority's (DCHBX) operational policy and EDI procedures on making necessary changes.

FEIN Correction- There is a change to the FEIN due to human error (ex: incorrectly placed digits).

- EDI Process: XML with event type: "urn:openhbx:events:v1:employer#fein_corrected" will be transmitted to the carrier.

FEIN Change- There is a complete change of the FEIN to a different unique FEIN.

- EDI Process: Termination XML is transmitted for the old FEIN then an initial XML is transmitted for the new XML.
- This new group must follow the same guidelines as all new groups which includes making a binder payment

KEY DATES for Plan Year 2018

Activity		Dates
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	7/31/2017
	Final Deadline for submission of all plan data	8/15/2017
	SBCs Due	9/1/2017
	Deadline to submit all plan corrections	10/1/2017

ANNOUNCEMENTS

Plan Management Certification Calendar

Coming Soon

CARRIER WORKING GROUP CALENDAR

Q3 Meeting Scheduled for August 30, 2017

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DC Health Benefit Exchange Authority

Carrier Reference Manual UPDATE

May 7, 2018 | 2017.0006

SHOP Voluntary Termination Policy

The SHOP Termination Policy currently in effect states that employers may elect to terminate their DC Health Link coverage at any point during the plan year. To terminate a group's coverage, the employer must provide a written request 30 days in advance of the desired termination date. For voluntary terminations, the group's coverage can only be terminated at the end of a calendar month.

In an effort to align more with employers' desired termination date and mitigate financial risk for our carrier partners, the following SHOP Termination Policy will be in effect beginning January 1, 2018.

An employer may elect to terminate their DC Health Link Coverage at any point during the plan year by providing a written request to the DC Health Benefit Exchange Authority. When an employer requests that the entire group's coverage be terminated, the termination may only be effective on the last day of any month. The employer must make the request no later than the 15th of the month in which the employer wants the termination to be effective. A request to terminate an entire group that is submitted after the 15th of the month, will not be effective until the last day of the following month. For example, an employer who provides a request for termination on August 15th will receive an August 31st termination date. An employer who provides a request for termination on August 16th will receive a September 30th termination date.

KEY DATES for Plan Year 2018

Activity		Dates
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	7/31/2017
	Final Deadline for submission of all plan data	8/15/2017
	SBCs Due	9/1/2017
	Deadline to submit all plan corrections	10/1/2017

ANNOUNCEMENTS

Plan Management Certification Calendar

Coming Soon

CARRIER WORKING GROUP CALENDAR

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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

September 28, 2017 | 2017.0007

Decertification of Qualified Health Plans

Federal requirements under 45 CFR §155.1080(b) require that Exchanges establish a process for the decertification of QHPs. Since 2013, the DC Health Benefit Exchange Authority (HBX's) decertification process has leveraged the existing mechanism for suspending a carrier's authority to operate in the District. In November 2016, the Plan Management Advisory Committee met to discuss the decertification of plans and HBX reiterated reliance on the District of Columbia's Department of Insurance, Securities and Banking (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, the 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).

KEY DATES for Plan Year 2018

Activity		Dates
QHP Application Submission & Review	Finalized SBCs Due	9/1/2017
	Deadline to submit all plan corrections	10/1/2017

To the degree an appeal is permitted by federal regulation under 45 CFR §155.1080(d),carriers are permitted to appeal to the DISB Commissioner permitted by §31-4305(b).

Upon decertification of a QHP, DISB will notify the QHP issuer and HBX will notify enrollees of the QHP and provide information about their special enrollment period options. In addition, HBX will notify HHS of the decertification. The carrier must also continue to comply with any DC statute, regulation, or DISB instruction regarding direct notification of enrollees.

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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

May 7, 2018 | 2017.0008

Anti-Duplication and Medicare Eligibility

Section 1882(d)(3) of the Social Security Act (SSA) prohibits the sale or issuance of an individual health insurance policy to an individual entitled to benefits under Part A or enrolled under Part B of Medicare with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under Medicare or Medicaid (the "Anti-Duplication Provision"). Section 2702 of the Public Health Service (PHS) Act generally requires guaranteed availability of individual market coverage. Sections 2703 and 2742 of the PHS Act generally require guaranteed renewability of individual market coverage (the "Guaranteed Renewability Provision").

As discussed in the 2018 Notice of Benefit and Payment Parameters issued by the U.S. Department of Health and Human Services, the Anti-Duplication Provision prohibits issuers that have knowledge that an individual is entitled to Medicare Part A or enrolled in Medicare Part B from selling or issuing new policies to that individual an individual market policy that duplicates benefits to which that individual is entitled. However, consistent with the Guaranteed Renewability Provision, it does not prohibit renewal of policies that an individual is already enrolled in, regardless of whether that person is eligible for Medicare Part or enrolled in Part B.

(Continue on next page)

KEY DATES for Plan Year 2018

Activity		Dates
Plan Management Advisory Committee Meeting		Coming Soon
Lessons Learned Meetings (PM Certification)		Coming Soon
Plan Management Development	Plan List Re-Design	3/31/2018
	Plan Detail Re-Design	6/30/2018
	Dental Re-Design	01/01/2019
	Carrier Portal	Coming Soon

ANNOUNCEMENTS

Plan and Benefit Template working session for QDP's – coming soon

Certification Letters to be released by November 22, 2017

CARRIER WORKING GROUP CALENDAR

Q4 Meeting Scheduled for November 29, 2017

Enrollments at Renewal & Initial Enrollment

To comply with the Anti-Duplication Provision and the Guaranteed Renewability Provision, carriers receiving enrollment files from the D.C. Health Benefit Exchange Authority (HBX) for renewal of a customer into the same plan they were enrolled into for a prior plan year shall not reject or cancel that enrollment solely on the basis of Medicare eligibility or enrollment. The technical nature of the file that is sent does not control. For operational reasons, on the part of both HBX and the carrier, 834 files may be labeled as "new enrollments", but the customer is in-fact still enrolling into the same policy that they were previously enrolled in for the prior plan year, with the same HIOS identification number. Such enrollments are renewals and shall not be rejected or cancelled on the basis on Medicare eligibility or enrollment.

In contrast, if a customer is entitled to Medicare Part A or enrolled in Medicare Part B and seeks an initial enrollment into a Qualified Health Plan that duplicates Medicare coverage, carriers may cancel this enrollment within 31 days of receipt. To exercise this option, the carrier must send a cancellation file to HBX and a notice to the customer explaining the reason for the cancellation. All appropriate refunds shall be made for premiums paid for months that are cancelled. Notably, stand-alone dental coverage does not duplicate Medicare Part A or Part B coverage and thus could not be cancelled under this policy.

HBX-initiated Action

Federal regulations governing HBX do not permit the agency to deny QHP eligibility or enrollment to customers entitled to Medicare Part A or enrolled in Part B.[1] If a customer applies for advance premium tax credits (APTC) or cost-sharing reductions (CSR), HBX checks the Federal Data Services Hub to verify whether customer attestations as to their eligibility for Medicare is accurate, but if the attestation conflicts with the data source, the customer has 90 days to resolve the attestation and may receive APTC/CSR during this period.[1] Eligibility for APTC/CSR will be re-evaluated based on federal data sources if the customer fails to resolve the outstanding discrepancy within the 90 days and, if the data sources still indicate Medicare eligibility, APTC/CSR eligibility will be terminated prospectively.[1] Federal regulations do not permit a Medicare eligibility check to occur if a customer does not apply for APTC/CSR; the customer can enroll in a QHP without applying for these benefits.[1]

Additionally, receipt of Medicare does not constitute grounds for an Exchange or Carrier to terminate an individual's Qualified Health Plan (QHP) coverage under federal exchange regulations.[1] Accordingly, HBX will not cancel QHP plans based on Carrier reports of Medicare coverage. However, HBX will periodically send notices to such customers indicating that we have received information that they appear Medicare-eligible and encouraging them to explore non-QHP options to provide wrap-around coverage. If any of the customers are receiving APTC/CSR, termination efforts would also be initiated pursuant to federal requirements for information received from third-parties.

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[1] 45 C.F.R. §155.305
[1] 45 C.F.R. §155.320(b) & §155.315(f)
[1] 45 C.F.R. §155.315(f)(5) & 155.330(f)
[1] 45 C.F.R. §155.320(a)
[1] 45 C.F.R. §155.430(b)(2)

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DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

April 13, 2016 | 2016.0007

Guidance for Individual Market Binder Payments

Carriers offering qualified health plan (QHP), including qualified dental plan (QDP), in the individual market on DC Health Link must adhere to binder payment policies set forth in the Carrier Integration Manual. The Carrier Integration Manual permits carriers to require binder payments to effectuate coverage, **provided that carriers afford consumers 30 days to make the binder payment before the carrier is permitted to cancel coverage for nonpayment**.

This Bulletin clarifies that carriers offering individual market plans on DC Health Link must provide enrollees with at least 30 *calendar* days to make full payment on the binder payment before the carrier can cancel coverage. It also clarifies that this 30-day period begins on the date the coverage goes into effect.

Carriers may set their own binder payment policies based on this guidance. However, carriers must apply their binder payment policies uniformly to all of their individual market consumers. Where this rule cannot be implemented--for example, for certain special enrollment periods that provide for retroactive enrollments and in particular cases that are processed outside the regular system--HBX will work directly with carriers to determine the date by which the binder payment must be made.

KEY DATES for Plan Year 2017

Activity		Dates
Release of 2017 Carrier Reference Manual v. 1		4/1/2016
Rate & Form Filing Deadline		5/2/2016
QHP Application Submission & Review	Deadline for Submission of Templates and Supporting Documents in SERFF	8/1/2016
	SBCs Due	9/1/2016
	Deadline to submit all plan corrections	10/1/2016

ANNOUNCEMENTS

At the end of March, DC HBX officially announced the availability of dental benefits to small business employees. The press release reads: DC Health Link is now offering dental coverage to small businesses. "Group dental coverage is an important benefit we are now able to offer to our small business customers," said Mila Kofman, J.D., Executive Director of the DC Health Benefit Exchange Authority. "There are five top insurers including Delta, Dentegra, Dominion, MetLife, and CareFirst offering 13 different options through DC Health Link." Read the full press release posted on the DC Health Link website.

This update has been developed to keep all issuers of qualified health and qualified dental plans current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2017 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

DC Health Benefit Exchange Authority

Carrier Reference Manual UPDATE

July 6, 2016 | 2016.0008

Adult Dependents Aging Off a Policy

Following consultation with each carrier, we are updating our policy regarding adult dependents who age off of a policy. Going forward, the policy is that carriers shall terminate coverage for adult dependent children at the end of the calendar year (December 31st) during which the dependent turns 26 years of age. This applies in both the small group and individual markets. In connection with this policy, we are implementing two customer service enhancements:

1. Our system will automatically initiate a special enrollment period on the dependent's behalf in the individual market due to the life event.
2. We will also reach out to these members regarding this change in their coverage status and available options.

For any carriers not currently complying with this guidance, please note this is effective September 1, 2016 going forward.

KEY DATES for Plan Year 2017

Activity		Dates
Release of 2017 Carrier Reference Manual v. 1		4/1/2016
Rate & Form Filing Deadline		5/2/2016
QHP Application Submission & Review	**Submission of Templates and Supporting Documents in SERFF**	**8/1/2016**
	SBCs Due	9/1/2016
	Deadline to submit all plan corrections	10/1/2016

ANNOUCEMENTS & CARRIER WORKING GROUP CALENDER

All one-on-one conference calls have been scheduled with each carrier. These calls occur every other week. The scope of these calls is intended to be more policy focused. The Plan Management team sincerely appreciates your kindly submitting agenda items via email to

carrier.hbxinquiries@dc.gov

the day before your scheduled conference call so we may compile the agenda and distribute it to all meeting participants.

This update has been issued to keep all issuers of qualified health and qualified dental plans current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2017 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

August 30, 2016 | 2016.0008-Amendment

Adult Dependents Aging Off a Policy

Following consultation with each carrier, we are updating our policy regarding adult dependents who age off of a policy. Going forward, carriers shall terminate coverage for adult dependent children at the end of the calendar year (December 31st) during which the dependent turns 26 years of age. This applies in both the small group and individual markets.

In connection with this policy, we will provide notice to terminating dependents of their change in eligibility and their ability to enroll into their local individual Marketplace either via SEP or the upcoming Open Enrollment period.

Please note the following effective dates for this policy by market type:

Individual Market: September 1, 2016
SHOP Market: January 1, 2017

Note: Specific to SHOP, this policy is effective for all dependents turning 26 on or after January 1, 2017 for all groups enrolled in a plan through the DC Health Link.

KEY DATES for Plan Year 2017

Activity		Dates
Carrier Plan Management PY2017 Testing		9/19/16-10/12/2016
Open Enrollment Kick-Off Event		11/5/2016
QHP Application Submission & Review	**Submission of Templates and Supporting Documents in SERFF**	**8/1/2016**
	SBCs Due	9/1/2016
	Deadline to submit all plan corrections	10/1/2016

ANNOUCEMENTS & CARRIER WORKING GROUP CALENDER

This update has been issued to keep all issuers of qualified health and qualified dental plans current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2017 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

July 1, 2016 | 2016.0009

Eligibility of District Residence Temporarily Absent from DC Health Link Service Area

Individuals who are temporarily absent from the District of Columbia but otherwise meet the requirements for eligibility for enrollment in a qualified health plan (QHP) offered through DC Health Link may not be denied or terminated from coverage if they intend to return to the District of Columbia when the purpose of the absence has been accomplished.

The impact of this policy is that, effective now, DCHBX may on occasion generate 834 files containing home addresses that are not within the DCHBX service area. Carriers offering plans through DC Health Link must be able to accept data files on behalf of these individuals and facilitate enrollment.

DCHBX will consult with each carrier on a process for operationalizing this requirement.

KEY DATES for Plan Year 2017

Activity		Dates
Release of 2017 Carrier Reference Manual v. 1		4/1/2016
Rate & Form Filing Deadline		5/2/2016
QHP Application Submission & Review	Submission of Templates and Supporting Documents in SERFF	8/1/2016
	SBCs Due	9/1/2016
	Deadline to submit all plan corrections	10/1/2016

ANNOUNCEMENTS & CARRIER WORKING GROUP CALENDER

This update has been issued to keep all issuers of qualified health and qualified dental plans current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2017 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

DC Health Benefit Exchange Authority

Carrier Reference Manual

UPDATE

June 1, 2017 | 2016.0010

Guidance for Carriers on SHOP Groups Qualifying for Religious Objection Accomodation

This DC Health Benefit Exchange Authority (DCHBX) Carrier Reference Manual update clarifies that DCHBX has no role in the administration, verification, or enforcement of the religious objection accommodation requirements for the coverage of preventive health services, consistent with 45 C.F.R. §147.131.

Implementation of the religious objection accomodation for qualified small businesses is a matter to be addressed between the small business and the relevant carrier(s). Accordingly, should a small business have a religious objection and be an "eligible organization,"as described in the regulations, it is the responsibility of the small business to inform relevant carrier(s)through self-certification or provide notice to the Secretary of Health and Human Services, who will notify the small employer's carrier(s). DCHBX cannot take information related to a small business's religious objection from a small business, broker, or any other authorized representative of the small business, and DCHBX assumes no responsibility for passing along religious objection information to the relevant carrier(s).

Electronic data interchange (EDI) transactions will not reflect any information about a particular businesses qualification for this religious objection accomodation. Carriers should take steps consistent with 45 C.F.R. §147.131 to provide the appropriate benefit package(s) to qualifying employers.

This policy is effective upon release of this Carrier Reference Manual update.

KEY DATES for Plan Year 2017

Activity		Dates
QHP Application Submission & Review	Deadline for Submission of Templates and Supporting Documents in SERFF	8/1/2016
	SBCs Due	9/1/2016
	Deadline to submit all plan corrections	10/1/2016

ANNOUNCEMENTS

DC HBX announced the launch of a new prescription drug tool to find coverage and cost-related information in health plans. DC Health Link customers can now easily check whether a prescription medication is covered by a health plan and what the related out of pocket costs are. The prescription drug "look up" feature was added to DC Health Link Plan Match, which was launched last year to help DC Health Link customers estimate annual out of pocket costs and to see plans that covered particular doctors. The new prescription drug look up feature enables customers to compare plans and include their prescription medication in the comparison. Read the full press release posted on the DC Health Link website.

This update has been developed to keep all issuers of qualified health and qualified dental plans current on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority (HBX). It will be incorporated into the 2017 Carrier Reference Manual. To view the full Carrier Reference Manual, click here. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: June 3, 2015

SUBJECT: QHP Terminations (Carrier Reference Manual Update: 2015.0001)

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately.

QHP Terminations

DCHBX QHP and QDP carriers offering plans on either the Individual market, the small group/SHOP market, or both, must adhere to 45 CFR 156.270, Termination of Coverage for Qualified Individuals, and 45 CFR 155.430, Termination of Coverage.

77 Federal Register 18394 (March 27, 2012) states that a "request for termination may be received through either the Exchange or the QHP (carrier)," and that "regardless of which entity the enrollee contacts to terminate coverage, the Exchange and QHP carriers will need to notify the other entity of the enrollee's coverage status to keep updated enrollment records."

These regulations allow for an individual to terminate coverage directly with their carrier OR the Exchange. Up to this point, DCHBX has been the sole entity processing terminations of coverage for individuals, with those wishing to terminate coverage needing to contact the DCHBX directly or through referral by their carrier.

The DCHBX recognizes that customers must provide "reasonable notice" to either DCHBX or the carrier to terminate coverage. Fourteen (14) days is considered reasonable notice in advance of a termination request.

However, carriers are free to terminate, on the date the consumer requests, with less than 14 days' notice. This creates multiple scenarios depending on when a customer makes the request and for what date the termination is requested. See examples below:

Date of Request	Termination Request Date	Latest Date Term Can Occur	Earliest Date Term Can Occur	Explanation
1/17/2016	1/31/2016	1/31/2016	1/31/2016	Customer Provided Reasonable Notice (14 days) prior to requested date.
1/17/2016	2/8/2016	2/8/2016	2/8/2016	Customer Provided Reasonable Notice (22 days) prior to requested date.
1/24/2016	1/31/2016	2/7/2016	1/31/2016	Customer DID NOT provide reasonable notice, so cannot get date requested UNLESS carrier agrees.

DCHBX has established a **voluntary, manual** process to allow carriers to directly accept terminations by customers over the phone, via e-mail, or through other methods the customer is made aware of (i.e. secure consumer portal). This is based on our current procedures for terminations of individuals who reach out to the DCHBX as well as our experience with carriers in receiving timely and accurate EDI termination transactions.

Customer initiates Termination with Carrier:

1. Customer calls carrier call center and/or provides electronic communication indicating that they would like to terminate their coverage.
2. Carrier CSR takes down the following information:
    a. Date of desired termination (following the chart above)
    b. Enrollee full name
    c. Any dependents to be included in termination
    d. Enrollee DOB
    e. Enrollee plan selection

3. Carrier CSR informs customer that termination will be processed within 3 business days
4. Carrier representative provides information on termination to assigned HBX liaison, including whether they will exercise discretion and terminate in less than the required 14 days.
5. No less than every other day, carrier HBX liaison provides matrix to HBX Plan Management team for EDI processing.
6. DCHBX proceeds with termination transaction- providing an outbound 834 file to appropriate carrier.
7. Carrier provides acknowledgement of receipt of termination file and processes in a timely manner (3 business days).

In the event a carrier fails to adhere to these procedures, and a customer subsequently calls DCHBX requesting termination, the DCHBX will accept customer self-attestation of 1) the date they called the carrier to request termination and 2) whether the carrier agreed to terminate in less than 14 days from the date of that request. The carrier may submit contrary evidence within 7 days of a voluntary termination transmission.

Payment Grace Periods and QHP Terminations

For those DCHBX enrollees receiving APTC, federal regulations allow for a 3-month grace period in premium payments prior to termination for non-payment (by a carrier). Those enrollees who do not receive APTC are extended a 31-day grace period in premium payments prior to termination.

If a DCHBX enrollee can demonstrate that their carrier did not generate an invoice at least 7 days prior to the premium due date, that enrollee will be made eligible for a special enrollment period (SEP).

Mid-Month Terminations

DCHBX will accept mid-month terminations both directly and from carriers following the process laid out above. DCHBX follows the guidance of 77 Federal Register 18394 (March 27, 2012) that states "We want to ensure that individuals who have access to other coverage sources do not need to maintain Exchange coverage longer than necessary." No matter the origin of the mid-month termination, DCHBX requires that the following information is provided by the individual's carrier:

- Prorated premium amount (including refunding any amounts already paid)
- Prorated APTC amount (if applicable)

Timing of HBX receipts of prorated premium amount to be determined after initial analysis of carrier process (pending responses).

For mid-month terminations, whether originating with DCHBX or the carrier, carriers are expected to prorate both the premium amount and APTC according to Federal proration methodology (155.240(e)) as follows:

> *Premium/APTC/advance CSR/user fee for full month of coverage * (# daysof coverage/# days in month) = partial month premium/APTC/advance CSR/user fee 2*

Termination Grace Periods

Pursuant to federal regulations imposed on both carriers and the federally facilitated marketplace, DCHBX recognizes a grace period of no less than one-month for individual market enrollees who are late in their payments to be terminated (this period is expanded to three-months for individual market enrollees who receive financial assistance).

DCHBX expects that any termination for non-payment, an 834 termination file MUST be delivered to DCHBX with the appropriate termination date (not the date of file transfer) and any relevant premium or APTC proration information. DCHBX is not, however, waiving its right to terminate people for non-payment in those cases where we learn that a customer has not paid and the carrier has been delinquent in acting.

DCHBX reserves the right to initiate 834 termination files for of customers' QHP coverage, retroactively, when it learns that those customers have not paid for coverage for a period of time and the carrier has been delinquent in initiating or transmitting a termination file. This action is necessary to ensure accuracy of our enrollment records.

Retroactive SHOP Employee Terminations

DCHBX allows retroactive terminations of up to 60 days for SHOP employees. For example, if an employee is terminated on 1/1/2015, we allow until 3/1/2015 to be informed and process the termination with the respective carrier(s).

Until approximately March 2015, this rule was stretched by certain Congressional terminations due to internal operations within both the House and Senate that often prevented the timely transmission of terminations. Recognizing that the adverse impact this had on carriers we enforced the small group termination policy of 60 days on Congress. So far this has proven to be a success.

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. 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 the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: June 11, 2015

SUBJECT: Small Group Market (SHOP) Conversion Process Timeline: 2015.0002

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following timeline will go into effect immediately.

2015 SHOP Renewals into DC Health Link: Process & Timeline

Dates (Based on 1/1 renewal date)	Event/Action
Jan. 1, 2014	Start of 2014 plan year. Carrier direct enrollment.
Oct./Nov. 2014	Carrier sends 2015 renewal notice to employer containing information on 2015 SHOP conversion process
Dec. 2014	Employer completes normal carrier renewal process for 2015 plan year
	Employees enroll directly through normal carrier process
Jan. 1, 2015	Start of 2015 plan year.
	Employee enrollments throughout plan year continue directly through normal carrier processes.
Jun. 1, 2015	DC HBX provides format/templates to carriers for loading employer (group) information and employee information
Jul. 15, 2015	Carrier sends DCHBX (via e-mail) sample size of 1/1/16 employer data (5-10 groups) for initial load into DCHL.
Jul. 20, 2015	Carrier begins sending remaining 1/1/16 employer data to DCHBX

Jul. 20, 2015	DCHBX begins preparation of training plan for employers, brokers, TPAs
Aug. 3, 2015	Carrier sends DCHBX (via e-mail) sample size of 1/1/16 employee production data.
Aug. 18, 2015	Carrier Final date for submission of 1/1/16 employer data to DCHBX
Aug. 18, 2015	Carrier begins sending 2/1/16 employer data to DCHBX
Aug. 20, 2015	Carrier begins sending remaining 1/1/16 employee production data to DCHBX
Aug. 31, 2015	DCHBX Training materials finalized for employers, brokers, TPAs
Sept. 1, 2015	DCHBX: Employer, broker, TPA training begins
Sept. 22, 2015	Carrier Final date for submission of 2/1/16 employer data to DCHBX
Sept. 22, 2015	Carrier begins sending 3/1/16 employer data to DCHBX
Sept. 23, 2015	Carrier Final date for submission of 1/1/16 employee production data
Sept. 23, 2015	Carrier begins sending 2/1/16 employee production data to DCHBX
Oct. 1, 2015	DCHBX sends renewal notice to conversion employers.
Oct. 12, 2015	Brokers/TPAs can enter DCHL to review or modify 2016 coverage for 1/1/16 employer groups
Oct. 13, 2015	Employers can enter DCHL to review or modify 2016 coverage for 1/1/16 renewals
Oct. 20, 2015	Carrier Final date for submission of 3/1/16 employer data to DCHBX
Oct. 20, 2015	Carrier begins sending 4/1/16 employer data to DCHBX
Oct. 21, 2015	Carrier Final date for submission of 2/1/16 employee production data.
Oct. 21, 2015	Carrier begins sending 3/1/16 employee production data to DCHBX
Nov. 1, 2015	Employees with 1/1/16 renewing employer can begin shopping and enrollment
Nov. 1, 2015	Brokers/TPAs conclude reviewing or modifying coverage through DCHL for 1/1/16 employer groups
Nov. 9, 2015	Congressional Open Enrollment Begins
Nov. 17, 2015	Carrier Final date for submission of 4/1/16 employer data to DCHBX
Nov. 17, 2015	Carrier begins sending 5/1/16 employer data to DCHBX
Nov. 18, 2015	Carrier Final date for submission of 3/1/16 employee production data.
Nov. 18, 2015	Carrier begins sending 4/1/16 employee production data to DCHBX
Nov. 30, 2015	Final day for Employers to review or modify 2016 coverage for 1/1/16 renewals
Dec. 5, 2015	Open enrollment closes for 1/1/16 employer groups
Dec. 7, 2015	Congressional Open Enrollment Ends
Dec. 13, 2015	Final day to shop for and enroll in a plan for employees of 1/1/16 renewing groups.

Dec. 15, 2015	Reconciliation/snapshot of 1/1/16 employee census changes.
Dec. 22, 2015	Carrier Final date for submission of 5/1/16 employer group data to DCHBX
Dec. 22, 2015	Carrier begins sending 6/1/16 employer group data to DCHBX.
Dec. 23, 2015	Carrier Final data for submission of 4/1/16 employee production data
Dec. 23, 2015	Carrier begins sending 5/1/16 employee production data to DCHBX

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

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MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: June 12, 2015

SUBJECT: Individual Market Renewal Process Timeline: 2015.0003

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following timeline will go into effect immediately.

2015 Individual Market Renewal Process and Timeline

Dates	Event/Action
Jul. 10, 2015	DCHBX begins outreach to individual market consumers to obtain necessary IRS consent
Sept. 10, 2015	DCHBX mails PROJECTED eligibility redetermination notice
Sept. 15, 2015	Consumers can access DCHL account to report on any income and/or eligibility changes
Oct. 15, 2015	Final day for consumers to update income and/or eligibility changes in DCHL
Oct. 15, 2015	DCHBX mails FINAL eligibility redetermination notice
Oct. 15, 2015	DCHBX EDI begins delivery of passive renewals to carriers reflecting FINAL eligibility redetermination
Oct. 31, 2015	Final day for DCHBX EDI delivery of passive renewals to carriers.
Nov. 1, 2015	Open Enrollment Begins
Dec. 15, 2015	Final day for consumers to make an active plan selection for coverage beginning on 1/1/16

Dec. 16, 2015	DCHBX EDI delivers any active plan selection transactions to carriers, correcting previously delivered passive renewals (when applicable)
Dec. 28, 2015	DCHBX provides reminder (method TBD)
Dec. 30, 2015	Reconciliation of individual market renewals
Jan. 1, 2016	Coverage begins
Jan. 2, 2016	Reconciliation of individual market renewals

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

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MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy, and Operations

DATE: June 22, 2015

SUBJECT: Religious Accommodations (Carrier Reference Manual Update: 2015.0004)

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately .

Religious Accommodations

DCHBX QHP and QDP carriers offering plans on either the Individual market, the small group/SHOP market, or both, must adhere to 45 C.F.R. 147.131, Preventinve Health Services Exemption and Accomodations.

The federal regulations provide that a group health plan seeking to take advantage of the exemption for certain religious employers are required to complete a self-certification and provide it to the health insurance carrier or carriers providing coverage in connection with the plan. Alternatively, the group health plan can provide a notice to the Secretary of Health and Human Services that it is an eligible organization. If the group health plan provides the self-certification directly to the issuer, the issuer is solely responsible for providing the coverage the employer has self-certified it has a religious objection to providing in accordance with the preventive health services requirements set forth a 45 C.F.R. 147.130. If the group health plan elects to provide notice to the Secretary of HHS, HHS will then contact each carrier to inform them of their obligations with respect to that group health plan.

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier

Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

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MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: July 22, 2015

SUBJECT: Carrier Reference Manual Update: 2015.0005

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately.

SHOP Conversion

The DC Health Benefit Exchange Authority (HBX) is extending the phase-in period to complete the conversion of the District's small group marketplace to DC Health Link. Carriers will have an additional six months to provide the necessary data and set up their renewing groups with DC Health Link. **Carriers must set up groups with up to 50 employees who are renewing coverage effective July 1, 2016**, or later to enable the renewal through DC Health Link. An updated schedule for completion of the phased approach will be distributed to all carriers.

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

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MEMORANDUM

TO: Carriers Offering Health & Dental Insurance through DC Health Link

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: August 6, 2015

SUBJECT: SHOP Conversion #2 (Carrier Reference Manual Update: 2015.0006)

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately.

SHOP Conversion #2

In response to several questions received by DCHBX in relation to the SHOP Conversion and groups with 51-100 full-time equivalent employees (FTEs), the following is the framework for small group medical insurance purchases and renewals through July 1, 2016:

Present through 6/30/2016 plan years (GROUPS WITH 1-50 FTEs)

Must purchase through DC Health Link

- New groups of 1-50 FTEs (not currently offering coverage)
- Groups if 1-50 FTEs who already offer coverage through DC Health Link (upon their plan year renewal)
- Groups of 1-50 FTEs currently offering coverage, not through DC Health Link, that want to change carrier (upon their plan year renewal)

Choice to purchase directly through carrier or through DC Health Link

- Groups of 1-50 FTEs currently offering coverage, not through DC Health Link, that want to renew with the same carrier, but may change products within that carrier (upon their plan year renewal)

Beginning 7/1/2016 plan years (GROUPS WITH 1-50 FTEs)

Must purchase coverage through DC Health Link

- All groups with 1-50 FTEs, whether currently offering coverage through DC Health Link or through the carrier directly (upon their plan year renewal)
    - Groups currently offering coverage directly through the carrier will be pre-setup by DC Health Link and the carrier to expedite the renewal process which will be the first time these groups will be on DC Health Link

Beginning 1/1/2016 plan years (GROUPS WITH 51-100 FTEs)

Choice to purchase directly through carrier or through DC Health Link

- Groups with 51-100 FTEs purchasing small group products

Only purchase coverage directly through carrier (1/1/2016 – 10/1/2016 plan year **renewals only**)

- Groups with 51-100 FTEs who wish to purchase large group products, in accordance with DISB Bulletin 15-IB-05-04/28

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. 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 the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

MEMORANDUM

TO: Small Group (SHOP) Stand-Alone Dental Plan Carriers

FROM: DCHBX Office of Marketplace Innovation, Policy, and Operations

DATE: August 6, 2015

SUBJECT: Stand Alone Shop Dental Carrier OnBoarding Timeline (Carrier Reference Manual Update: 2015.0007)

In an effort to keep all health and dental carriers updated on the requirements set forth in section 1301 of the Patient Protection and Affordable Care Act (ACA) and by the DC Health Benefit Exchange Authority, the following policy will go into effect immediately .

STAND ALONE SHOP DENTAL CARRIER ON-BOARDING TIMELINE FOR 1/1/2016 ENROLLMENT

Beginning Date	Ending Date	Task
7/27	7/27	Carrier Reference Material sent by HBX
8/5	8/5	Carrier Meeting with HBX
8/7	8/7	Carriers to provide test infrastructure info
8/10	8/14	EDI Test Set up
8/17	8/21	EDI Test connectivity
8/10	11/6	EDI Testing period
8/28	8/31	Load SHOP Dental Plans
9/1	9/30	Carrier Plans Benefit and Rate testing

10/1	12/1	Employers can pick SHOP dental plans
11/1 (with ER Set-up complete)	12/10	EE's can shop for OE ending on 1/1
11/6	11/15	Carriers to provide info for Billing set-up
11/9	11/9	Prod info from Carriers due
11/16	12/1	Billing set up
11/16	11/20	Prod set up
11/23	12/1	Prod connectivity testing
12/1	12/1	Carrier Production connectivity established
12/21	12/21	EDI transmission to Carriers
12/24	12/24	1st 820 transmission

This update will be incorporated into the 2016 Carrier Reference Manual. To view the full Carrier Reference Manual, click here: 2016 Carrier Reference Manual. Should you have questions regarding the Carrier Reference Manual or this current update, please contact the DC Health Benefit Exchange Authority at Carrier.HBXInquiries@dc.gov or 202.715.7576.

The Health Benefit Exchange Authority Establishment Act of 2011 allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. The Carrier Reference Manual and its appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. 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 the Carrier Reference Manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

Appendix H

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

Please retain a copy of the completed Quality Improvement Strategy (QIS) Implementation Plan form so that it is available for future use for reporting on activities conducted to implement the QIS. For detailed instructions, please refer to the QIS Technical Guidance and User Guide for the 2017 Coverage Year.

QIS Submission Type

Part A. New or Continuing QIS Submission

This field is 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
◉ **New QIS[1] with No Previous QIS Submission**	Complete the Background Information Section (Parts B and C) and the Implementation Plan Section (Parts D and E).
○ **New QIS after Discontinuing a QIS Submitted during the Qualified Health Plan (QHP) Application Period[2]**	**Must complete two forms:** 1. Complete a form to close out the discontinued QIS, including the Background Information Section (Parts B and C); Implementation Plan Section (Parts D and E), with the discontinued QIS information; and Progress Report Section (Part F); AND 2. Complete a new/separate form to submit the new QIS, including the Background Information Section (Parts B and C) and the Implementation Plan Section (Parts D and E).
○ **Continuing a QIS with No Modifications**	Complete the Background Information Section (Parts B and C), Implementation Plan Section (Parts D and E), and the Progress Report Section (Part F).
○ **Continuing a QIS with Modifications[3]**	Complete the Background Information Section (Parts B and C); Implementation Plan Section (Parts D and E); and the Progress Report Section (Part F).

[1] A "new QIS" is defined as a QIS that has not been previously submitted to a Marketplace, or is a QIS that is based upon a different market-based incentive(s) and/or topic area(s) than the issuer's previous QIS.
[2] A new QIS is required if an issuer: changes its QIS market-based incentive type or sub-type, changes its QIS topic area, reaches one or more of its QIS performance targets, the QIS is not having the expected impact, or the QIS results in negative outcomes or unintended consequences.
[3] An issuer may continue with an existing QIS even if it changes the following: QIS activities, QIS goals, and/or QIS measures.

Background Information

Part B. Issuer Information

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

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 Marketplace

15. Current Payment Model(s) Description

Select the category(ies)[4] of payment models that are used by the issuer across its Marketplace product line. If "Fee for Service – Linked to Quality or Value" AND/OR "Alternative Payment Models Built upon Fee for Service Architecture" is checked, provide the percentage of payments tied to quality or value.

Payment Model Type	Payment Model Description
☐ **Fee for Service – No Link to Quality or Value**	Payments are based on volume of services and not linked to quality or efficiency.
☐ **Fee for Service – Linked to Quality or Value**	At least a portion of payments vary based on the quality or efficiency of health care delivery.
☐ **Alternative Payment Models Built upon Fee for Service Architecture**	Some payment is linked to the effective management of a population or an episode of care. Payments still are 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 volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., more than one year).

Provide percentage of payments:

Percentage of Fee for Service payments linked to quality or value: ☐ %

Percentage of payments tied to quality or value through alternative payment models: ☐ %

[4] Categories of payment models are defined in Rajkumar R, Conway PH, and Tavenner M. CMS— Engaging Multiple Payers in Payment Reform. JAMA. 311:19. See the *QIS Technical Guidance and User Guide for the 2017 Coverage Year* for examples of payment models within each category.

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

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

16. Data Sources

Indicate the data sources used for identifying QHP enrollee population needs and supporting the QIS rationale (Element 22). 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

If you checked "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.

17. QIS Title

Provide a short title for the QIS.

(200 character limit)

18. QIS Description

Provide a brief summary description of the QIS. The description must include the market-based incentive type and topic area.

(1,000 character limit)

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

○ Yes ○ No

Is the QIS submission[5] a strategy that the issuer currently has in place for its Marketplace product line and/or for other product lines?

○ Yes ○ No

[5] Issuers may use existing strategies employed in non-Marketplace 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)

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

Note: *Measures described in Element 24 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. All elements must receive a "meets" score during the QIS evaluation. If any elements are scored as "does not meet" in the QIS evaluation, the issuer must revise those elements and resubmit its Implementation Plan for re-review.

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

Select the type and sub-type of market-based incentive(s) the QIS includes. Check all that apply. If either "In-kind incentives" or "Other provider 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)*

20. Topic Area Selection (Must Pass)

Select the topic area(s) this QIS addresses, as defined in the Affordable Care Act.[6] Check each topic area that applies.

QIS Topic Area	Example Activities Cited in the 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

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

21. Targets All Health Plans Offered Through a Marketplace (Must Pass)

21a. Indicate if this QIS is applicable to all QHPs you offer or are applying to offer through the Marketplaces, or to a subset of QHPs.

- ○ All QHPs
- ○ Subset of QHPs*

* If "Subset of QHPs" was selected above, an additional QIS Implementation Plan(s) (Parts D and E of this form) must be submitted for QHPs not covered by this QIS.

If "Subset of QHPs" was selected above, please indicate the number of forms that will be submitted: This is form [ ] of [ ].

21b. In the space provided, specify all QHPs covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]). Indicate if each one is a new or existing QHP. Note: Please list additional health plans covered by the QIS on page 25.

HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan

21c. 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

22. Rationale for QIS (Must Pass)

Provide a rationale for the QIS that describes how the QIS will address the needs of the current QHP enrollee population(s).

(1,000 character limit)

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

23a. List the activities that will be implemented to achieve the identified goals.

(1,000 character limit)

23b. Describe how the activities relate to the selected market-based incentive (see Element 19).

(1,000 character limit)

23c. Describe how the activities relate to the topic area(s) selected (see Element 20).

(1,000 character limit)

23d. If health and health care disparities was not chosen as a selected topic area in Element 20, does the QIS include any activities related to addressing health and health care disparities? If yes, describe the activities below. If (1) health and health care disparities is one of the topic areas selected in Element 20; OR (2) health and health care disparities are not addressed in this QIS, check ☐ Not Applicable.

(1,000 character limit)

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

Restate the goal(s) identified in the QIS description (see Element 18).

QIS Goal 1:

(500 character limit)

For this goal, identify at least one (but no more than two) primary measure(s) used to track progress against the goal.

24a. **Measure 1a**

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 4-digit ID number: ☐ If no, check ☐ Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

◯ Yes ◯ No ◯ Not Applicable

24b. Describe how [Measure 1a] supports the tracking of performance related to [Goal 1].

(1,000 character limit)

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion): ☐

Numerator: ☐

Denominator: ☐

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

☐ – ☐

24e. Provide numerical value performance target for this measure: ☐

24a. **Measure 1b**

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 4-digit ID number: ☐ If no, check ☐ Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

○ Yes ○ No ○ Not Applicable

24b. Describe how [Measure 1b] supports the tracking of performance related to [Goal 1].

(1,000 character limit)

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion): ☐

Numerator: ☐

Denominator: ☐

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

☐ – ☐

24e. Provide numerical value performance target for this measure: ☐

QIS Goal 2:

(500 character limit)

For this goal, identify at least one (but no more than two) primary measure(s) used to track progress against the goal.

24a. **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 4-digit ID number: If no, check ☐ Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

◯ Yes ◯ No ◯ Not Applicable

24b. Describe how [Measure 2a] supports the tracking of performance related to [Goal 2].

(1,000 character limit)

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion): [ ]

Numerator: [ ]

Denominator: [ ]

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

[ ] – [ ]

24e. Provide numerical value performance target for this measure: [ ]

24a. **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 4-digit ID number: [ ] If no, check ☐ Not Applicable

Is the NQF-endorsed measure used without modification to the measure specification?

◯ Yes ◯ No ◯ Not Applicable

24b. Describe how [Measure 2b] supports the tracking of performance related to [Goal 2].

(1,000 character limit)

[ ]

24c. Baseline Assessment. Provide the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion): ☐

Numerator: ☐

Denominator: ☐

24d. Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

☐ – ☐

24e. Provide numerical value performance target for this measure: ☐

25. Timeline for Implementing the QIS

25a. QIS Initiation/Start Date: ☐

25b. Describe the milestone(s) and provide the date(s) for each milestone (e.g., when activities described in Element 23 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.

26. Risk Assessment

26a. List any known or anticipated barriers to implementing QIS activities.

(1,500 character limit)

26b. Describe the mitigation activities that will be incorporated to address each barrier identified in Criterion 26a.

(1,500 character limit)

QIS Progress Report Section

Part F. Progress Report Summary

The elements in Part F will be scored as part of the QIS evaluation*. All elements must receive a "meets" during the QIS evaluation. If any elements are scored as "does not meet" in the QIS evaluation, the issuer must revise its Progress Report and submit it for re-review.*

27. Addition of QHPs to the Issuer's QIS

27a. Indicate if the issuer is adding any QHPs to the QIS originally listed in 21b.

- ○ Add QHP(s)
- ○ No additional QHP(s)

27b. If "Add QHP(s)" was selected, list all new QHPs and provide each plan's unique 14-digit HIOS Plan ID (SCID). If no additional QHPs were included, check ☐ Not Applicable.

Note: Please list additional health plans covered by the QIS on page 26.

HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	

28. QIS Modifications

28a. If "**Continuing a QIS with Modifications**" was selected in Part A, Element 1, please indicate what type of modification the issuer is making to its QIS. Check all that apply. Note that modifications only apply to elements in Part D (Implementation Plan). If no modifications are being made, check ☐ Not Applicable.

Element Being Modified
☐ Goals
☐ Performance measure(s)
☐ Activities

28b. Provide a justification and brief description of the modification(s) selected in Criterion 28a. If "Continuing a QIS with Modifications" was **NOT** checked in Part A, Element 1, check ☐ Not Applicable.

(500 character limit)

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

Restate the goals identified in the Implementation Plan (see Elements 18 and 24). For each goal, restate the measure(s) information identified in Element 24, and complete the tables below.

QIS Goal 1:

(500 character limit)

Measure 1a:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

_____ – _____

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

_____ – _____

29c. Measure 1a Name:

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

Was the performance target (Criterion 24e) achieved?

○ Yes ○ No

Measure 1b:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

–

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

–

29c. Measure 1b Name:

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

Was the performance target (Criterion 24e) achieved?

Yes No

QIS Goal 2:

(500 character limit)

Measure 2a:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

–

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

–

29c. Measure 2a Name:

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator:

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion):

Numerator:

Denominator: [ ]

Was the performance target (Criterion 24e) achieved?

○ Yes ○ No

Measure 2b:

29a. Baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

[ ] – [ ]

29b. Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment:

[ ] – [ ]

29c. Measure 2b Name: [ ]

29d. Restate the baseline results, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion): [ ]

Numerator: [ ]

Denominator: [ ]

29e. Provide the follow-up results. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

Rate or other data point (e.g., count, ratio, proportion): [ ]

Numerator: [ ]

Denominator: [ ]

Was the performance target (Criterion 24e) achieved?

○ Yes ○ No

30. Summary of Progress (Must Pass)

Indicate why progress was or was not made toward the performance target(s) documented in Element 24. Include a description of activities that led to the outcome.

If modifications were checked in Criterion 28a, indicate whether the information provided here affects the decision to modify or change the QIS:

(1,500 character limit)

31. Barriers

31a. Were barriers encountered in implementing the QIS?

○ Yes ○ No

If "Yes," describe the barriers.

(1,500 character limit)

31b. Were there problems meeting timelines as indicated in Element 25?

◯ Yes ◯ No

If "Yes," describe the problems in meeting timelines.

(1,500 character limit)

32. Mitigation Activities

If "Yes" was selected in 31a or 31b, describe the mitigation activities implemented to address each barrier or problem in meeting the timeline. Also, describe the result(s) of the mitigation activities.

If "No" was selected in 31a and 31b, check ☐ Not Applicable.

(1,500 character limit)

Criterion 21b continued

In the space provided, place specify any additional health plans (outside of those already listed in Criterion 21b) covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]). Indicate if each one is a new or existing health plan.

HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan
HIOS Plan ID (SCID)		○ New Health Plan	○ Existing Health Plan

Criterion 27b continued

In the space provided, place specify any additional health plans (outside of those already listed in Criterion 27b) covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]).

HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	
HIOS Plan ID (SCID)		HIOS Plan ID (SCID)	

Appendix I

Health Benefit Exchange Authority Decision Support Tools

CONSUMERS' CHECKBOOK
Center for the Study of Services
www.checkbook.org | www.cssresearch.org

DC Health Link 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.

Plan Match Tool

DC Health Link provides consumers with a Plan Match tool to help them compare available health plans. Consumes 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. It is completely anonymous.

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 data for the Plan Match tool are the SERFF/CCIIO template data submitted by the carriers to DC Health Link. The provider participation data is submitted by the carriers to Checkbook via Checkbook's data aggregation partner, Zelis (formerly Strenuus).

Formulary Updates – Note, Checkbook uses the SERFF/CCIIO Prescription Drug template data to populate the formulary component of Plan Match. Carriers have the option to submit updated formulary data files to Checkbook after the initial SERFF/CCIIO filings. Checkbook will refresh formulary data with any newly submitted carrier data on a monthly basis. Updated formulary data files must be submitted in the SERFF/CCIIO format, or in the CMS Machine Readable Drugs.json format.

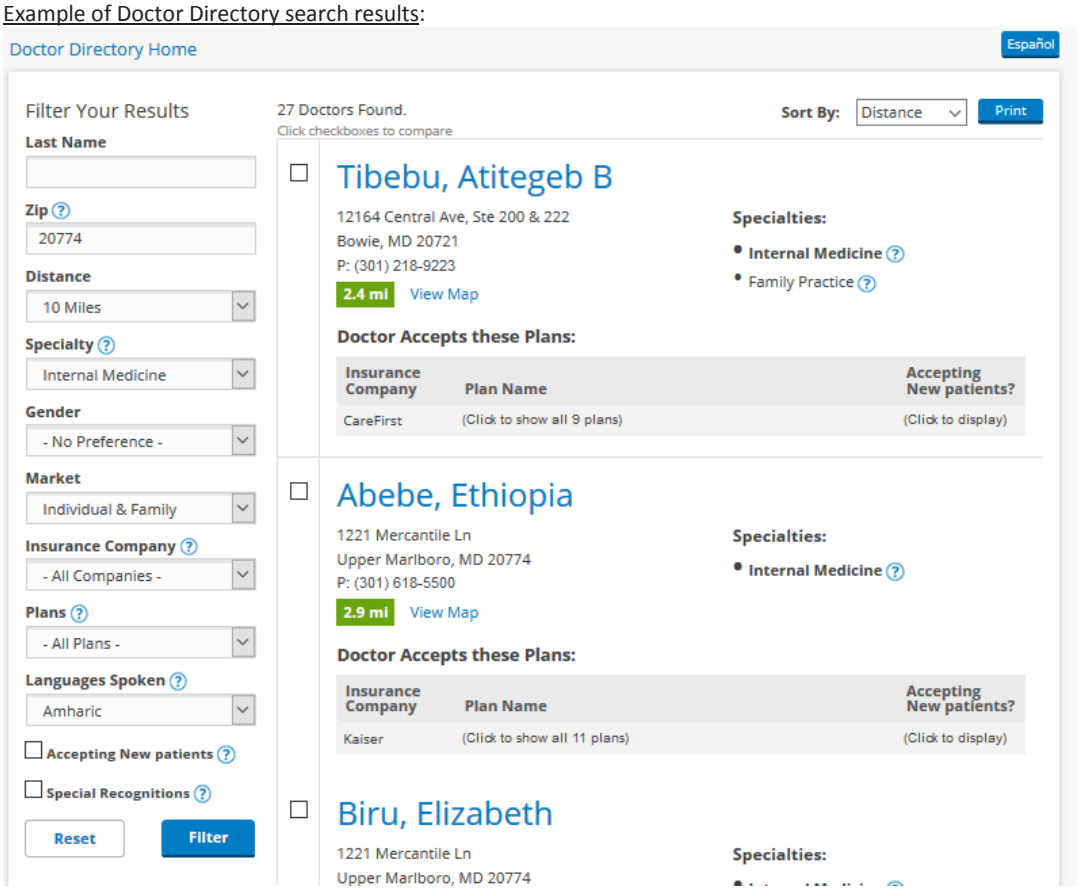
All-Plan Doctor Directory

DC Health Link 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.

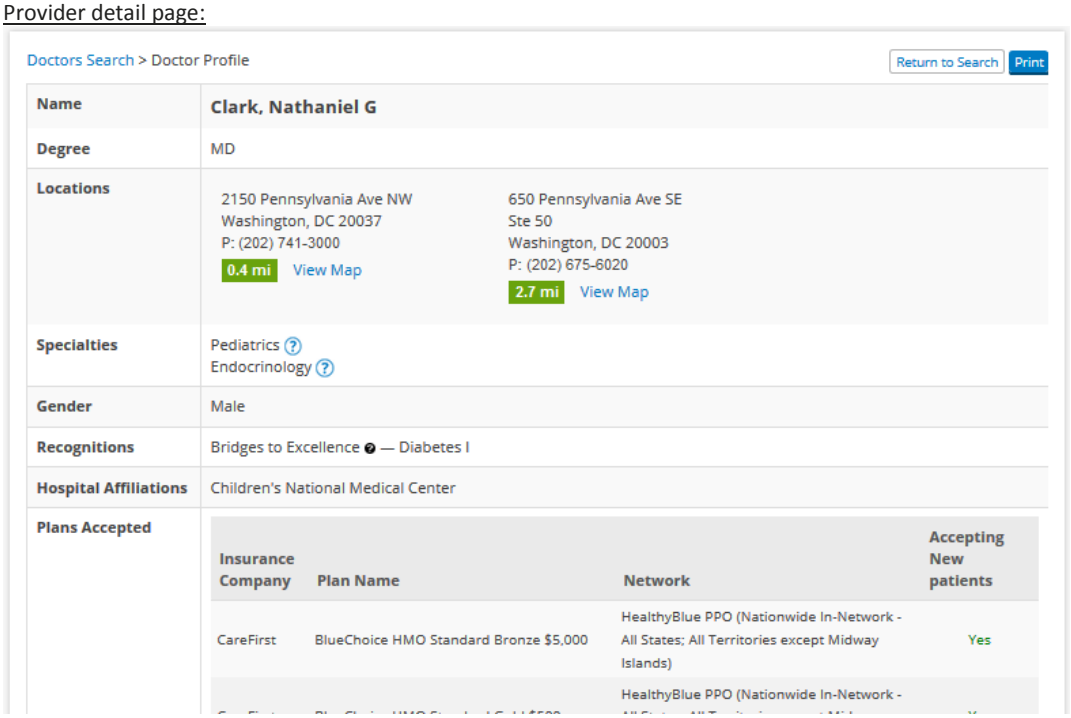
The doctor directory, which Checkbook maintains in collaboration with their data aggregation partner Zelis, allows consumers to see the plans in which their doctors participate in a single interface. The doctor directory tool only includes networks and QHPs available through the DC Health Link exchange,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



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; 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 NPI dataset.
    c. Checkbook then pushes the refreshed doctor data in the DC Health Link all-plan doctor directory.

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 DC Health Link's Plan Management team at carrier.hbxinquiries@dc.gov and the Health Benefit Exchange Authority Plan Management Deputy Assistant Director Luis Vasquez (Luis.Vasquez3@dc.gov).