

Form Review Checklist

V9_Revised March 19, 2024

Company Name:	
Product Type:	
Product Name:	
Plan:	
SERFF Tracking Number:	
Plan Form Number:	
Market	<input type="checkbox"/> Individual <input type="checkbox"/> Small Group
<input type="checkbox"/>	60% AV (Bronze)
<input type="checkbox"/>	70% AV (Silver)
<input type="checkbox"/>	80% AV (Gold)
<input type="checkbox"/>	90% AV (Platinum)
<input type="checkbox"/>	Catastrophic

Instructions

1. Issuers are requested to complete the checklist for Plan Year 2025. 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.
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).

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
A.1	<p>Guaranteed availability of coverage</p> <p>Carriers that offer coverage in a state must accept every individual or employer in that state that applies for coverage, subject to certain exceptions</p> <p><u>Federal & DC Law</u></p> <ul style="list-style-type: none"> 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 	<p><u>Exceptions to guaranteed availability</u></p> <ul style="list-style-type: none"> Enrollment may be restricted to open or special enrollment periods (SEPs) 		✓	✓			
A.2	<p>Guaranteed renewability of coverage</p> <p>Issuers must renew or continue in force coverage at the option of the plan sponsor or individual with six exceptions:</p> <ul style="list-style-type: none"> Nonpayment of premiums Fraud Violation of participation or contribution rules (SHOP) Termination of product Enrollees' movement outside service area Association membership ceases 	<p><u>Uniform modification of coverage exception:</u> 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.</p> <ul style="list-style-type: none"> 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 <u>not later than 60 days prior to the date on which the modification will become effective.</u> <p>Tip: Renewability statements that include other reasons for not renewing are not permissible.</p>		✓	✓			

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	<p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 							
A.3	<p>Preexisting condition exclusions</p> <p>Carriers of group and individual health insurance coverage may not apply pre-existing condition exclusions to any individual or enrollee.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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) 	<p>Examples of problematic language:</p> <ul style="list-style-type: none"> Benefits limited by the onset of the illness/injury: “Reconstructive surgery to correct an accidental injury will be covered if the accidental injury happened no more than 24 months before your surgery.” Refusal to cover services to treat illness/injury resulting from non-covered services when such services are otherwise covered (commonly bariatric surgery or cosmetic surgery): “Treatment of complications of bariatric surgery are not covered.” 		✓	✓			

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	<ul style="list-style-type: none"> 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. 							
B.1	<p>Essential Health Benefits (EHB): Coverage of EHB</p> <p>Issuers must provide benefits that are substantially equal to the EHB-benchmark plan, including covered benefits and limitations on coverage, for the following categories:</p> <ul style="list-style-type: none"> 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 <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 	<p>DC does not permit benefit substitutions.</p> <p>Note: rehabilitative and habilitative benefits must be offered separately. They may not have combined day or visit limits.</p> <p>Excluded from EHB even though an EHB benchmark plan may cover them:</p> <ul style="list-style-type: none"> Adult dental, adult vision, long-term/custodial nursing home care benefits, non-medically necessary orthodontia Abortion services <p>Carriers cannot exclude or limit these benefits that are in the DC benchmark:</p> <ul style="list-style-type: none"> Reversal of voluntary sterilization <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 		✓	✓			

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	<ul style="list-style-type: none"> 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/ccio/resources/data-resources/ehb.html#District%20of%20Columbia 	<ul style="list-style-type: none"> 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]. 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]. <p>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.</p> <p>Tip: Check benefit maximums and service limitations to ensure no dollar limits for EHBs.</p>						
B.2	EHB: Ambulatory Patient Services			✓	✓			
B.3	EHB: Emergency Services			✓	✓			
B.4	EHB: Hospitalization			✓	✓			
B.5	<p>Maternity coverage (see EHB) and required benefits for hospital stays in connection with childbirth:</p> <ul style="list-style-type: none"> Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. <p>EXCEPTION: this does not apply if the provider, in</p> <ul style="list-style-type: none"> 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. 	<p>Note: In the case of multiple births, hospital length of stay begins at the time of the last delivery.</p>		✓	✓			

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	<ul style="list-style-type: none"> 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. <p>The issuer is not allowed to:</p> <ul style="list-style-type: none"> 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. <p><i>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.</i></p> <p><u>Federal & DC Law</u></p>							

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	<ul style="list-style-type: none"> PHSA §2725 45 CFR §146.130 D.C. Code § 31-3801 – Coverage for postpartum care 							
B.6	EHB: Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment			✓	✓			
B.7	<p>EHB: Prescription Drug Benefits</p> <p>To provide EHB, a plan must:</p> <ol style="list-style-type: none"> 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, <u>and</u> 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. <p>Federal & DC Law</p> <ul style="list-style-type: none"> 45 C.F.R. § 156.122: Prescription drug benefits <ul style="list-style-type: none"> Note: exceptions process for non-formulary drugs is described in 45 C.F.R. § 156.122(c) D.C. Code § 31-3171.09 D.C. Code §48-855 Specialty Drug Copayment Limitation (see also D.C. 30 below, new insulin copay cap) 	<p>Carriers cannot exclude or limit these benefits that are in the DC benchmark:</p> <ul style="list-style-type: none"> Methadone maintenance treatment <ul style="list-style-type: none"> Benchmark: “methadone maintenance treatment” is a covered benefit. Description of covered services, p.[B][31]. 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). A health benefit plan that provides coverage for prescription drugs shall ensure that a required copayment or coinsurance applicable to a drug on a specialty tier does not exceed \$150 per month for up to a 30-day supply of the specialty drug or \$300 for a 90-day supply. Increases annually on July 1 and posted to DISB website. <p>Model language</p> <p>“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.”</p>		✓	✓			

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B.8	EHB: Rehabilitative and Habilitative Services and Devices			✓	✓			
B.9	EHB: Laboratory Services			✓	✓			
B.10	EHB: Preventive and Wellness Services and Chronic Disease Management			✓	✓			
B.11	EHB: Pediatric Services, including Oral and Vision Care			✓	✓			
B.12	<p><input type="checkbox"/> No annual limits on the dollar value of EHB:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care <p><u>Federal & DC Law</u></p> <ul style="list-style-type: none"> • PHS A §2711 • 80 Fed Reg 72191 • 45 CFR §147.126 • D.C. Code § 31-3272: Habilitative services for children under 21. 	<p>Tip: If there are maximum dollar limits, check to ensure that these are not for benefits within one of the EHB categories.</p> <p>Problematic contract language/example: EHB-eligible hospital services limited to \$100,000 annually. This violates prohibition on annual dollar limits on EHB.</p>		✓	✓			
C.1	Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)	<p><u>Common issues</u></p> <ul style="list-style-type: none"> • Prior authorization requirements that are not imposed on medical/surgical services • Treatment plan requirements 		✓	✓			

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	<p>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:</p> <ul style="list-style-type: none"> • Lifetime and annual dollar limits, • Financial requirements • Quantitative treatment limits, • Cumulative financial requirements and quantitative treatment limits, and • Non-quantitative treatment limits (NQTLs) <p>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.</p> <p>☐ Completed Mental Health Parity and Addiction Equity Act Checklist and Certification is included with filing.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Benefits restricted for failure to follow a course of treatment • 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 <p>MHPAEA applies to benefits for Medication Assisted Treatment (MAT) for opioid use disorder:</p> <ul style="list-style-type: none"> • Q11, CCIIO FAQs set 31 (4/20/16) • Q6-Q9, CCIIO FAQs set 34 (10/27/16) <p>See also D.C. Code §§ 31-3175 and 7-3201-3205 regarding additional requirements related to parity, opioid treatment and prevention, and reporting.</p>						
C.2	Lifetime and Annual Dollar Limits			✓	✓			
C.3	Financial Requirements			✓	✓			
C.4	Quantitative Treatment Limits			✓	✓			
C.5	Cumulative Financial Requirements and Quantitative Treatment Limits			✓	✓			

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C.6	Non-Quantitative Treatment Limits			✓	✓			
C.7	<p>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</p> <p>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.</p>							
C.8	<p>Drug Abuse, Alcohol Abuse, Mental Illness Act of 1986 (D.C.)</p> <p>D.C. Code § 31-3102:</p> <p>Except as otherwise provided, each health insurer shall provide coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness.</p> <p>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.</p> <p>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.</p> <p>All individual health benefit plans or certificates shall offer coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness.</p>			✓	✓			

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	<p>Drug Abuse, Alcohol Abuse D.C. Code §§ 31-3102, 3103, 3110:</p> <ul style="list-style-type: none"> • 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 <p>Mental Illness D.C. Code § 31-3104:</p> <ul style="list-style-type: none"> • 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 <p>Exemptions D.C. Code § 31-3105:</p> <ul style="list-style-type: none"> • 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 							

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	consideration usual, customary, and reasonable charges for those services.							
D.1	<p>Prohibition on excessive waiting periods* *applies to group coverage, <u>not</u> individual</p> <p>A carrier may not apply any waiting period that exceeds <u>90 days</u>. 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.</p> <p>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).</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> PHS Act §§ 2708 (42 U.S.C. §§ 300gg-3(b)(4), 300gg-7) 45 C.F.R. § 147.116: Prohibition on waiting periods that exceed 90 days 	<p><u>Note</u>: the potential participant/beneficiary is waiting for coverage of <u>all</u> benefits to take effect. This is different from imposing a waiting period on a specific benefit when an individual is already covered, which is permissible.</p> <ul style="list-style-type: none"> Exception: Carriers may not impose a waiting period on pediatric orthodontia. CCIIO FAQ 5/26/16. 			✓			
D.2	<p>Coverage of clinical trials</p> <p>Carriers that cover a “qualified individual” may not:</p> <ul style="list-style-type: none"> 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. 	<p>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.</p> <p>Note: if a carrier generally covers chemotherapy to treat cancer for a qualified individual who is not enrolled in a clinical trial, the carrier cannot deny (or limit or impose additional conditions on) the coverage of such item or service on the basis that it is furnished in connection with participation in an approved clinical trial.</p> <p>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</p>		✓	✓			

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	<p>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.</p> <ul style="list-style-type: none"> 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. <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 	<p>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))</p> <p>Examples of problematic language</p> <ul style="list-style-type: none"> Not covering all four phases of clinical trials Only covering the routine patient costs for clinical trials in which “[t]here is no clearly superior, non-investigational treatment alternative” or “[t]he available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.” Restricting clinical trials to only those for cancer Incomplete or incorrect list of sources of approved clinical trials Not including DC-specific requirements (monitoring; chronic disease) 						
D.3	<p>No lifetime or annual dollar limits on EHB</p> <p>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).</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> PHS Act § 2711 (42 U.S.C. § 300gg-11) 45 C.F.R. § 147.126(a): No lifetime or annual limits D.C. Bulletin 10-IB-02-08/10 	<p><u>Tip</u>: if you see a benefit with a maximum dollar limit, check the DC benchmark to make sure the benefit is not an EHB. Remember that the following are <u>not EHB</u> even though they may be included in the benchmark:</p> <ul style="list-style-type: none"> Adult dental, adult vision, long-term/custodial nursing home care benefits, non-medically necessary orthodontia Abortion services 		✓	✓			

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D.4	<p>Rescissions</p> <p>Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid.</p> <p>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 <u>fraud</u>, or makes an <u>intentional misrepresentation of material fact</u>, as prohibited by the terms of the plan or coverage.</p> <p>Prior to rescinding coverage, a carrier must provide at least 30 days advance written notice to each participant who would be affected.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 	<p><u>Tip</u>: Discontinuation or cancellation with a retroactive effect due to non-payment of premiums = NOT a rescission</p> <p><u>Tip</u>: Look for insurer’s right to cancel to ensure that in a case of retroactive cancellation, the only conditions listed in the contract are fraud or intentional misrepresentation of material fact.</p> <p>Example of problematic language “We may immediately end your coverage if:</p> <ul style="list-style-type: none"> You act in such a disruptive way as to prevent or adversely affect our operations or those of a network provider.” <u>DC law</u>: the situations in which a carrier may terminate coverage are set forth in D.C. Code § 31-3302.05 (individual renewability), D.C. Code § 31-3303.03 (small group renewability), and D.C. Code § 31-3311.06 (post-claims underwriting and prior approval for rescission, cancellation, or limitation). DC law does not permit termination of coverage for disruptive behavior. <u>Federal law</u>: the situations in which a carrier may terminate coverage are set forth in 45 C.F.R. § 147.106 (guaranteed renewability) and 45 C.F.R. § 147.128 (rescissions). Neither regulation lists the situation described in the form as being a permissible reason to terminate coverage. <u>Requested change</u>: remove sentence. <p><u>FAQs</u>: Q7, CCIIO FAQs set 2 (10/8/10); Q3, CCIIO FAQs set 31 (4/20/16)</p>		✓	✓			
D.5	<p>Dependent coverage until 26 years of age</p> <p>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.</p>	<p><u>Eligible if under age 26</u>:</p> <ul style="list-style-type: none"> 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 the child resides with the primary subscriber) Grandchildren in the primary subscriber’s court-ordered custody 		✓	✓			

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	<p>Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on:</p> <ul style="list-style-type: none"> • Financial dependency on primary subscriber, • Residency, • Student status, • Employment, • Eligibility for other coverage, • Marital status. <p><input type="checkbox"/> Terms of the policy for dependent coverage cannot vary based on the age of a child.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> - 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 <p>Impermissible restriction example: Adult child can stay on parent’s coverage only if child spends at least 6 months in the state.</p> <p>Issuers are not required to cover the child of a child dependent.</p>						
E.1	<p>Internal claims and appeals, external review processes</p> <p>Carriers must implement an effective internal claims and appeals process, which includes, but is not limited to:</p> <ul style="list-style-type: none"> • 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 	<p>Enrollees have:</p> <ul style="list-style-type: none"> • 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) 		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>established to assist such enrollees with the appeals processes; and</p> <ul style="list-style-type: none"> Allowing an enrollee to review the claim file and present evidence and testimony as part of the internal claims and appeals process. <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 D.C. Code § 44-301.08: Independent review organizations 							
E.2	<p>Claims procedures, including applicable time frames</p> <p>General requirements: Required to include a description of:</p> <ul style="list-style-type: none"> Claims procedures; Procedures for obtaining prior approval; Preauthorization procedures; Utilization review procedures; and Applicable time frames. <p>The claims procedure cannot unduly inhibit the initiation or processing of claims.</p> <p>A “claim for benefits” is a request for benefits made by a claimant in accordance with an issuer’s reasonable procedure</p>	<p>Tip: If the issuer requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination, it is considered to unduly inhibit the initiation and processing of claims.</p> <p>Tip: Check for any additional criteria in the contract that a patient must meet before being allowed to submit claims and for asking for review of claims to ensure that the procedure does not unduly inhibit initiation or processing of claims.</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>for filing benefit claims, including pre-service and post-service claims.</p> <p>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—</p> <ul style="list-style-type: none"> (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. <p>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.</p> <p><u>Federal Laws</u> 45 CFR §147.136 29 CFR §2560.503-1</p>							

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
E.3	<p>Time and process for urgent care (pre-service, post-service):</p> <ul style="list-style-type: none"> • 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). 			✓	✓			
E.4	<p>Time and process for concurrent urgent care (at the request of the claimant):</p> <ul style="list-style-type: none"> • 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. 			✓	✓			
E.5	<p>Time and process for pre-service claim:</p> <ul style="list-style-type: none"> • 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. 			✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> • 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. • 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. 							
E.6	<p>Time and process for on-going services/treatment (concurrent care decisions):</p> <ul style="list-style-type: none"> • 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. 			✓	✓			
E.7	Time and process for post-service claim:			✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> • 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. 							
E.8	<p>Standards for all required notices:</p> <ul style="list-style-type: none"> • 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 			✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>description of the issuer’s standard that was used in denying the claim.</p> <ul style="list-style-type: none"> • A <u>final internal adverse benefit</u> decision must include: <ul style="list-style-type: none"> ○ A discussion of the decision; ○ A description of available internal appeals and external review processes; and ○ A description of how to initiate an appeal. • An adverse benefit determination must describe: <ul style="list-style-type: none"> ○ Applicable expedited review process; and ○ Availability of and contact information for health insurance consumer assistance or ombudsman. 							
F.1	<p>Internal appeals of adverse benefit determinations - processes, rights and required notices:</p> <ul style="list-style-type: none"> • 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. • 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. 			✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>An “<i>adverse benefit determination</i>” 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.</p> <p>A rescission of coverage must be treated as an adverse benefit determination.</p> <p>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.</p> <ul style="list-style-type: none"> • 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. <p><u>Federal Laws</u> PHSA §2719</p>							

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	75 Fed Reg 43330 76 Fed Reg 37208 45 CFR §147.136							
F.2	<u>Pre-service claim:</u> <ul style="list-style-type: none"> • 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. 			✓	✓			
F.3	<u>Post-service claim:</u> <ul style="list-style-type: none"> • 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. 			✓	✓			
F.4	<u>Urgent claim:</u> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Notify the claimant within 24 hours of the information necessary to complete the claim. ○ Give the claimant at least 48 hours to provide the specified information. ○ 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. 			✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
F.5	<p>In the case of an adverse benefit determination, the notification shall include:</p> <ul style="list-style-type: none"> 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. 			✓	✓			
F.6	<p><u>Ongoing (concurrent care) decisions:</u></p> <ul style="list-style-type: none"> 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. 			✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> Provide advance notice and an opportunity for a review in advance of reducing or terminating benefits. 							
F.7	<p>External review processes rights and required notices:</p> <ul style="list-style-type: none"> External review of an adverse benefit determination for: <ul style="list-style-type: none"> Medical necessity; Appropriateness; Health care setting; Level of care; Effectiveness of a covered benefit; and Rescission. External review of adverse benefit determinations for experimental or investigational treatments or services. <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Issuer did not meet internal appeal process timelines (with limited exceptions); or In cases of urgent care. Cost of an external review must be borne by the issuer. Claimant cannot be charged a filing fee greater than \$25. Restriction on the minimum dollar amount of a claim is not allowed. 	Tip: If there is a filing fee, it cannot be more than \$25.		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> 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. <p>Urgent care:</p> <ul style="list-style-type: none"> 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. <p><u>Federal Laws</u> PHSA §2719 75 Fed Reg 43330 76 Fed Reg 37208 45 CFR §147.136</p>							
G.1	<p>Choice of health care professional</p> <p>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.</p> <p><u>Federal & DC Law</u></p>	<p>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:</p> <ol style="list-style-type: none"> Designation of a primary care provider and The enrollee's right to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. 		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> PHS Act § 2719A (42 U.S.C. § 300gg-19a) 45 C.F.R. § 147.138(a)(1): Patient protections 	<p>Model language from regulation</p> <p>“[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].”</p>						
G.2	<p>Choice of pediatrician as PCP</p> <p>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.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 	<p>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:</p> <ul style="list-style-type: none"> The enrollee’s right to designate any participating physician who specializes in pediatrics as the primary care provider. <p>Model language from regulation</p> <p>“For children, you may designate a pediatrician as the primary care provider.”</p>		✓	✓			
G.3	<p>Patient access to obstetrical and gynecological (OB/GYN) care</p> <p>Carriers of group and individual health insurance coverage that provide coverage for OB/GYN care and requires the designation of a PCP:</p>	<p>Tip: Remember to check for any prior authorization or referral requirements for OB/GYN providers. Note that OB/GYN providers don’t have to be physicians.</p> <p>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:</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Group Small	Yes	No	N/A
	<ul style="list-style-type: none"> 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. <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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. <p>Model language from regulation</p> <p>“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].”</p>						
H.1	<p>Coverage of emergency services</p> <p>Carriers of group and individual health insurance coverage must cover emergency services benefits in a hospital must cover those services:</p> <ul style="list-style-type: none"> 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 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. <p>Federal & DC Law</p>	<p>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))</p> <p>NOTE: DC law requires coverage of one annual HIV screening test performed while enrollee is receiving emergency medical services at a hospital emergency department.</p> <p>Examples of problematic language</p> <p>Restricting out-of-network coverage based on whether you could anticipate needing emergency care: “We do not cover services outside our service area for conditions that, before leaving the service area, you should have known might require services while outside our service area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.”</p> <p>Restricting out-of-network coverage based on failure to seek treatment within certain time period after onset of illness/injury</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> 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 							
H.2	<p>Coverage of preventive health services (general)</p> <p>Carriers of group and individual health insurance coverage must provide coverage of the following items and services without imposing any cost-sharing requirements:</p> <ul style="list-style-type: none"> 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 <p><u>DC Mandates</u></p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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). <ul style="list-style-type: none"> 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). <ul style="list-style-type: none"> <u>Exception:</u> 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). May get charged for office visit if: <ul style="list-style-type: none"> 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 		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Group Small	Yes	No	N/A
	<ul style="list-style-type: none"> Prostate cancer screenings: must be in compliance with ACS recommendations , which say prostate-specific antigen (PSA) screening must be covered <ul style="list-style-type: none"> 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 <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> For example, benefits in connection with screening colonoscopy that must be covered: <ul style="list-style-type: none"> Polyp removal (Q5, CCIIO FAQs set 12 (2/20/13)) Anesthesia (Q7, CCIIO FAQs set 26 (5/11/15)) Specialist consultation prior to exam (Q7, CCIIO FAQs set 29 (10/23/15)) Pathology exam on polyp biopsy (Q8, CCIIO FAQs set 29 (10/23/15)) Bowel preparation medications (Q1, CCIIO FAQs set 31 (4/20/16)) Example of problematic language <ul style="list-style-type: none"> Non-preventive services that are subject to a copay or coinsurance: “Lab, imaging, and other ancillary Services associated with sterilizations.” 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: <ul style="list-style-type: none"> Group and individual sessions of high intensity (12 to 26 sessions in a year) Behavioral management activities, such as weight loss goals 						

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
		<ul style="list-style-type: none"> • Improving diet or nutrition and increasing physical activity • Addressing barriers to change • Self-monitoring • Strategizing how to maintain lifestyle changes <p>*Important: carriers may use reasonable medical management techniques to determine frequency, method, treatment, or setting for recommended preventive services, but <u>cannot</u> impose general exclusions that would include recommended preventive services. Q6, CCIIO FAQs set 29 (10/23/15).</p> <ul style="list-style-type: none"> • Updated recommendation on tobacco cessation for non-pregnant adults <ul style="list-style-type: none"> • 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). <ul style="list-style-type: none"> ○ Behavioral interventions: individual, group, and over the phone ○ Pharmacotherapy <ul style="list-style-type: none"> • 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®) • Prescription-only bupropion hydrochloride sustained release (2): Zyban® or generic and varenicline tartrate (Chantix®), which do not contain nicotine. <p>Note: Issuers must make changes to coverage and cost-sharing based on new recommendations/guidelines for the first policy year beginning on or after the date that is one year after the new recommendation/guideline went into effect. An issuer does not have to cover items/services if removed from guidelines.</p>						

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
		<p>Tip: If a policy has co-pays, co-insurance, deductibles or other cost-sharing, look for language that exempts preventive benefits from those cost-sharing provisions.</p> <p>Look for exclusionary language for any of the preventive benefits.</p> <ul style="list-style-type: none"> • <p>Issuers must provide 60 days advance notice, generally, to enrollees before the effective date of any material modification and this includes changes in preventive benefits.</p> <p>An issuer may provide or deny coverage for items and services in addition to the defined preventive services.</p> <p>An issuer may impose cost-sharing requirements for a treatment not included in the defined preventive services, even if the treatment results from an item or service described as a preventive service.</p>						
H.3	<p>Coverage of women’s preventive services (excluding contraception)</p> <p>HRSA recommendations</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> • 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 • D.C. Code § 31-3834.02 coverage of preventive health services 	<p><u>DC Mandates</u></p> <ul style="list-style-type: none"> • 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. • Adjuvant screening, including MRI, ultrasound if appropriate • 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. 		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
		<p><u>Notes</u></p> <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> ○ Lactation counseling cannot be limited to inpatient setting (Q4, CCIIO FAQs set 29 (10/23/15)) ○ Must cover out-of-network lactation counseling providers if none in-network (Q2 and Q3, CCIIO FAQs set 29 (10/23/15)) ○ 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)) ○ <u>DC law</u>: 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. 						
H.4	<p>Coverage of women’s preventive services: contraception</p> <p>HRSA recommendations</p> <p><u>Federal & DC Law</u></p> <ul style="list-style-type: none"> • PHS Act § 2713 (42 U.S.C. § 300gg-13) • 45 C.F.R. § 147.130: Coverage of preventive health services 	<p>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.</p> <p>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.</p> <p>Fact Sheet: Religious and Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ 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. ○ • D.C. Code § 31-3834.01: Full-year coverage for contraception <p>The Department will provide carriers with an annual notice of their obligation to provide women’s preventive services.</p>	<p><u>DC law</u>: must allow for the dispensing of up to a 12-month supply of a covered prescription contraceptive at one time.</p> <p><u>Tips</u></p> <ul style="list-style-type: none"> • 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 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). 						
H.5	Contraception: Religious exemption/accommodation	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:			✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Group Small	Yes	No	N/A
	<p>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.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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 § 31-3834.04 	<ol style="list-style-type: none"> Complete EBSA Form 700 or Provide appropriate notice of the objection to HHS. <p>Q1, CCIIO FAQs set 20 (7/17/14); Q9, CCIIO FAQs set 29 (10/23/15); Q1, CCIIO FAQs set 36 (1/9/17).</p> <p>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:</p> <ul style="list-style-type: none"> 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; 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. <p>Fact Sheet: Religious and Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act</p>						
H.6	<p>Women’s Health and Cancer Rights Act (WHCRA)</p> <p>A carrier that provides medical and surgical benefits with respect to a mastectomy must provide, in a case of a</p>	<p>This includes nipple and areola reconstruction, including nipple and areola re-pigmentation to restore the physical appearance of the breast. (Q12, CCIIO FAQs set 31 (4/20/16))</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> 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 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. <p><u>Federal & DC Law</u></p> <ul style="list-style-type: none"> 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: Prohibitions 	<p><u>Important!</u> 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”).</p> <p><u>Example of problematic language:</u></p> <ul style="list-style-type: none"> Requiring that the mastectomy was treatment for breast cancer (impermissibly excludes women who’ve had mastectomies for other reasons from accessing these benefits) <p>Tip: Look for exclusions for cosmetic surgery and make sure it is clear that reconstructive surgery for mastectomy is NOT considered cosmetic and therefore excluded.</p>						

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)</p> <p>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.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> Carrier <u>may not</u> 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 		✓	✓			
H.7	<p>Newborn and Maternity Benefits under DC Law</p> <ul style="list-style-type: none"> 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 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) 			✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
H.8	<p>Maximum out-of-pocket (proposed)</p> <p>The maximum out-of-pocket (MOOP) cost for plan year 2025 may not exceed \$9,200 for self-only coverage and \$18,400 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 required to include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-EHBs.</p> <p>Federal & DC Law</p> <ul style="list-style-type: none"> 45 C.F.R. § 156.130(a): Cost-sharing requirements 	<p>For PY2025, the MOOP* cannot exceed: \$9,200 for individual \$18,400 for family</p>		✓	✓			
H.9	<p>Coverage for dependent student on <u>medically necessary leave of absence</u> (“Michelle’s Law”)</p> <p>Issuer cannot terminate coverage due to a medically necessary leave of absence before:</p> <ul style="list-style-type: none"> 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. <p>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 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.</p>	<p>Note: ACA requires issuers to provide dependent coverage to age 26 regardless of student status. Under some circumstances, an issuer may provide dependent coverage beyond age 26, in which case these provisions would apply.</p> <p>The issuer can require receipt of written certification by a treating physician of the dependent child that states that the dependent is suffering from a serious illness or injury and that the leave of absence is medically necessary</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>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.</p> <p>“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:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p><u>Federal Law</u></p> <ul style="list-style-type: none"> • PHSA § 2728 • 45 C.F.R. § 147.145 • 42 U.S.C. § 300gg-28 							
H.10	<p>Coverage is not based on <u>genetic information (GINA)</u></p> <p>An issuer is not allowed to:</p> <ul style="list-style-type: none"> • Adjust premiums based on genetic information; • Request /require <u>genetic testing</u>; or • Collect genetic information from an individual prior to/in connection with enrollment in a plan, or at any time for <u>underwriting purposes</u>. 	<p>Tip: A test to determine whether an individual has a BRCA1 or BRCA2 mutation, genetic variants associated with a significantly increased risk for breast cancer, is a genetic test. An HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p>EXCEPTION FOR MEDICAL APPROPRIATENESS (only if the individual seeks a benefit under the plan):</p> <ul style="list-style-type: none"> 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. <p>EXCEPTIONS:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Research must be in accordance with Federal regulations and applicable state/local law or regulations; 							

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<ul style="list-style-type: none"> ○ 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; ○ No information collected can be used for underwriting purposes; and ○ The issuer completes a copy of the “Notice of Research Exception under the Genetic Information Nondiscrimination Act.” <p><u>Federal Law</u></p> <ul style="list-style-type: none"> ● PHSA § 2753 ● Genetic Information Nondiscrimination Act of 2008, Pub. Law 110-223 ("GINA") ● 74 Fed Reg 51664 ● 45 C.F.R. § 146.122 (group), 45 C.F.R. § 148.180 (individual) 							
I.1	<p>Providers operating within their scope of practice and authorized by the issuer to provide services cannot be discriminated against.</p> <p>Issuers may not discriminate against any provider contracted with the issuer to provide services and operating within the provider’s scope of practice.</p> <p><u>Federal Law</u></p> <ul style="list-style-type: none"> ● PHSA § 2706 ● 42 US Code § 300gg-5 ● CCIIO ACA Implementation FAQs - Set 15 	<p>Tip: Check to ensure that, if a service /treatment is covered, there are no limitations on specific providers licensed and contracted with the issuer to provide services under the policy.</p>		✓	✓			
J.1	<p>Issuers must provide applicants and enrollees information in plain language and in a manner that is accessible and timely (QHPs only).</p>	<p><u>District’s top 15 languages:</u></p> <ol style="list-style-type: none"> 1. Spanish 2. Amharic 		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p><u>Required notices must meet the following standards:</u></p> <ul style="list-style-type: none"> For individuals living with disabilities: <ul style="list-style-type: none"> Accessible Web sites and The provision of auxiliary aids and services 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: <ul style="list-style-type: none"> Oral interpretation, including telephonic interpreter services in at least 150 languages; Written translations; and Taglines in non-English languages indicating the availability of language services. <p>Issuers must inform individuals of the availability of these services and how to access them.</p> <p><u>Federal Law</u></p> <ul style="list-style-type: none"> 45 CFR §155.205 D.C. Code § 31-3171.09 <u>CCIIO Technical Guidance</u>: 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) <u>CCIIO: Sample translated taglines</u> 	<ol style="list-style-type: none"> Chinese French Tagalog Russian Portuguese Italian Vietnamese 10.-12. Kru, Ibo, and Yoruba Bengali Japanese Korean 						
K.1	<p>Minimum 60% actuarial value is required Health plans must meet the AVs in the metal tiers. <i>Reviewer check: included printout of AV calculator and methodology.</i></p>	<p>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</p>		✓	✓			

Issue #	Category	Reminders	Page # or Confirmation	Individual	Small Group	Yes	No	N/A
	<p><i>Reviewer check: included disclosure of how benefits were defined and entered into AV calculator</i></p> <p><u>Federal Law</u> 42 USC §18021</p>							
L.1	<p>No Surprise Act</p> <p>§300gg–111. Preventing surprise medical bills §300gg–112. Ending surprise air ambulance bills §300gg–113 - Patient Protections - Continuity of Care</p>	<p>Under the Act, the No Surprises Act prohibits balance billing by non-Network providers in the following instances:</p> <ol style="list-style-type: none"> 1) When ancillary services, as described in the Act, are received at certain Network facilities on a non-Emergency basis from non-Network Physicians. 2) When non-ancillary services are received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria as described in the Act. 3) When Emergency health care services are provided by a non-Network provider. 4) When air ambulance services are provided by a non-Network provider. <p>Include the DISB contact information for complaints regarding the No Surprise Act:</p> <p>Commissioner Department of Insurance, Securities and Banking (DISB) 1050 First St. N.E., Suite 801 Washington, D.C. 20002 Phone: (202) 727-8000 Fax: (202) 671-0650 Email: disbcomplaints@dc.gov</p>						

Issue #	Other DC Health Insurance Mandates	Page # or Confir- mation	Individual	Small Group	Yes	No	NA
DC.1	<p>D.C. Code §44-302.01 (2001 ed.) Access to Specialists as Primary Care Providers (<i>applicable to HMOs only</i>) 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</p>		✓	✓			
DC.2	<p>D.C. Code §31-4712 (2011 ed.) Accident and Sickness Policies</p>		✓	✓			
DC.3	<p>D.C. Code §16-4403 Applicability of Arbitration Act of 2007</p> <ul style="list-style-type: none"> 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 		✓	✓			
DC.4	<p>D.C. Code §31-2995.01-0.3 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</p>		✓	✓			
DC.5	<p>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.</p> <ul style="list-style-type: none"> 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. <p>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.</p>		✓				
DC.6	<p>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</p>			✓			
DC.7	<p>D.C. Code § 44-303.01 Continuity of Coverage (HMO)</p>		✓	✓			

Issue #	Other DC Health Insurance Mandates	Page # or Confir- mation	Individual	Small Group	Yes	No	NA
	<p>Member notification, transition period where provider contract is terminated during course of treatment</p> <ul style="list-style-type: none"> 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. 						
DC.8	<p>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.</p>		✓	✓			
DC.9	<p>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:</p> <ul style="list-style-type: none"> 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; <p>Upon approval, insurer must provide:</p> <ul style="list-style-type: none"> Written notice to each policyholder, participant, and beneficiary of discontinuance at least 90 days prior to date of discontinuance; <p>Offer to each policyholder the option to purchase all other hospital, surgical, and medical expense coverage currently offered by insurer in group market.</p>			✓			
DC.10	<p>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.</p>		✓	✓			
DC.11	<p>D.C. Code §32-701 Domestic Partnership Registration Procedures and Fees Approval Resolution of 2002 & Domestic Partnership Notice Update</p>		✓	✓			
DC.12	<p>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</p>		✓	✓			
DC.13	<p>D.C. Code Chapter 31. Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage (Mental Parity Provisions)</p>		✓	✓			
DC.14	<p>D.C. Code §46-401 Equal Access to Marriage</p>		✓	✓			
DC.15	<p>D.C. Code §22-3225.09 et seq. FRAUD WARNING: Compliance with the Insurance Fraud Prevention and Detection Amendment Act of 1998</p>		✓	✓			
DC.16	<p>D.C. Code §31-3201 Health Insurance Claim Forms – Uniformity</p>		✓	✓			

Issue #	Other DC Health Insurance Mandates	Page # or Confir- mation	Individual	Small Group	Yes	No	NA
	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.						
DC.17	D.C. Code §31-3301.1 Health Insurance Portability and Accountability <ul style="list-style-type: none"> • Guaranteed DC HIPAA individual health benefit plans for eligible individuals • Renewability of current health benefit plans Availability of health benefit plans by small employers		✓	✓			
DC.18	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: <ul style="list-style-type: none"> • 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.		✓	✓			
DC.19	D.C. Code §31-3501 Hospital and Medical Services Corporation Regulation <ul style="list-style-type: none"> • § 31-3508 – Filing of subscriber contract forms and rates § 31-3512 Group subscriber contract standard provisions		✓	✓			
DC.20	D.C. Code § 31-3407 HMO Form Requirements Group or individual contracts shall contain a clear statement of the following: <ul style="list-style-type: none"> • 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; 		✓	✓			

Issue #	Other DC Health Insurance Mandates	Page # or Confir- mation	Individual	Small Group	Yes	No	NA
	<ul style="list-style-type: none"> • Extension of benefits, if any; • Coordination of benefits, if applicable; • Subrogation, if any; • Description of the service area; • 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.						
DC.21	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.		✓	✓			
DC.22	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) <ul style="list-style-type: none"> • 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; 		✓	✓			
DC.23	D.C. Act 18-0070 Jury and Marriage Amendment		✓	✓			
DC.24	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.		✓	✓			
DC.25	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 <u>Medically Necessary</u> or covered by the Group Policy			✓			

Issue #	Other DC Health Insurance Mandates	Page # or Confir- mation	Individual	Small Group	Yes	No	NA
DC.26	<p>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</p> <ul style="list-style-type: none"> 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. 		✓	✓			
DC.27	<p>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.</p> <ul style="list-style-type: none"> 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 <p>D.C. Bulletin 13-IB-01-30/15 (Revised): Prohibition of discrimination in health insurance based on gender identity or expression</p>		✓	✓			
DC.28	<p>D.C. Code §31-4724 Psychologists or Optometrists – Access to psychologists or optometrists under group 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.</p>			✓			
DC.29	<p>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)</p>		✓	✓			
DC.30	<p>D.C. Act 23-0588 Insulin Affordability Amendment Act (Projected Law Date March 15, 2021)</p> <ul style="list-style-type: none"> The total amount that an insured is required to pay for a 30-day supply of covered prescription insulin drugs at an amount not to exceed \$30. total amount that an insured is required to pay for a 30-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices that are in accordance with ‘the insureds diabetes treatment plan at an amount not to exceed \$100 						
DC.31	<p>26-A DCMR § 4702 Network Adequacy</p>						

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	A health carrier providing a network plan shall maintain a network that is sufficient in numbers and facilitates access to appropriate types of providers						
DC.32	B25-0034 – Expanding Access to Fertility Treatment Amendment Act of 2023 Requires an individual health plan, group plan, or health insurer offering health insurance coverage through Medicaid and D.C. Healthcare Alliance program to provide for the diagnosis and treatment of infertility.						