2016 Carrier Reference Manual

July 2015
Version 2

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Appendices

Summary of Changes from 2015 Carrier Manual

The significant updates in this 2016 Carrier Manual are as follows:

- The Essential Health Benefits (EHB) benchmark plan remains in effect.
- A section on Network Adequacy has been added to reflect new certification standards adopted by HBX. Carriers are required to take steps to maintain a high level of accuracy in their provider directories.
- A section on Nondiscrimination has been added to reflect new certification standards adopted by HBX. Carriers must submit to the HBX a copy of the insurance contract also known as a certificate of coverage/evidence of coverage for each certified qualified health plan. Further, DISB Guidance on Nondiscrimination in Benefit Design is attached as new Appendix D.
- Language has been added to the Rating Rules and Rate Review section clarifying issues around the index rate and merged risk pool.
- A section on Summary of Benefits and Coverage (SBCs) has been added, giving guidance on format and file name conventions, and deadlines.
- The Carrier Submission process section has been updated with new filing deadlines for 2016 and new CCIIO templates for 2016 that must be submitted.

Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. A key provision of the law requires all states to participate in an American Health Benefit Exchange beginning January 1, 2014. The District of Columbia declared its intention to establish a state -based health benefit exchange in 2011 with the introduction and enactment of the *Health Benefit Exchange Authority Establishment Act of 2011*, effective March 3, 2012 (D.C. Law 19-0094).

The *Health Benefit Exchange Authority Establishment Act of 2011* establishes the following core responsibilities for the Exchange:

(1) Enable individuals and small employers to find affordable and easier-to-understand health insurance;
(2) Facilitate the purchase and sale of qualified health plans;
(3) Assist small employers in facilitating the enrollment of their employees in qualified health plans;
(4) Reduce the number of uninsured;
(5) Provide a transparent marketplace for health benefit plans;
(6) Educate consumers; and

(7) Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions.[1]

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

- Certification of Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs)
- Operation of a Small Business Health Options Program (SHOP)
- Consumer support for making coverage decisions
- Eligibility determinations for individuals and families
- Enrollment in QHPs
- Contracting with certified carriers
- Determination for exemptions from the individual mandate

The *Health Benefit Exchange Authority Establishment Act of 2011* allows the Executive Board of the DC Health Benefit Exchange Authority to adopt rules and policies. The adoption of rules and policies enables the Exchange to meet federal and District requirements and provides health carriers with information necessary to design and develop qualified health plans and qualified dental plans. This manual and appendices document the rules and policies that have been adopted by the Executive Board of the DC Health Benefit Exchange Authority to guide health and dental carriers offering coverage through DC Health Link in plan year 2016. Health and dental carriers offering coverage in the individual and/or small group markets are subject to these rules and policies, as well as all applicable federal and District laws. The standards in this manual do not apply to health insurance coverage considered to be a grandfathered health plan as defined in section 1251 of the ACA.

[1] Sec.3, *Health Benefit Exchange Authority Establishment Act of 2011*

Carrier Participation

The DC Health Link is open to all health and dental carriers and qualified health and dental plans that meet the requirements set forth in Section 1301 of the ACA and by the DC Health Benefit Exchange Authority (the "Authority"). The Authority intends to contract with any licensed health carrier ("Carrier") that offers a health insurance plan that meets minimum requirements for certification as a qualified health plan (QHP) under federal and District law and Exchange requirements. Licensed health carriers include an accident and sickness insurance company, a health maintenance organization (HMO), a hospital and medical services corporation, a non-profit health service plan, a dental plan organization, a multistate plan, or any other entity providing a qualified health benefit plan.

HBX will also contract with any licensed dental carrier that offers a stand-alone dental plan for the individual market that meets minimum requirements for certification as a qualified dental plan (QDP) under federal and District law and exchange requirements. Stand-alone dental plans will be added to SHOP when the functionality becomes available.

Essential Health Benefits

Pursuant to HHS requirements, the District designated the Group Hospitalization and Medical Services, Inc. BluePreferred PPO Option 1 as the base-benchmark plan.[2] Pediatric vision and dental benefits in the Federal Employees Dental and Vision Insurance Program (FEDVIP) with the largest national enrollment have been defined as the pediatric vision and pediatric dental essential health benefits. Habilitative services have been defined as services that help a person keep, learn, or improve skills, and functioning for daily living, including, but not limited to, Applied Behavioral Analysis for the treatment of autism spectrum disorder. The EHB benchmark plan remains the same for 2016.

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

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

[3] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule." 78 Federal Register 37 (25 February 2013). pp. 12834 – 12872.

[3] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule." 78 Federal Register 37 (25 February 2013). pp. 12834 – 12872.

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

Network Adequacy

A carrier is required to submit the CCIIO Federal Network Template and the CCIIO Network Adequacy Template to DISB when the carrier files QHPs for approval.

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

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

By October 1, 2015, carriers must prominently post a phone number or email address on their on-line and print provider directories (not necessarily a dedicated phone number or email address) for consumers to report inaccurate provider directory information. Carriers must will be required, within 30 days, validate reports that directories are inaccurate or incomplete and, when appropriate, to correct the provider information. The carrier will be required to maintain a log of consumer reported provider directory complaints that would be accessible to DISB or HBX upon request.

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

1) Perform regular audits reviewing provider directory information.
2) Validate provider information where a provider has not filed a claim with a carrier in 2 years (or a shorter period of time).
3) Take other innovative and effective actions approved by DISB to maintain accurate provider directories. For example, an innovative and effective action is validating provider information based on provider demographic factors such as an age where retirement is likely.

Carriers must submit an Access Plan to HBX upon request. The template for the Access Plan will be developed by the Plan Management Advisory Committee.

Nondiscrimination

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

Standard Plans

In the individual marketplace, carriers are required to offer one standard QHP plan for each metal level of QHPs it offers. Standard plans for 2016 can be found here. If a benefit is not listed on the standard plan template, carriers must follow the DC Benchmark Plan for non-listed benefits. In this context, "Carrier" means each licensed entity with its own NAIC Company Code.

Rating Rules and Rate Review

Merged Risk Pool

The individual and small group market shall be merged into a single risk pool for rating purposes in the District. [4] The index rate must be developed by pooling individual and small group market experience at the licensed entity level. The merged risk pool does not change how Carriers may choose to offer plans in the individual or small group markets. For federal reporting purposes, Carriers shall use unmerged market standards.[5] Limited exceptions to the merged risk pool include student health plans, and grandfathered health plans. [6] Catastrophic plans must be developed by making plan level adjustments to the index rate.[7]

The index rate for federal reporting must be the same for individual and small group markets. Carriers should merge claims experience for the individual and small group markets into a single risk pool in order to calculate this single index rate prior to applying separate modifiers for risk adjustment, reinsurance, and risk corridors. Carriers should then apply the separate modifiers and, therefore, create separate "market-adjusted index rates" for individual and small group markets, i.e. , the market-level adjustments made to the Index Rate to produce the Market Adjusted Index Rate, and the plan-level adjustments that are applied to produce the Plan Adjusted Index Rates .

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

For federal reporting purposes, medical loss ratios should also be calculated separately for each market.[8]

In addition, filing for the small group can include a quarterly adjustment to the index rate as authorized by federal regulations. Due to limitations with federal systems, rates may only be submitted once per year for both markets.[9]

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[4] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule." 78 Federal Register 39 (27 February 2013). pp. 13406 – 13442.
[5] Id.
[6] Id.
[7] 45 CFR 156.80(d)(2)
[8] "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule." U.S. Department of Health and Human Services (December 1. 2010)

Carriers should follow the approach below to rate setting for QHPs in the merged risk pool:

Step 1: Determine the base period allowed cost PMPM by combining the small group and individual experience.

Step 2: Develop the Index Rate by projecting PMPM from the result of Step 1 and adjusting for the following items:

(a) Trend (including cost, utilization, changes in provider mix, etc.)
(b) Future population morbidity changes for the combined individual and small group markets (due to the impact of items such as guarantee issue, premium subsidies, impact of adjusted community rating, etc.)
(c) Adding or removing benefits to arrive at the projected Essential Health Benefits (EHB) benchmark.

Step 3: Apply modifiers to the Index Rate separately for individual and small group:

(a) Apply projected transitional reinsurance receipts and subtract/add expected individual risk adjustment receipts/payments to the Index Rate to use for individual insurance.
(b) Subtract/add expected small group risk adjustment receipts/payments to the Index Rate to use for small group insurance.

Step 4: Develop plan-specific rates from the results of Step 3 by adjusting for plan-specific modifiers.

Please note that transitional reinsurance receipts should be applied only to the individual market to be consistent with federal regulations.

Permissible Rating Factors

Rates may be adjusted for age and family composition. All other rate factors – including but not limited to gender, tobacco use, group size (small businesses), industry, health, and geographic rating within the District – are prohibited.

[9] "Rate Changes for Small Group Market Plans and System Processing of Rates." Centers for Medicare and Medicaid Services Memorandum (April 8, 2013).

Carriers must use standardized age bands comprised of a single age band for children aged 0 to 20, one year age bands for adults 21 to 64, and a single age band for adults 64 and older. Age rating cannot vary by more than 3:1 between adults that are 21 and adults that are 64.[10] The Exchange will use an age curve developed by the Department of Insurance Securities and Banking (DISB). See Appendix A for more information about the age rating curve.

Plans Using the AVC

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

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

A de minimis variation of ±2 percentage points is used for standard metal-level plans, while ±1 percentage point is used for CSR silver plan variations.

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

The employer contribution is not allowed to be included in determining the Actuarial Value (AV) of a QHP.

Rate Development and Review

The Department of Insurance Securities and Banking will review all rates including rates for DC Health Link products. DISB evaluates rates based on recent and future costs of medical care and prescription drugs, the company's financial strength, underwriting gains, and administrative costs. DISB also considers the company's overall profitability, investment

[10] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule." 78 Federal Register 39 (27 February 2013). pp. 13406 – 13442.

income, surplus, and public comments. Companies must show that the requested rate is reasonable considering the plan's benefits, and overall rates must be projected to meet minimum medical loss ratio requirements. Health insurance rates must not be excessive, inadequate or unfairly discriminatory. In addition, proposed rates must reflect risk adjustment, reinsurance, and risk corridors. If the company's data does not fully support a requested rate, DISB will ask for more information, approve a lesser rate, or reject the requested rate increase.

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

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

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

DISB shall, after the May 1, 2015 due date, make all rate filings, including all supporting documentation, amended filings, and reports available for public inspection on its website. DISB will consider comments received on any rate filings during the review of the rates.

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

Summary of Benefits and Coverage (SBC) Guidelines

HBX requires carriers to use the standard Federal format for SBCs submitted for **BOTH** QHPs and QDPs where applicable.

Format and File Name Conventions

SBCs, prior to submission to HBX, must be created and saved as PDF file formats (.pdf). Failure to use this format (and the associated file extension) will result in delays in processing.

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

Examples of Correct Naming Conventions

SHOP
Marketing name: Carrier PPO Bronze 6500
SBC Title name: Carrier PPO Bronze 6500
SBC File name (inbound to HBX): Carrier PPO Bronze 6500_SHOP

Individual Marketplace
Marketing name: Carrier POS Silver 2500
SBC Title name: Carrier POS Silver 2500
SBC File name (inbound to HBX): Carrier_POSSilver2500_50CSR_IVL, carrier_POSSilver2500_75CSR_IVL, Carrier_POSSilver2500_0CSR_IVL

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

Deadlines for Submission

The deadline for SBCs is September 10, 2015, and will be loaded into DC Health Link by HBX plan management staff in advance of scheduled carrier testing and carrier review.

The deadline for corrected SBC is September 30, 2015. In response to issues identified by customers, HBX staff and carrier staff, HBX Plan Management team will focus its resources to review the accuracy of SBCs.

Carrier Submission Process for Qualified Health Plans (QHPs)

The Authority, in coordination with DISB, has set forth the following timeline for QHP certification and re-certification for 2016

QHP Rate, Form Filings, and Carrier Certification

There are two categories of forms that Carriers must complete: Plan Rate & Form Filings and Carrier Certification. DISB will review and approve/disapprove forms and rates to ensure that QHPs meet District and federal exchange standards for rates and benefits. DISB will also review and approve/disapprove Carrier Certification submissions on behalf of DC Health Link.

All federal templates referenced below can be found at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html.

For plan year 2016, Federal Template submissions (with the exception of the Uniform Rate Review Template) will not be required until the conclusion of the plan form and rate review by DISB. All required Federal Templates- including the Federal Plan & Benefits template and the Federal Rate Table template- will be submitted through SERFF and passed via web service to the DC Health Link insurance marketplace.

Plan Form Filing and Certification Application Deadline April 1, 2015

Plan Rate Filing Deadline May 1, 2015

Federal Templates Filing Deadline August 15, 2015

QHP Benefit Summary/SBC Submission Deadline September 10, 2015

Final SBC Revision Deadline September 30, 2015

DISB will publish initial rate filings on their website no later than May 30, 2015 and will make final rate approval determinations by July 15, 2015.

Form Filings: All Carriers must submit the following information to DISB via SERFF:

1. DISB Required Form Submissions (see Appendix B)

Carrier Certification Application: All Carriers must submit the following information in SERFF:

1. Federal Attestation Form- Federally required Program Attestations for State Based Exchanges.
2. Quality Improvement Plan- Existing Carrier Quality Improvement Plan

Rate Filings: All Carriers must submit the following information to DISB via SERFF:

1. Federal Uniform Rate Review Template – Data for market-wide review.
2. DISB Actuarial Value Input Template – Collects plan actuarial value data (Available on SERFF).
3. DISB Rate Requirements – See Appendix B (Available on SERFF).

DISB will notify carriers of form and rate approval no later than July 15, 2015.
QHP Data for DC Health Link Each carrier must submit the following Federal QHP Templates through SERFF for certification to offer QHPs through DC Health Link:

1. Administrative Data Template – Collects general company and contact information.
2. Essential Community Providers (ECP) Template- Collects identifying information for Essential Community Providers.
3. Plan/Benefit Template- Collects plan and benefit data for medical and dental; basis of plan display in DC Health Link insurance marketplace.
4. Plan/Benefit Add-In- To be utilized in conjunction with submission of the Plan/Benefit Template.
5. Prescription Drug Template- Collects formulary data for plans.
6. Network ID Template- Information identifying a provider's network.
7. Network Adequacy Template- Detailed provider network information.
8. Rate Data Template- Rating tables; basis of premium display in DC Health Link insurance marketplace.
9. Business Rules Template- Supporting carrier business rules.
10. Accreditation Template- Collects information related to a carrier's NCQA and/or URAC accreditation status.
11. Plan Crosswalk Template

All Federal Templates listed above must be submitted to DC Health Link via SERFF no later than August 15, 2015. Failure to meet this deadline can impact the time allotted to carriers to test plan, benefit, and rate display in DC Health Link.

Contracting

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

Carrier Submission Process for Qualified Dental Plans (QDPs)

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

The Authority, in coordination with DISB has set forth the following timeline for QDP renewal, recertification, and any new plan offerings for 2016:

Plan Form Filing and Certification Application Deadline April 1, 2015

Plan Rate Filing Deadline May 1, 2015

Federal and District HPM Templates Filing Deadline August 15, 2015

QDP Benefit Summary/SBC Submission Deadline September 10, 2015

Final QDP Benefit Summary/SBC Revision Deadline September 30, 2015

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

1. DISB Required dental plan form and rate submissions

Carrier Certification Application: All carriers must submit the following information in SERFF:

1. Federal Attestation Form: Federally Required Program Attestation for State Based Exchanges.

QDP Data for DC Health Link: All dental carriers must submit the following Federal Templates through SERFF for certification to offer QDPs on the DC Health Link insurance marketplace:

1. Administrative Data Template – Collects general company and contact information.
2. Network ID Template- Information identifying a provider's network.
3. Network Adequacy Template- Detailed provider network information.
4. District HPM Dental Plan & Benefit Template
5. District HPM Dental Rate Data Templates
6. Business Rules Template- Supporting carrier business rules

7. Plan Crosswalk Template

Like QHPs, all Federal and District templates listed above must be submitted to DC Health Link via SERFF no later than August 15, 2015. Failure to meet this deadline can impact the time allotted to carriers to test plan, benefit, and rate display in DC Health Link.

Contracting

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

Additional Information and Requirements

Transparency

The ACA requires that all health plans and health insurance policies provide enrollees and applicants with a uniform summary of benefits and coverage (SBC). The SBC provides consumers consistent information about what health plans cover and what limits, exclusions, and cost-sharing apply. It must be written in plain language. At the outset, the final rule requires two illustrations of typical patient out-of-pocket costs for common medical events (routine maternity care and management of diabetes). Carriers must provide the SBC as part of the qualified plan certification process for participation in DC Health Link. A SBC template and sample completed SBC are posted at http://cciio.cms.gov

Federal regulations implementing the ACA (45 CFR §156.220(d)) require Carriers to make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through a web site and through other convenient means for individuals without access to the Internet.

ACA implementing regulations (45 CFR §156.220) require Carriers to also disclose other information that would help consumers understand how reliably each QHP reimburses claims for covered services, whether the provider network is adequate to assure access to covered services, and other practical information. The required information must be provided to DC Health Link, HHS and DISB in plain language that the intended audience, including individuals with limited English proficiency, can readily understand and use. DC Health Link will make accurate and timely disclosure to the public of the following information:

- Claims payment policies and practices
- Financial disclosures
- Information on enrollee rights
- Data on rating practices
- Data on enrollment/disenrollment
- Data on number of claims that are denied
- Information on cost-sharing and payments with respect to out-of- network coverage

- Upon request of an individual, information on cost-sharing with respect to a specific item/service

Quality Data

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

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

It is expected that QHP issuers will report data in mid- 2016 for care provided in 2015. This rating system is expected to be functional in time for the open enrollment period for the 2017 coverage year.

In accordance with 45 CFR §156.275, DC Health Link will accept Carrier accreditation based on local performance of its QHPs by the two accrediting agencies currently recognized by HHS: the National Committee for Quality Assurance (NCQA) and URAC. Carriers that are not accredited at this time will be provided a grace period for accreditation, pursuant to 45 CFR § 155.1045 (Accreditation timeline for federally facilitated exchanges).

For DC Health Link in 2016, Carriers will be required to attest to meeting the federal quality standards. However, no quality data will be displayed on the web portal during open enrollment for the second year of DC Health Link operation. During 2015 and 2016, HBX will continue to collect information from Carriers on their existing quality improvement plans (QIPs). In future years, HBX will issue guidance specifying format and content requirements for health plan submission of QIPs. The Authority will endeavor to coordinate with Maryland and Virginia to standardize QIP information collected from carriers across the tri- state area. Going forward, the HBX will work to coordinate with public and private payers and other stakeholders to update QIP requirements and public reporting thereof based on stakeholder input, continuing federal guidance and the District's public health priorities.

Marketing Guidelines

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

Enrollment

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

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

Carriers and HBX will observe the federal requirements for initial, annual, and special open enrollment periods established by HHS in 45 CFR §155.420. For the 2016 plan year, the open enrollment period for individuals will run from November 1, 2015 through January 31, 2016. Special enrollment periods must be provided for qualified individuals experiencing certain triggering events.

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

QHP Certification

Pursuant to 45 CFR §1080, HBX may decertify any QHP that fails to meet the required certification standards or the requirements for recertification. Carriers will have the right to appeal decertification decisions through DISB.

The standards for decertification will be developed through the Plan Management Standing Advisory Committee.

Appendix A

District of Columbia Age Factors and Rating Curve

District of Columbia Age Factors and Rating Curve

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

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

Appendix B

District of Columbia Department of Insurance, Securities, and Banking (DISB) Health Insurance Rate Filing Requirements

DC DISB Health Insurance Rate Filing Requirements

Health insurance rate filings should be submitted to DISB through SERFF and include the following information as pertinent to the nature of the purpose of the filing.

For dental carriers: Please respond to the following requirements in all product filings. If a requirement is not applicable, please indicate in response.

1) **Cover Letter (includes)**
    A. Company Name
    B. NAIC Company Code
    C. Marketing Name of Product(s)
    D. Date Filing Submitted
    E. Proposed Effective Date
        i. First effective date when quarterly trend increases are being filed for the small group market
    F. Type of Product
    G. Market (Individual or Small Group)
    H. Scope and Purpose of Filing
    I. Indication Whether Initial Filing or Rate Change
    J. Overall Premium Impact of Filing on DC Policyholders
    K. Contact information, Name, Telephone, E-mail

2) **For Renewal Filings, One Page Consumer Summary (includes)**
    A. Marketing Name of Company Issuing Product
    B. Marketing Name of Product
    C. Renewal Period for which Rates are Effective (Start and End Dates)
    D. Proposed Rate Increase/Decrease
    E. 5 Year History of Rate Increases/Decreases for this Product
    F. Justification for Rate Increase/Decrease in Plain Language

3) **Actuarial Memorandum (includes)**
    A. Description of Benefits
    B. Issue Age Range
    C. Marketing Method
        i. Describe the marketing method(s) used to inform consumers of the availability and details of the product(s)
        ii. Identify which, if any, products are marketed through an association
    D. Premium Basis

i. Confirm member level rating will be used in the individual market
ii. If composite rates are used in the small group market, describe the methodology that will be used to calculate composite rates from the total member based premium for the group

E. Nature of Rate Change and Proposed Rate/Methodology Change
   i. A brief description of how rates were determined
F. For Each Change, Indication if New or Modified
G. For Each Change Comparison to Status Quo
H. Summary of How Each Proposed Modification Differs from Corresponding Current/Approved Rate/Methodology
I. Annual Rate Change for DC Policyholders
   i. State the average rate change across the entire market to which the filing applies
   ii. State the average cumulative rate change over the prior 12 months in a manner consistent with the calculation of the threshold increase as defined by CCIIO
   iii. State the minimum and maximum rate adjustment that any policyholder will receive
   iv. A completed copy of the following chart, indicating the number of contracts and members that would receive rate and premium changes for each of the ranges indicated. A rate change reflects the impact of items which alter the underlying rate tables (e.g., trend, the impact of adjusted community rating, changes in covered benefits, changes in the average morbidity of the population, impact of new taxes and fees, etc.). A premium change reflects the items underlying a rate change plus any additional items that impact the premium paid by a given policyholder (e.g., aging, changes in plan cost sharing design).

	Rate Impact		Premium Impact	
	# of Contracts Impacted	# of Members Impacted	# of Contracts Impacted	# of Members Impacted
Reduction of 15% or more				
Reduction of 10.01% to 14.99%				
Reduction of 5.01% to 10.00%				
Reduction of 0.01% to 5.00%				
No Change				
Increase of 0.01% to 5.00%				
Increase of 5.01% to 10.00%				
Increase of 10.01% to 14.99%				
Increase of 15.00% or more				
Total				

J. Base Period Experience
    i. Confirm the base period experience represents all of the carrier's non-grandfathered individual and small group business in the DC market
    ii. State the dates of service represented by the base period claims experience, and the date through which payments were made on claims incurred during the base period
    iii. State the estimate included for claims incurred but not paid as of the paid through date
    iv. Demonstrate any adjustments made for large claim pooling, including claims pooled and the pooling charge added, if applicable
K. Projected Base Period Experience
    i. Demonstrate and support each adjustment made to the base period experience for:
        1. Removal of claims for services covered during the base period that are not an essential health benefit
        2. Addition of cost for services not covered during the base period that represent essential health benefits required to be covered during the projection period.
    ii. Describe and provide support for the development of each of the following projection factors applied to the base period:
        1. Medical and prescription drug trends including a description of the methodology used for calculating, data relied upon, and all adjustments made to the data (e.g., normalization factors) and quantitative support
            a. In addition to unit cost and utilization, the issuers must disclose if the following factors were utilized in their trend determination:
                i. Deductible leveraging
                ii. Benefit buy-down impact
                iii. Future/new benefits and/or mandates
                iv. Risk profile changes
                v. Aging of population (both utilization and mix of service changes)
                vi. Increased portion of pool from conversion policies
                vii. Changes in gender and other demographic characteristics
        2. Projected changes in the underlying demographics of the population anticipated to be insured in the merged individual and small group pool,

including a description of the factors used to adjust the base period experience

3. Projected changes in the average morbidity of the population anticipated to be insured in the merged individual and small group pool, including but not limited to the separately identifying the impact of guaranteed issue, premium and cost sharing subsidies, a mandate that most individuals obtain coverage, pent-up demand, and termination of current high risk pools
4. The impact on utilization due to projected changes in average cost sharing in force across the merged individual and small group pool

L. Manual Rate Development
   i. Support for the appropriateness of the data used for developing the manual rate
   ii. A description of the methodology used and support for the development of the manual rate, if applicable
      1. Source of data used as a basis for the manual rate
      2. Support that the data used is fully credible
      3. Demonstration that the underlying benefits represent the essential health benefit package for DC
      4. Adjustments made to the data to reflect the carrier's provider contracts
      5. Adjustments made to the data to reflect the demographics, benefits and morbidity of the merged individual and small group population anticipated to be covered during the projection period
   iii. Demonstration that any capitation payments were included

M. Credibility
   i. Describe the credibility methodology used and demonstrate it is consistent with standard actuarial practice
   ii. State and support the credibility level assigned to the projected base period experience
   iii. Provide adjustments made to the credibility calculation when the base period experience also represents a portion of the manual rate, in order to assign the appropriate level of credibility

N. Projected Index Rate
   i. Confirm the index rate represents the average allowed claim cost per member per month for coverage of essential health benefits for the market (individual or small group), prior to adjustment for payments and charges under the risk adjustment and transitional reinsurance programs, as defined by 45 CFR 156. 80(d)

ii. Indicate whether allowed or paid claims were used as a basis for developing the index rate. If paid claims were used, describe how they were adjusted to reflect the allowed claims which the index rate represents
iii. Demonstrate how the projected claims experience and the manual rate were combined to reflect the credibility blended experience, if applicable
iv. Demonstrate how the projected credibility blended merged individual and small group experience was adjusted to represent the average demographics and utilization (cost sharing induced only) of the market (individual or small group) which is the subject of this filing. Demonstrate that an adjustment for differences in anticipated morbidity between the individual and small group markets is not included

O. Market-wide Adjustments to the Index Rate
   i. Support for the market-wide risk transfer payment/charge assumed, including the following support
      1. A description of the data used for the calculation
      2. A discussion of the methodology used
      3. The assumed risk of the carrier's projected population for the market and the assumed risk of the market (individual or small group) statewide, and support for these assumptions.
      4. The resulting risk transfer payment on a PMPM basis
      5. Actual historical risk transfer payments PMPM for the last three years, once available
   ii. Support for the market-wide adjustment for assessments and recoveries under the transitional reinsurance program
      1. Demonstrate that the assessment is consistent with the amount published in the Annual Notice of Benefit and Payment Parameters
      2. For the individual market, describe the data used to calculate the estimated recoveries, the methodology used to calculate the estimate, confirmation that the attachment point and claims limit used is consistent with that for the projection year as published by HHS, and the resulting estimated recovery on a PMPM basis
   iii. The amount of any federal or DC Health Link user fees PMPM including, a demonstration of how they were calculated and that they were applied as an adjustment on a market-wide basis, if any

P. Plan Level Adjustments to the Index Rate
   i. Adjustments to reflect the actuarial value and cost sharing design of each plan

1. Separately demonstrate the portion that reflects the paid-to-allowed ratio and the portion that reflects any expected differences in utilization due to differences in cost sharing
2. Describe the methodology used to estimate the adjustments

ii. Support for any differences at the plan level due to provider network, delivery system characteristics, and utilization management practices

iii. Support for additional costs added for benefits provided that are in addition to essential health benefits

iv. The expected impact of the specific eligibility categories for a catastrophic plan offered in the individual market, if applicable

Q. Non-Benefit Expenses

i. Support for proposed non-benefit expenses included in the development of rates
1. General administrative expenses
2. Sales and marketing
3. Commissions and broker fees
4. Premium tax
5. Other taxes, licenses and fees
6. Quality improvement and fraud detection
7. Other expenses
8. Profit or contribution to surplus
9. Any additional risk margin

ii. Provide a comparison of current and proposed non-benefit expenses

iii. Additional support if non-benefit expense loads do not represent the same PMPM or same percent of premium across all plans

R. Filed Loss Ratio

i. State the anticipated traditional loss ratio (incurred claims divided by premium)

ii. State the anticipated Federal Medical Loss Ratio (MLR)
1. Do not include the adjustment for credibility outlined in 45 CFR 158.230 as the projected claims should represent the actuary's best estimate
2. State the adjustments made to claims in the numerator and premium in the denominator

S. Actuarial Certification

i. Identify the certifying actuary

ii. Certification that the index rate is in compliance with 45 CFR 156.80(d)(1) and developed in compliance with applicable ASOPs

iii. Certification that the index rate and only the allowable modifiers in 45 CFR 156.80(d)(1) and (2) were used to generate the plan level rates

iv. Certification that the standard AV calculator was used to develop the Metal AV except for any plans specified
v. Certification that the rates are reasonable in relation to the benefits provided, are not excessive, deficient nor unfairly discriminatory
vi. Certification that the rates comply with all applicable District of Columbia and Federal laws and regulations

T. District of Columbia Loss Ratio Analysis (Include Countrywide Loss Ratio Analysis separately, if applicable)
   i. Evaluation Period (Experience Year, etc)
   ii. Earned Premiums
   iii. Claims
   iv. Number of Claims
   v. Loss Development Factors
   vi. Loss Ratio Demonstrations
   vii. Permissible Loss Ratio (includes)
      1. Expenses
      2. Profit & Contingency Provision
   viii. Credibility Analysis (if applicable)
      1. DC Credibility
      2. Countrywide Credibility
      3. Complimentary Credibility
   ix. Determination of Overall Annual Rate Change

U. District of Columbia and Countrywide Experience
   i. Earned Premium
   ii. Number of Contracts/Policyholders
   iii. History of Past Rate Changes
      1. Include SERFF tracking numbers for all rate changes effective during the past 12 months

Appendix C

CCIIO Program Attestations for State Based Exchanges

State Partnership Exchange Issuer Attestations:
Statement of Detailed Attestation Responses

Instructions: Please review and respond **Yes** or **No** to each of the attestations below and sign the Statement of Detailed Attestation Responses document. CMS may accept a **No** response to the compliance plan attestation if a justification is included with this submission. All other attestations are required.

Program Attestations

General Issuer Attestations

1. By the first resubmission period during the QHP certification process, applicant is in good standing and as such is licensed, by all applicable states, to offer the specific type of health insurance or health plans that the issuer is submitting to CMS for certification; is in compliance with all applicable state solvency requirements; and is in compliance with all other applicable state laws and regulations.

   ☐ Yes ☐ No

2. Applicant attests that it will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation in accordance with 45 CFR §156.200(e).

   ☐ Yes ☐ No

3. Applicant attests that it will market its QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.

   ☐ Yes ☐ No

4. Applicant attests that it will adhere to all non-renewal and decertification requirements, in accordance with 45 CFR 156.290.

   ☐ Yes ☐ No

5. Applicant attests that it will adhere to requirements related to the segregation of funds for abortion services consistent with 45 CFR 156.280 and all applicable guidance.

   ☐ Yes ☐ No

6. Applicant attests that it will adhere to provisions addressing payment of federally-qualified health centers in 45 CFR 156.235(e).

   ☐ Yes ☐ No

Compliance Plan Attestations

1. Applicant attests that it is submitting a compliance plan that adheres to all applicable laws,

regulations, and guidance, that the compliance plan is ready for implementation, and that the applicant agrees to reasonably adhere to the compliance plan provided. The applicant agrees to submit in advance any changes to the compliance plan to HHS for review. Applicant will submit a copy of the applicant's compliance plan.

☐ Yes ☐ No

If Yes, applicant should submit a copy of the applicant's compliance plan.

Organizational Chart Attestations

1. Applicant attests that it is providing its organizational chart and that it will inform HHS of any significant changes to the organizational chart provided within 30 days of that change after the submission of this application. Applicant will submit a copy of the applicant's organizational chart.

   ☐ Yes ☐ No

   If **Yes**, applicant should submit a copy of the applicant's organizational chart.

Operational Attestations

1. Applicant attests that, in accordance with 45 CFR 156.330, it will notify HHS of a change in ownership if one or more of its FFM QHPs undergoes a change in ownership as recognized by the state in which the issuer offers the QHP. The applicant understands that in accordance with 156.330, the new owner must adhere to all applicable statutes and regulations.

   ☐ Yes ☐ No

2. Applicant attests that it will comply with all QHP requirements, including technical requirements related to the use of FFM plan management system, on an ongoing basis and comply with Marketplace systems, tools, processes, procedures, and requirements.

   ☐ Yes ☐ No

3. Applicant understands and acknowledges that the Marketplace website may display that applicant is accredited if that applicant is accredited on its commercial, Medicaid, or Marketplace product lines by one of the HHS-recognized accrediting entities. Applicant understands and acknowledges that the Marketplace website may display applicant as "Not yet accredited" if the applicant does not provide accreditation information that can be verified with a recognized accrediting entity, or does not have any products that the applicable accrediting entity considers to be accredited (e.g., an applicant will be displayed as "Not yet accredited" if the accreditation review is "scheduled" or "in process").

   ☐ Yes ☐ No

State Partnership Exchange Issuer Attestations:
Statement of Detailed Attestation Responses

Benefit Design Attestations

1. Applicant attests that it will not employ marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs in accordance with 45 CFR 156.225.

   ☐ Yes ☐ No

2. Applicant attests that, in complying with the benefit design standards, it will not design or implement a benefit design that discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions, in accordance with 45 CFR 156.200(b)(3) and 156.125(a).

   ☐ Yes ☐ No

3. Applicant attests that it will comply with all benefit design standards, federal regulations and laws, and state mandated benefits for all services including, but not limited to: preventive services, emergency services, and formulary drug list.

   ☐ Yes ☐ No

4. Applicant attests that it will abide by all applicable cost-sharing limit requirements, including, but not limited to,:

   a. the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) for emergency department services is the same regardless of provider network status, in accordance with 45 CFR 147.138(b)(3);

   b. the requirement that it will make available enrollee cost sharing under an individual's plan or coverage for a specific item or service, consistent with 45 CFR 156.220;

   c. the requirement that the plan's annual limitation on cost sharing must comply with the annual limitation on cost sharing requirements under 45 CFR 156.130 and may not exceed the annual limitation on cost sharing for the plan year that is established in the annual HHS notice of benefits and payment parameters; and

   d. the requirement that it will maintain appropriate systems to accurately calculate cost sharing amounts and ensure compliance with deductible (if applicable) and cost sharing limits required under 45 CFR 156.130.

   ☐ Yes ☐ No

5. Applicant attests that it will follow all Actuarial Value requirements, including 45 CFR 156.135 and 156.140, or 156.150 for stand-alone dental plans.

   ☐ Yes ☐ No

6. Applicant attests that it will offer through the Marketplace a minimum of one QHP at the silver coverage level and one QHP at the gold coverage level in accordance with 45 CFR 156.200(c), or a minimum of one plan at either a high or low coverage level for issuers of stand-alone dental plans.

   ☐ Yes ☐ No

7. Applicant attests that its catastrophic QHPs will only enroll (or re-enroll) individuals under the age of 30 prior to the first day of the plan year or individuals who receive a certificate of exemption from the requirement to maintain minimum essential coverage by reason of hardship or inability to afford coverage, in accordance with 45 CFR 156.155.

   ☐ Yes ☐ No

8. Applicant attests that its QHPs provide coverage for each of the 10 statutory categories of Essential Health Benefits (EHB) in accordance with the applicable EHB benchmark plan and federal law:

   a. its QHPs provide benefits and limitation on coverage that are substantially equal to those covered by the EHB-benchmark plan pursuant to 45 CFR 156.115(a)(1);

   b. it complies with the requirements of 45 CFR 146.136 with regard to mental health and substance use disorder services, including behavioral services;

   c. it provides coverage for preventive services described in 45 CFR 147.130;

   d. it complies with EHB requirements with respect to prescription drug coverage pursuant to 45 CFR 156.122;

   e. any benefits substituted in designing QHP plan benefits are actuarially equivalent to those offered by the EHB benchmark plan and are in the same EHB category pursuant to 45 CFR 156.115(b);

   f. its QHPs' benefits reflect an appropriate balance among the EHB categories, so that benefits are not unduly weighted toward any category pursuant to 45 CFR 156.110(e).

   ☐ Yes ☐ No

Stand-Alone Dental Attestations

1. Applicant attests that all stand-alone dental plans that it offers will comply with all benefit design standards and federal regulations and laws for stand-alone dental plans in 45 CFR 155.1065 and 156.150, as applicable, including that:

   a. the out-of-pocket maximum for its stand-alone dental plan complies with the regulatory standard in 45 CFR 156.150, including for the coverage of pediatric dental;

b. it offers the pediatric dental EHB;

c. it does not include annual and lifetime dollar limits on the pediatric dental EHB.

☐ Yes ☐ No

2. Applicant attests that any stand-alone dental plans it offers are limited scope dental plans.

☐ Yes ☐ No

3. Applicant attests that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit, including 45 CFR 155.340(e) and (f).

☐ Yes ☐ No

Rate Attestations

1. Applicant attests that it will comply with all rate requirements as applicable, including that it will:

   a. charge the same rates for each qualified health plan, or stand-alone dental plan, of the issuer without regard to whether the plan is offered through an Marketplace or whether the plan is offered directly from the issuer or through an agent;

   b. set rates for an entire benefit year, or for the SHOP plan year and submit the rate and benefit information to the Marketplace as required in 45 CFR 156.210;

   c. submit to the Marketplace a justification for a rate increase prior to the implementation of an increase;

   d. prominently post rate increase justifications on its Web site pursuant to 45 CFR 155.1020;

   e. adhere to all rating area variation requirements pursuant to 45 CFR 156.255 for QHPs;

   f. comply with federal rating requirements or the state's Affordable Care Act compliant rating requirements, as applicable.

☐ Yes ☐ No

Enrollment Attestations

1. Applicant attests that it will meet the individual market requirement to:

   a. enroll a qualified individual during the initial and subsequent annual open enrollment periods and abide by the effective dates of coverage pursuant to 45 CFR 156.260;

b. make available, at a minimum, special enrollment periods (SEPs) established by the Marketplace and abide by the effective dates of coverage determined by the Marketplace pursuant to 45 CFR 156.260.

☐ Yes ☐ No

2. Applicant attests that it will process enrollment changes, to include terminations, made by enrollees during annual open enrollment and during any applicable special enrollment periods for which they become eligible.

☐ Yes ☐ No

3. Applicant attests that it will only terminate coverage as permitted by the Marketplace and applicable State or Federal law including pursuant to 45 CFR 156.270:

   a. the applicant will abide by the termination of coverage effective dates requirements;

   b. the applicant will maintain termination records in accordance with Marketplace standards;

   c. If terminating an enrollee's coverage for any reason, the applicant will provide the enrollee with a notice of termination of coverage consistent with the effective date required by applicable regulations. Notice must include an explanation of the reason for the termination. When applicable, the applicant will include in the notice an explanation of the enrollee's right to appeal;

   d. the applicant will establish a standard policy for the termination of coverage of enrollees due to non-payment of premium, fraud, and free-look.

☐ Yes ☐ No

4. Applicant attests that it will provide enrollees with required documentation including: an enrollment information package, effective dates of coverage, summary of benefits and coverage, evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials, ID cards, and any notices as required by State or Federal law.

☐ Yes ☐ No

5. Applicant attests that it will adhere to enrollment information collection and transmission requirements and will:

   a. accept enrollment information in an electronic format from the Marketplace that is consistent with requirements;

   b. reconcile enrollment files with the Marketplace no less than once a month;

   c. acknowledge receipt of enrollment information in accordance with Marketplace standards and;

d. timely, accurately and thoroughly process enrollment transactions and submit to the marketplace required electronic 834 transactions including, but not limited to, confirmations, cancellations, terminations and other transactions as applicable.

☐ Yes ☐ No

6. Applicant attests that if applicant uses the Application Programming Interface (API) provided by the Marketplace, the applicant will:

   a. direct individuals to the Marketplace in order to receive a determination of eligibility;

   b. enroll an individual only after receiving confirmation from the Marketplace that the individual has been determined eligible for enrollment in a QHP, in accordance with the standards.

☐ Yes ☐ No

7. Applicant attests that it will follow the premium payment process requirements established by the Marketplace in accordance with §156.265(d), and 156.1240 and applicable guidance.

☐ Yes ☐ No

8. Pursuant to 45 CFR 156.270, Applicant attests that it will

   a. provide a non-payment grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid-in-full at least one month's premium. If an enrollee exhausts the grace period without submitting full payment of all outstanding premium due, the applicant will terminate the enrollee's coverage effective at the end of the first month of the grace period;

   b. provide a non-payment grace period pursuant to applicable state law for any enrollee who is not receiving advance payments of the premium tax credit. If an enrollee exhausts the grace period without submitting full payment of all outstanding premium due, the applicant will terminate the enrollee's coverage effective with state rules.

☐ Yes ☐ No

9. Applicant attests that it will provide the enrollee with notice of payment delinquency if an enrollee is delinquent on premium payment.

☐ Yes ☐ No

10. Applicant attests that it will develop, operate and maintain viable systems, processes, procedures, and communication protocols for:

    a. the timely, accurate and valid enrollment and termination of enrollees' coverage

within the Marketplace;

b. the prompt resolution of urgent issues affecting enrollees, such as changes in enrollment and discrepancies identified during reconciliation.

☐ Yes ☐ No

11. Applicant attests that it will accept the total premium breakdown as determined by the Marketplace and as specified in either the electronic enrollment transmission or reconciliation files. This includes:

    a. the total premium amount which is based on rate attestations submitted by the applicant;

    b. the APTC amount;

    c. any other payment amounts as depicted on the enrollment transmission.

☐ Yes ☐ No

12. Applicant attests that it will accept the advance CSR amount as determined by the Marketplace and as specified in either the electronic enrollment transmission or reconciliation files.

☐ Yes ☐ No

13. Applicant attests that it will approve of the use of the following information for display on the FFM web site for consumer education purposes: information on rates and premiums, information on benefits, the provider network URL(s) provided in this application, the URL(s) for the summary of benefits and coverage provided in this application, the URL(s) for payment provided by this application, and information on whether the issuer is a Medicaid managed care organization.

☐ Yes ☐ No

Financial Management Attestations

1. Applicant attests that it will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit and cost sharing reductions, including the provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, 156.460, and 156.470.

☐ Yes ☐ No

2. Applicant attests that it will submit to HHS the applicable plan variations that adhere to the standards set forth by HHS at 45 CFR 156.420.

☐ Yes ☐ No

3. Applicant attests that it will pay all user fees in accordance with 45 CFR 156.200(b)(6).

☐ Yes ☐ No

4. Applicant attests that it will reduce premiums on behalf of eligible individuals if the Marketplace notifies the QHP Issuer that it will receive an APTC on behalf of that individual pursuant to 45 CFR 156.460.

☐ Yes ☐ No

5. Applicant attests that it will adhere to the data standards and reporting for the CSR reconciliation process, pursuant to 45 CFR 156.430(c) for QHPs.

☐ Yes ☐ No

6. The following applies to applicants participating in the risk adjustment and reinsurance programs inside and/or outside of the Marketplace. Applicant attests that it will:

    a. adhere to the risk adjustment standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR 153 Subparts G and H);

    b. remit charges to HHS under the circumstances described in 45 CFR 153.610.

☐ Yes ☐ No

SHOP Attestations

1. Applicant attests that it will adhere to the SHOP issuer requirements set by HHS in 45 CFR 156.285, or that it offers no SHOP plans.

☐ Yes ☐ No

Reporting Requirements Attestations

1. Applicant attests that it will provide to the Marketplace the following information in a time and manner identified by HHS, as applicable: claims payment policies and practices; periodic financial disclosures; data on enrollment; data on disenrollment; data on the number of claims that are denied; data on rating practices; information on cost-sharing and payments with respect to any out-of-network coverage; and information on enrollee rights under title I of the Affordable Care Act.

☐ Yes ☐ No

2. Applicant attests that it will report required data on prescription drug distribution and costs consistent with 45 CFR 156.295 and all applicable guidance, in a time and manner identified by HHS.

☐ Yes ☐ No

3. Applicant attests that it will comply with the specific quality disclosure, reporting, and implementation requirements at 45 CFR 156.200(b)(5) and 45 CFR 156 Subpart L.

☐ Yes ☐ No

4. Applicant attests that with regard to the policies and procedures applicable to the qualified health plan(s) for which it seeks certification, Applicant is in compliance with the timeline established for accreditation under 45 CFR 155.1045(b).

☐ Yes ☐ No

Accreditation Attestations

1. The QHP issuer authorizes the release of its accreditation data from its accrediting entity to the Federally Facilitated Marketplace (FFM) (if applicable).

☐ Yes ☐ No

Network Adequacy Attestations

1. Does the applicant attest that it will maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay? This includes providers that specialize in mental health and substance abuse services for all plans except stand-alone dental plans.

☐ Yes ☐ No

2. Does the applicant attest that it will maintain a provider directory that is up-to-date, clear, and accessible in accordance with all of the requirements listed in 45 CFR 156.230(b)?

☐ Yes ☐ No

Signature	Date
Printed Name	Title/Position

Attestation Justification

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

Appendix D

DISB Guidance on Nondiscrimination in Benefit Design

Government of the District of Columbia
Muriel Bowser, Mayor
Department of Insurance, Securities and Banking

Chester A. McPherson
Acting Commissioner

Nondiscrimination in Benefit Design

The intent of this guidance is to clarify non-discrimination standards and provide examples of benefit design for Qualified Health Plans (QHP) that are potentially discriminatory under the Affordable Care Act (ACA)[1]. The ACA enacted standards that protect consumers from discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or health condition and prohibit issuers from designing benefits or marketing QHPs in a manner that would discourage individuals with significant health care needs from enrolling in QHPs. In addition, The Public Health Service Act (PHS) Section 2711 generally prohibits group health plans and health insurance issuers offering group insurance coverage from imposing lifetime or annual limits on the dollar value of essential health benefits offered under the plan or coverage. Furthermore, with respect to plans that must provide coverage of the essential health benefit package, issuers may not impose benefit-specific waiting periods, except in covering pediatric orthodontia, in which case any waiting periods must be reasonable pursuant to 45 CFR §156.125[2] and providing EHB. It is also important to note that benefit designs must meet the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements. These standards do not apply to stand-alone dental plans (SDP).

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

[1] For additional guidance please see the 2016 Letter to Issuers in the Federally-facilitated Marketplaces and the 2016 Notice on Benefit and Payment parameters released by the Department of Health and Human Services (HHS).
[2] 45 CFR §156.125 – Prohibition on discrimination – "(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. (b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and (c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques." §156.200(e) QHP issuer participation standards states that "A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation."

A number of benefit design features are utilized in the context of medical management, including but not limited to: exclusions; benefit substitution; utilization management; cost-sharing; medical necessity definitions; drug formularies; and/or visit limits. Each of these features has the potential to be either discriminatory or an important element in a QHP's quality and affordability, depending on how the feature is designed and administered. CMS has identified examples of potentially discriminatory benefit design within each of these domains, as well as best practices for minimizing the discriminatory potential of these features. These examples[3] are not definitively discriminatory. As potential discrimination is assessed, issuers should consider the design of singular benefits in the context of the plan as a whole, taking into account all plan features, including maximum out of pocket (MOOP) limits.

[3] The table below is taken from the Ohio Department of Insurance Plan Management Toolkit guidance on Non-discrimination in Benefit Design document posted at http://www.insurance.ohio.gov/ .

Examples of Potentially Discriminatory Benefit Design: *Note. This is not an exhaustive list of examples of potentially discriminatory benefit designs.*

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Exclusions	Transplant	Bone marrow transplants are excluded from transplant coverage, regardless of medical necessity	Excluding bone marrow transplants regardless of medical necessity may discriminate against individuals with specific conditions, including certain cancers and immune deficiency disorders, for which this procedure is a medically necessary treatment	Transplant coverage is dictated by medical evidence and consideration of patient history
Cost-Sharing	Emergency Room Services	Emergency room services with significantly increasing cost-sharing burden as the number of visits increases	Increasing the cost-sharing burden with increasing emergency room visits may discriminate against individuals with certain medical conditions that reasonably necessitate more frequent emergency room usage (for example, but not limited to, asthma, sickle cell anemia, heart failure)	Emergency room services cost-sharing design that is not contingent on the frequency of service utilization
Medical Necessity Definitions	Speech Therapy	Medical necessity for rehabilitative speech therapy services that is defined with the use of restrictive phrases such as "recovery of lost function" or "restoration to previous levels of functioning" when habilitative speech therapy is not covered	Defining medical necessity for rehabilitative speech therapy with restrictive phrases may discriminate against individuals with health conditions that would benefit from this therapy in order to improve functionality that may have never been present (e.g. individuals with cerebral palsy) and/or to prevent further deterioration of function (e.g. multiple sclerosis)	Medical necessity for rehabilitative speech therapy services includes coverage for all conditions in which medical evidence supports the use of speech therapy services, regardless of whether this service is used to recover lost function, improve functionality that was never present, or to prevent further deterioration of function

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Drug Formularies	Non-Preferred Brand/Specialty Drugs	Requiring consumers to receive specialty medications particularly for certain medical conditions from mail-order pharmacies and not allowing the use of retail pharmacies	Eliminating access to certain specialty medications through retail pharmacies may discriminate against individuals with significant health care needs or with certain conditions, such as rheumatoid arthritis, who are eligible to receive discounts on those drugs through retail pharmacies	Permitting consumers to use retail pharmacies when discounts are available and the cost-sharing is lower than the mail-order pharmacy option
	Non-Preferred Brand/Specialty Drugs	Placing expensive life-saving or life-prolonging drugs, for which there is no generic and/or less expensive comparable alternative treatment, in tiers with high consumer cost-sharing	Placing high consumer cost-sharing on life-saving or life-prolonging drugs may discriminate against individuals with conditions such as HIV/AIDS for which these drugs are a necessary treatment	Structuring prescription drug cost-sharing design in manner that does not place disproportionate burden on individuals with specific conditions
Visit Limits	Outpatient Rehabilitation Services	The number of covered outpatient rehabilitation visits is limited without regard to best medical practices for a given condition	Limiting the number of covered outpatient rehabilitation visits without regard to medical necessity may discriminate against individuals conditions that require more rehabilitation services than are covered in order to fully regain function after certain conditions, such as stroke	The number of covered outpatient rehabilitation visits is determined by medical necessity and best medical practices

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Utilization Management	Non-Preferred Brand/ Specialty Drugs	Requiring prior authorization and/or step therapy for most or all drugs in drug classes such as anti-HIV protease inhibitors, and/or immune suppressants regardless of medical evidence	Requiring prior authorization and/or step therapy for most or all medications in a specific drug class may discriminate against individuals with conditions for which those drug classes are applicable, such as HIV or rheumatoid arthritis, and cause undue burden to receive necessary therapies	Using current medical evidence to establish clinically appropriate prior authorization, step therapy, or unrestricted coverage for drugs in a given drug class
	Imaging (CT/PET Scans, MRIs)	Covering mammography alone and not covering breast MRIs in combination with mammography, for individuals who would benefit from breast cancer evaluation that incorporates an MRI	Denying coverage of diagnostic imaging without regard to medical evidence and necessity may discriminate against individuals who have either been previously diagnosed with or are more susceptible to developing breast cancer	Determining cancer diagnostic testing and treatment coverage based on current medical evidence and medical necessity

Additional Guidance on Drug Formularies and Coverage of Behavioral Health Care Services

Drug Formularies

In the event that a QHP imposes overly restrictive utilization management which unduly limits access to commonly used medications for any chronic disease, including HIV/AIDS, the regulators may find this to be a discriminatory practice and de-certify a plan. Moreover, by placing all medications for a single chronic disease, including generics, on the highest cost-sharing tier, and/or requiring all such medications be accessed through a mail-order pharmacy, health plans discourage people living with those chronic diseases from enrolling in those health plans – a practice which unlawfully discriminates on the basis of disability. A QHP formulary drug list URL must be easily accessible, and its information up-to-date, accurate, and inclusive of a complete list of all covered drugs. The information should also provide a clear description of any tiering structure that the plan has adopted and any restrictions on the manner in which a drug can be obtained.

Behavioral Health Care

All QHP's are required to comply with the Mental Health Parity and Addiction Equity Act (45 CFR 156.115). The DISB will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. The DISB will use CCIIO tools for outlier analysis on specific QHP benefits, including: inpatient mental/behavioral health stays, specialist visits, specific conditions including behavioral health conditions such as mental health disorders and substance abuse, and prescription drugs. Moreover, the DISB and HBX will review provider networks to ensure sufficient access to behavioral health and substance use and recovery providers[4].

[4] Pursuant to 45 C.F.R. Section 156.230 (a)(2) which requires a QHP issuer to maintain a network that has sufficient numbers and types of health care providers, including providers specializing in the delivery of mental health and substance use disorder services.

Appendix E

Standardized Plan Benefit Design Guidance

Standard Plans Advisory Working Group
Platinum Plan 2016

Actuarial Value		89.40%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
Medical		$0	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$2,000	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$20	
	Specialist visit	$40	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$20	
	X-rays and diagnostic imaging	$40	
	Imaging (CT/PET scans, MRIs	$150	
Drugs to treat Illness or Condition	Generic	$5	
	Preferred brand	$15	
	Non-preferred Brand	$25	
	Specialty	$100	
Outpatient Surgery	Facility fee (e.g. hospital room)	$250	
	Physician/Surgeon fee		
Need Immediate Attention	Emergency room services (waived if admitted)	$150	
	Emergency medical transportation	$150	
	Urgent Care	$40	
Hospital Stay	Facility fee (e.g. hospital room)	$250 per day up to 5 days	
	Physician/surgeon fee		
Mental/Behavioral Health	M/B outpatient services	$20	
	M/B inpatient services	$250 per day up to 5 days	
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$20	
	Substance abuse disorder inpatient services	$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services: Hospital	$250 per day up to 5 days	
	Delivery and all inpatient services: Professional		
Help recovering or other special health needs	Home health care	$20	
	Outpatient rehabilitation services	$20	
	Outpatient habilitation services	$20	
	Skilled nursing care	$150 per day up to 5 days	
	Durable medical equipment	10%	

	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

Standard Plans Advisory Working Group
Silver Plan 2016

Actuarial Value		69.2%	
Individual Overall Deductible		N/A	
Other individual deductibles for specific services			
Medical		$2,000	
Prescription Drugs		$250	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$25	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$45	
	X-rays and diagnostic imaging	$65	
	Imaging (CT/PET scans, MRIs	$250	
Drugs to treat Illness or Condition	Generic	$15	
	Preferred brand	$50	X
	Non-preferred Brand	$70	X
	Specialty	20%	X
Outpatient Surgery	Facility fee (e.g. hospital room)	20%	X
	Physician/Surgeon fee	20%	X
Need Immediate Attention	Emergency room services (waived if admitted)	$250	X
	Emergency medical transportation	$250	X
	Urgent Care	$90	
Hospital Stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B outpatient services	$25	
	M/B inpatient services	20%	X
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$25	
	Substance abuse disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	20%	x
	Delivery and all inpatient services — Professional		x
Help recovering or other special health needs	Home health care	$45	
	Outpatient rehabilitation services	$45	
	Outpatient habilitation services	$45	
	Skilled nursing care	20%	x
	Durable medical equipment	20%	
	Hospice services	$0	

Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

Standard Plans Advisory Working Group
Bronze Plan 2016

Actuarial Value		61.3%	
Individual Overall Deductible		$4,500	
Other individual deductibles for specific services			
Medical		$4,500	
Prescription Drugs		$250	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,850	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$50	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$50	x
	X-rays and diagnostic imaging	$50	x
	Imaging (CT/PET scans, MRIs	$500	x
Drugs to treat Illness or Condition	Generic	$25	
	Preferred brand	50%	x
	Non-preferred Brand	50%	x
	Specialty	50%	x
Outpatient Surgery	Facility fee (e.g. hospital room)	20%	x
	Physician/Surgeon fee	20%	x
Need Immediate Attention	Emergency room services	20%	x
	Emergency medical transportation	0	
	Urgent Care	$50	
Hospital Stay	Facility fee (e.g. hospital room)	20%	x
	Physician/surgeon fee	20%	x
Mental/Behavioral Health	M/B outpatient services	$50	
	M/B inpatient services	20%	x
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$50	
	Substance abuse disorder inpatient services	20%	x
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	20%	x
	Delivery and all inpatient services — Professional		x
Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	$0	x
	Outpatient rehabilitation services	$50	x
	Outpatient habilitation services	$50	x
	Skilled nursing care	20%	x
	Durable medical equipment	20%	x
	Hospice services	20%	x
Child eye care	Eye exam (OD)	$50	

	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$41	
Child Dental Major Services	Root canal - molar	$512	
	Gingivectomy per Quad	$279	
	Extraction – single tooth exposed root or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	

Standard Plans Advisory Working Group
Gold Plan 2016

Actuarial Value		78.7%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
Medical		$500	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$3,500	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$25	
	Specialist visit	$50	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$30	
	X-rays and diagnostic imaging	$50	
	Imaging (CT/PET scans, MRIs	$250	
Drugs to treat Illness or Condition	Generic	$15	
	Preferred brand	$50	
	Non-preferred Brand	$70	
	Specialty	20%	
Outpatient Surgery	Facility fee (e.g. hospital room)	$600	
	Physician/Surgeon fee		
Need Immediate Attention	Emergency room services (waived if admitted)	$250	
	Emergency medical transportation	$250	
	Urgent Care	$60	
Hospital Stay	Facility fee (e.g. hospital room)	$600 per day up to 5 days	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B outpatient services	$25	
	M/B inpatient services	$600 per day up to 5 days	X
Substance Abuse needs	Substance abuse disorder outpatient services	$25	
	Substance abuse disorder inpatient services	$600 per day up to 5 days	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	$600 per day up to 5 days	X
	Delivery and all inpatient services — Professional		X
Help recovering or other special health needs	Home health care	$30	
	Outpatient rehabilitation services	$30	
	Outpatient habilitation services	$30	
	Skilled nursing care	$300 per day up to 5 days	
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	

Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive - cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers - Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal - molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

Appendix F

DCHBX Authority Executive Board Resolutions

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish the minimum employer contribution and minimum employee participation standards within the District of Columbia Small Business Health Options Program (SHOP) marketplace.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(2)) requires the Authority to establish a SHOP Exchange and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, §1201 of the ACA made guaranteed renewability a requirement in the small group and individual marketplace (§2703 of the Public Health Service Act, 42 U.S.C. 300gg-2)), and made non-compliance with material plan provisions relating to participation or contribution rules an exception allowing non-renewal of group coverage (42 U.S.C. 300gg-2(b)(3));

WHEREAS, 45 C.F.R. §147.106(b)(3)(i) defines "employer contribution rule" as a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

WHEREAS, 45 C.F.R. §147.106(b)(3)(ii) defines "group participation rule" as a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

WHEREAS, 45 C.F.R. §§155.705(b)(10) & 156.285(e) permit SHOP Exchanges to restrict participating QHP issuers to a uniform group participation rule for the offering of health insurance coverage in the SHOP, with the caveat that such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer;

WHEREAS, minimum contribution and participation requirements do not apply to employers who enroll during an annual open enrollment;

WHEREAS, employers have broad flexibility in the amount and percentage they can choose to contribute to help pay for health insurance for their workers;

WHEREAS, on March 26, 2013, the Employer and Employee Choice Working Group presented a non-consensus recommendation, for referral to the Board's Insurance Working Committee, relating to minimum SHOP employer contribution and minimum SHOP employee participation; and

WHEREAS, on March 28, 2013, the Insurance Working Committee deliberated on the "employer contribution rule" and the "group participation rule", at a meeting open to the public, and approved a recommendation for Board consideration.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation presented by the Insurance Working Committee based on current market practices:

Minimum Contribution and Participation Requirements:

As a requirement to offer coverage through the SHOP Exchange, an issuer's 'minimum contribution rate' must be at 50% of the employee's individual reference plan premium and 'minimum participation rate' at 2/3 of qualified SHOP employees who do not waive coverage due to having coverage elsewhere.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**8th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To prohibit tobacco use as a rating factor.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152).

WHEREAS, §1201 of the ACA prescribed permissible rating factors in the small group and individual marketplaces (§2701 of the Public Health Service Act, 42 U.S.C. 300gg(a)(1)), and specifically limited rating variations based on tobacco use to no more than a ratio of 1.5:1;

WHEREAS, the U.S. Department of Health and Human Services has determined that the federal statute, and its own regulation, does not prevent states from prescribing a narrower ratio or from prohibiting the variation of rates based on tobacco use, or from having requirements for health insurance issuers that are more consumer protective than those under federal law (78 Fed. Reg. 13406, 13414 (Feb. 27, 2013) (interpreting the preemption and state flexibility rules at §2724 of the Public Health Service Act, 42 U.S.C. 300gg-23(a)(1));

WHEREAS, the Standing Advisory Board was asked for a recommendation on allowing use of tobacco rating factors in the individual and small group health insurance markets, as well as if allowed what permissible limits should be. After receiving public input and reviewing written reports, the Standing Advisory Board recommended to prohibit tobacco use as a rating factor in a vote of 6 to 2, with one abstention;

WHEREAS, current market practice in the District of Columbia is not to vary rates in the small group and individual marketplaces based on tobacco use;

WHEREAS, on April 4, 2013, the Insurance Working Committee deliberated on the topic of tobacco use as a rating factor, at a meeting open to the public, and approved a recommendation for Board consideration in a two to one vote to prohibit tobacco use as a rating factor; and

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation presented by the majority of the Insurance Working Committee:

Rate Variations Based on Tobacco Use: Issuers may not vary rates based on tobacco use.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**8th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish the range of plan selection choices, for plan year 2014, within the District of Columbia Small Business Health Options Program (SHOP) Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, section 5 of the Act (D.C. Official Code §31-3171.04(a)(2)) requires the Authority to establish a SHOP Exchange and ensure that qualified employers are able to specify a level of coverage available to qualified employees;

WHEREAS, 45 C.F.R. §155.705(b)(3), as proposed in 78 Fed. Reg. 15553, 15557 (Mar. 11, 2013), provides state-based SHOP exchanges with broad discretion to establish plan selection choices for qualified SHOP employers in plan year 2014;

WHEREAS, on March 26, 2013, the Employer and Employee Choice Working Group presented a non-consensus recommendation, on employee choice models, that was referred to the Board's Insurance Working Committee for further consideration; and

WHEREAS, on March 28, 2013, the Insurance Working Committee deliberated on employee choice models, at a meeting open to the public, and approved a recommendation for Board consideration.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation presented by the Insurance Working Committee:

Employee Choice Models

The Exchange will offer qualified SHOP employers three options to pick from in establishing the range of QHPs qualified employees may enroll in:

- *Option 1*: *All Issuers & QHPs/One Tier* – all issuers and all Qualified Health Plans (QHPs) on one actuarial value (AV) metal level.

- *Option 2*: *One-issuer/two Metal Levels* – all the QHPs that one issuer offers on any two contiguous AV metal levels, if feasible and practicable. If not, then all AV metal levels.

- *Option 3*: *One-QHP* – a single QHP offered by a single issuer.

BE IT FURTHER RESOLVED that, after a reasonable time to collect valid data, the Authority shall conduct a market study, which must include, at a minimum:

- A survey of employees and employers examining their experience with employee choice options and employees' satisfaction with the range of health plan choices made available to them by their employer in the Exchange;
- An actuarial analysis of premiums;
- An examination of options to expand employee choice; and
- An evaluation of employers', carriers', and the Exchange's experience in administering employee choice.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**4th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a premium rating and employer contribution approach within the District of Columbia Small Business Health Options Program (SHOP) marketplace.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(2)) requires the Authority to establish a SHOP Exchange and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, §1201 of the ACA made premium fairness a requirement in the small group and individual marketplace (§2701 of the Public Health Service Act, 42 U.S.C. 300gg);

WHEREAS, 45 C.F.R. §147.102(c)(3) allows states to require composite premium rating in the small group market; and

WHEREAS, on March 26, 2013, the Employer and Employee Choice Working Group presented a consensus recommendation on a premium rating and employer contribution approach.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the "Reallocated Composite Premium, with qualified SHOP employees paying the difference in list billing between the reference plan and the plan they select" method as the premium rating approach in the SHOP marketplace. As recommended by the Employer and Employee Choice Working Group, this rating approach would operate as follows:

- Issuers receive list bill premiums.
    - The only exception to this may be with regard to mid-year census changes.
- Composite rates are calculated for all plans that employees of a group could select.
    - Rates for any one plan are calculated based on the assumption that all qualified employees of a group enroll in that plan.
- A reference Qualified Health Plan (QHP) and contribution amount is selected by the

employer.

- The employer pays the same dollar amount for each employee, regardless of age or plan selected by the employee.
- For employees who select the reference plan, their premium payments are the same dollar amount, regardless of age.
- In addition to the employee contribution for the reference plan, if an employee selects a plan other than the reference plan, the employee pays (or receives) the difference between the list bill of the selected plan and the list bill of the reference plan with employees paying the difference in list billing between the reference plan and the plan they select.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**4th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish further Essential Health Benefit standards and to establish additional Qualified Health Plan (QHP) certification standards to promote benefit standardization in the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1302(a) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) requires the Qualified Health Plans certified by the District of Columbia Health Benefit Exchange provide a benefits package that meets or exceeds the Essential Health Benefit (EHB) benchmark;

WHEREAS, §1301(a)(1)(C)(ii) of the ACA requires QHP issuers to offer one silver-level and one gold-level plan at a minimum;

WHEREAS, 45 C.F.R. §155.1000(c) allows state exchanges to limit certification to those plans that it finds are in the best interest of qualified individuals and employers and 45 C.F.R. §156.200(d) allows state exchanges to require additional certification requirements beyond the federal minimums;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHPs;

WHEREAS, the Executive Board received a series of non-consensus recommendations from the EHB Working Group on February 13, 2013 and from the Plan Offering and Qualified Health Plan Benefit Standardization Working Group on March 7, 2013,

WHEREAS, on March 7, 2013, the Executive Board referred these non-consensus recommendations to its Insurance Working Committee; and

WHEREAS, on March 19, 2013, the Insurance Working Committee deliberated on these recommendations at a meeting open to the public.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendation from the Insurance Working Committee as part of the EHB standard in the District of Columbia:

1. DC's essential health benefit habilitative services category shall be defined as: Health care services that help a person keep, learn or improve skills and functioning for daily living, including, but not limited, to applied behavioral analysis (ABA) for the treatment of autism spectrum disorder.

BE IT FURTHER RESOLVED that the Board hereby approves the Insurance Working Committee's recommendations regarding additional certification standards for QHPs in the District of Columbia:

1. The Board recommends no limits on the number of QHPs. The Board asks DISB to monitor the number and diversity of plan offerings and to report back to the exchange on consumer choices and reports of satisfaction.

2. The Executive Board asks the Department of Insurance, Securities, and Banking (DISB) to apply the Federally Facilitated Exchange's "meaningful difference" standard, the elements of which are outlined in a letter from the Centers for Consumer Information and Insurance Oversight (CIIO) and the Centers for Medicare and Medicaid Services (CMS) to issuers dated March 1, 2013 (available at http://cciio.cms.gov/resources/files/issuer-letter-3-1-2013.pdf, see page 16), as a part of their certification of qualified health plans for the 2014 plan year. The Executive Board asks that the marketplace offerings continue to be monitored and the "meaningful difference" standard updated as needed to provide for meaningful consumer choices.

3. The Executive Board asks DISB to develop one or more standardized benefit plans (benefits and cost sharing) at the silver and gold metal level for the 2015 plan year and at the bronze and platinum metal level not later than the 2016 plan year based on input from consumers, employers, carriers, and based on early purchaser preferences. Carriers will be required to offer one or more standardized plans at each metal level in which the carrier is participating for plan years where there is a standardized plan in addition to other plans the carrier may offer.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 22 day of March 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

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Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a process for certification of Qualified Health Plan (QHP) Issuers in the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(c) of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152) and 45 CFR Part 156, Subpart C establish minimum certification standards for Qualified Health Plans (QHPs) offering coverage on American Health Benefit Exchanges;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHP issuers;

WHEREAS, the Executive Board established an Issuer Certification Process Workgroup, which included health insurance carriers, consumer advocates, and employers, to recommend a process for certifying insurance companies as QHP issuers; and

WHEREAS, the Issuer Certification Process Workgroup presented recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the certification process consensus recommendations, as reflected in the Workgroup's February 28, 2013 report (as corrected – "recertification") (attached).

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date

District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

RESOLUTION OF THE EXECUTIVE BOARD DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a transition process for individual and small business health benefit plan enrollees into the District of Columbia Health Benefit Exchange ("Marketplace Exchange").

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §7 of the Act (D.C. Code §31-3171.06) authorizes the Executive Board to take actions necessary to carry out the functions necessary to establish an American Health Benefit Exchange;

WHEREAS, on October 3, 2012, the Executive Board voted unanimously to create one large marketplace for the sale of individual coverage and small group coverage to businesses with 50 or fewer employees. One big marketplace means all individual and small group coverage is sold through one distribution channel – the Exchange. This does not apply to grandfathered plans;

WHEREAS, the Executive Board directed the Executive Director to consult with a broad array of stakeholders – insurers, employers, producers, consumer and patient advocates, and providers – to identify the optimal way to move from the current market to this new marketplace and return with a recommendation to the Executive Board;

WHEREAS, in addition to consultations with stakeholders, the Executive Director requested that the Standing Advisory Board provide recommendations to the Executive Director on the transition considering a one and two year transition period;

WHEREAS, the Standing Advisory Board held three public meetings to consider options for a market transition with the support of Linda Blumberg, PhD, an economist and senior fellow with the Urban Institute, who provided valuable information on market competition and transition options as well as pros and cons associated with the options;

WHEREAS, the Standing Advisory Board accepted written and oral testimony from a variety of stakeholders, including insurance carriers, brokers, employers, and consumer/patient advocates; and

WHEREAS, the Executive Director adopted the recommendations of the Standing Advisory Board after a review of the work of the Standing Advisory Board, a review of materials including testimony, Dr. Blumberg's written materials prepared for the Standing Advisory Board, and the majority and minority reports provided by the Standing Advisory Board. The Executive Director's recommendations were presented to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Board hereby approves the following as recommended by the Executive Director, based on the majority recommendations of the Standing Advisory Board:

- In the individual market, consumers should enter the Marketplace Exchange in CY2014.
- New entrants to the small group market should enter the Marketplace Exchange in CY2014.
- Currently insured small businesses wishing to change carriers or stay with their current carrier should transition into the Marketplace Exchange over a two-year period. In CY2015, renewals will be through the Exchange web portal.
- All plans sold outside of the Marketplace Exchange during the two-year transition period should be required to comply with all of the requirements applicable to coverage sold through the Marketplace Exchange.
- Beginning in 2016, the small group market will expand to include businesses with 51 to 100 employees. The addition of this market segment should be addressed in subsequent years (assuming there are no related amendments to the ACA).

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a process whereby Qualified Health Plan applying for certification by the District of Columbia Health Benefit Exchange will demonstrate compliance with network adequacy standards.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(c)(1)(B) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) and D.C. Official Code §31-3171.09(a)(6)(B) establishes network adequacy as a minimum certification standard for Qualified Health Plans (QHPs) offering coverage on the District of Columbia Health Benefit Exchange;

WHEREAS, 45 C.F.R. §155.1050 requires states to ensure all QHPs meet the minimum network adequacy standards specified in 45 C.F.R. §156.230, but also allows states to develop standards in a way that meets their own unique healthcare market;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHPs;

WHEREAS, the Executive Board established a Network Adequacy Workgroup, composed of insurance carriers, small businesses, brokers, health care providers, and consumer advocates, to review existing network adequacy requirements and recommend any new standards/changes if necessary; and

WHEREAS, the Network Adequacy Workgroup presented recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the network adequacy consensus recommendations, as reflected in the Workgroup's March 5, 2013 report (attached).

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish premium collection standards and processes within the Individual Marketplace of the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, 45 C.F.R. §155.240(c) provides options to state exchanges, which includes the option of establishing a process to facilitate the collection and payment of premiums from individuals;

WHEREAS, the Executive Board established an Individual Premium Billing Workgroup, which included health insurance carriers, a broker, and consumer advocates, to assess the various options available to the Exchange and recommend a course of action with respect to premium billing for individuals;

WHEREAS, the Individual Billing Workgroup focused on four criteria for evaluating options and making a recommendation:

- The ability of the Exchange's selected vendor and carriers to implement billing systems in a timely manner;
- Providing the enrollee with a smooth, easy enrollment experience and good customer service;
- Strategic considerations related to ongoing communications with enrollees; and
- The cost of performing premium billing and collection.

WHEREAS, Individual Premium Billing Workgroup presented a summary of its work and

recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations for individual (non-group) premium collection standards for QHPs in the District of Columbia:

(1) All billing and collection of payments for an individual's initial enrollment (or subsequently switching issuers) will be performed by the Exchange.

(2) The Exchange will then pass the first month's premiums and enrollee information to the issuer(s) for effective enrollment.

(3) After the first month's billing and payment are completed and the enrollment information is passed from the Exchange to the issuer(s), the responsibility for subsequent month's billing and collection functions pass to the respective Issuer of a Qualified Health Plan(s) selected by the household.

(4) The Exchange will develop policies and procedures to address billing and collections during future open enrollment periods; during enrollment periods a change in carrier would result in an initial billing from the Exchange while renewal with the same carrier would result in a continuation of billings from the existing carrier.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish additional Qualified Health Plan (QHP) certification standards to promote benefit standardization in the District of Columbia Health Benefit Exchange.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(c)(1)(A) of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152) establishes non-prejudicial benefit design as a minimum certification standard for Qualified Health Plans (QHPs) offering coverage on American Health Benefit Exchanges;

WHEREAS, §1301(a)(1)(C)(ii) of the ACA requires QHP issuers to offer one silver-level and one gold-level plan at a minimum;

WHEREAS, 45 C.F.R. §155.1000(c) allows state exchanges to limit certification to those plans that it finds are in the best interest of qualified individuals and employers and 45 C.F.R. §156.200(d) allows state exchanges to require additional certification requirements beyond the federal minimums;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(7)) authorizes the Authority to implement procedures for certification, recertification, and decertification of QHPs;

WHEREAS, the Executive Board established a Benefit Standardization Workgroup, composed of health insurance carriers, small businesses, brokers, health care providers, benefit consultants, and consumer advocates, to make recommendations on additional plan offering and standardization options; and

WHEREAS, the Benefit Standardization Workgroup presented recommendations to the Board on March 7, 2013.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations regarding additional certification standards for QHPs in the District of Columbia:

(1) QHP issuers should be allowed to add benefits, defined as services eligible for claims submission and reimbursement, in excess of the Essential Health Benefit (EHB) benchmark.

(2) QHP issuers must offer at least one bronze-level plan.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**March**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To recommend further policy regarding the Essential Health Benefit (EHB) benchmark standard for the District of Columbia.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1302(a) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) requires the Qualified Health Plans certified by the District of Columbia Health Benefit Exchange provide a benefits package that meets or exceeds the Essential Health Benefit (EHB) benchmark;

WHEREAS, §7 of the Act (D.C. Code §31-3171.06) authorizes the Executive Board to take actions necessary to carry out the functions necessary to establish an American Health Benefit Exchange;

WHEREAS, the District of Columbia Department of Insurance, Securities, and Banking (DISB) selected the largest small group plan available in the District, BlueCross BlueShield CareFirst Blue Preferred PPO Option 1, as its EHB benchmark plan and the FEDVIP BlueVision plan and FEDVIP MetLife plan as supplementary standards for the pediatric vision and pediatric dental benefits respectively;

WHEREAS, the EHB Working Group was established with membership composed of patient and consumer advocacy groups, physicians and other providers, health insurers, insurance brokers, and many other stakeholders to review outstanding policy questions related to the EHB benchmark selection for the District of Columbia and make recommendations to the Executive Board, including questions of (1) parity with the mental health and substance abuse benefits, (2) drug formulary compliance with federal minimum standards, (3) substitution of benefits, and (4) definition of habilitative services;

NOW, THEREFORE, BE IT RESOLVED that the Board hereby approves the following consensus recommendations (brackets [] indicate word change due to reference to appendix in the Working Group's final report) for adoption as part of the EHB standard in the District of Columbia.

Behavioral Health (Mental Health and Substance Abuse):

Behavioral health inpatient and outpatient services be covered without day or visit limitations to the benefit.

Prescription Drug Formulary

The drug formulary of every issuer of qualified health plans include at least the number of drugs listed in each category [found in the benchmark plan's formulary and in compliance with the minimum number of drugs, by category, as established by the federal Center for Consumer Information and Insurance Oversight (CCIIO).]

Substitution of Comparable Benefits

Issuers not be allowed to substitute coverage of one [benefit] for another, at least for 2014.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**13th**___ day of _**February**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

CORPORATE ACTION OF THE EXECUTIVE BOARD

DISTRICT OF COLUMBIA

HEALTH BENEFIT EXCHANGE AUTHORITY

WHEREAS, over the past four weeks, the Health Benefit Exchange Insurance Working Committee has been meticulously reviewing the market recommendations proposed by the Insurance Subcommittee in April 2012. This included an in-depth review of the Mercer deliverables, supplemental materials, stakeholder comment, and consultation with District staff.

WHEREAS, the Insurance Subcommittee recommendations are listed below with DC Health Benefit Exchange Insurance Working Group actions listed after each:

1. Health insurance plans that meet minimum requirements set forth by the ACA for qualified health plans (QHPs) as well as any additional requirements set forth by the DC HBX Authority can be offered in the DC HBX insurance marketplace.
    - *The working committee supports this recommendation to preserve and expand current health insurance plan choices and presents it for formal consideration to the Executive Board.*

2. The DC HBX insurance marketplace should be the sole marketplace in the District of Columbia for the purchase of individual and small group health insurance plans.
    - *The working committee supports this recommendation to promote fair competition in the small group and individual health insurance markets and presents it for formal consideration to the Executive Board.*

3. The risk pools of the small group market and individual markets in the DC HX insurance marketplace should be merged into one single risk pool.
    - *The working committee supports this recommendation in recognition of the need to make quality, affordable health coverage seamlessly available to all District residents irrespective of employment status and presents it for formal consideration to the Executive Board.*

4. Small group size in the District of Columbia should be defined as 2-100 as opposed to the current practice of 2-50.
    - *The working committee amends this recommendation to maintain the current practice of defining small group as 2 to 50 as opposed to 2 to 100 and presents it for formal consideration to the Executive Board.*
        - *Along with this amendment is direction to the Insurance Subcommittee to research and analyze methods to regulate stop-loss insurance for self-funded plans.*

5. The District of Columbia should opt into the federal administered risk adjustment and reinsurance programs for the DC HBX insurance marketplace.
    - *The working committee supports this recommendation and presents it for formal consideration to the Executive Board.*

WHEREAS, the DC Health Benefit Exchange Insurance Working Group emphasizes that these recommendations, if adopted, will be implemented with the aid of a detailed work plan developed in conjunction with stakeholders and with final approval by the Exchange Board. In the course of developing such a work plan for implementing these recommendations, the DC Health Benefit Exchange working group strongly supports continued consultation with all interested parties to help ensure that these principles are adopted in a way that minimizes market disruption and enables a smooth transition for D.C. residents.

NOW, THEREFORE, BE IT RECORDED that the Board hereby adopts the HRIC insurance market recommendations endorsed by the Insurance Market Working Committee.

I HEREBY CERTIFY that the foregoing Corporate Action was adopted on the 3rd day of October, 2012, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Dental Working Group Report

April 13, 2013

This report is submitted to the Health Benefit Exchange Authority by the Dental Plan Advisory Working Group Chair (Leighton Ku) and Co-Vice Chairs (Katherine Stocks and Anupama Rao Tate). The purpose of this report is to outline the recommendations of the Dental Plan Advisory Working Group regarding what stand-alone dental plan issuers will be required to submit the DC Health Benefit Exchange Authority (HBX) with respect to becoming certified to sell stand-alone dental plans covering the Essential Health Benefit pediatric dental benefits, and non-pediatric dental benefits if chosen by the issuer, through the HBX.

Background

For dental coverage beginning in 2014, individuals and small groups will be able to purchase coverage through exchanges, the purpose of which is to provide a competitive marketplace and facilitate comparison of dental plans based on price, coverage and other factors. Dental plan issuers must be certified as meeting minimum standards in order to participate in the exchange and issue qualified dental plans. In March of 2012, the U.S. Department of Health and Human Services issued a final (some parts interim final) rule on "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers." (45 CFR Parts 155, 156 and 157). The preamble to the rule and the rule itself provide detailed guidance to exchange operators on the federal standards with which the exchange and the issuers must comply, such as state licensure; benefit and product standards; rating, rate filing and rating disclosures; marketing; quality, network adequacy and accreditation; and other required processes, procedures and disclosures.

Dental Issuer Certification Process

Discussion

The working group was charged with coming to consensus on the process by which dental carriers become certified to offer dental plans in the DC HBX. To assist in its discussions and deliberations, the working group used a checklist approved by the Board for use with QHP issuer certification, modified as appropriate for stand-alone dental plans. That document is attached. (Attachment A)

Additional information provided to the Working Group was the narrative regarding Departments of Insurance (DOIs) across the states, including DC's Department of Insurance Securities and Banking (DISB), use of attestations of compliance with required standards, as recited in the QHP Issuer Certification Process Working Group report:

> One of the ways departments of insurance (DOIs) across the nation operate is to use attestations (also known as certifications) of issuers that they are in compliance with the law. For example, company actuaries routinely certify that their rates are reasonable in relation to the premium charged and that they are not unfairly discriminatory. State DOIs, including DC's Department of Insurance Securities and Banking (DISB), accept these actuarial certifications. Similarly, issuers file annual financial statements and certify that they are correct. Again, state DOIs, including DISB, routinely accept these certifications.
>
> DISB retains regulatory authority by acceptance of attestations, since it has full authority to enforce correction of an issuer error and impose any sanction, such as a fine, commensurate with the gravity of the error.

A significant portion of the working group's discussion recognized the fact that the DC HBX is in start-up mode, and time is of the essence in getting processes underway in order for plans to have qualified products and the HBX to be ready for the initial open enrollment period, which starts on October 1, 2013. Due to this very real time crunch, the bulk of the working group's recommendations are to accept issuer certifications of compliance with the various standards for first plan year. However, the working group also recognizes that operation of the HBX will be an evolving experience and in fact the HBX will have more data as the HBX grows and adds more enrollees. The working group recommends that the HBX Board revisit these standards prior to QHP recertification in the second plan year, since the HBX will have additional data and experience to evaluate whether regulator verifications based on prospective evidence or means of accreditation other than issuer certifications should be required for certain standards.

It is also important to note that under the federal regulation, exchanges have an obligation to monitor compliance with federal standards for QHP and issuer certification. As HBX gains experience, becomes fully staffed and gains enrollees, actions such as spot checks of issuer websites and other monitoring activities should increase.

Consensus Recommendation

The Working Group reached a consensus recommendation to follow the general certification process adopted by the Board for QHP issuers, with certain categories modified or deleted as appropriate to dental plans.

I – Licensed and in good standing

- The regulator will verify that the issuer has a certificate of authority to conduct insurance business in DC for health (or dental) insurance
- Attestations for the following will be accepted:
  - Service area
  - General attestation that QDP issuer has appropriate structure, staffing, management, etc. to administer QDP effectively and in conformance with federal requirements now and in the future

II – Benefit Standards and Product Offerings
III – Rate Filings, Standards and Disclosure Requirement
IV – Marketing

Attestations for all the standards in II, III and IV will be accepted.

V – Network Adequacy Requirements

Attestations for all the standards in V will be accepted.

VI– Applications and Notices
VII – Transparency Requirements
VIII– Enrollment Periods
IX– Enrollment Process for Qualified Individuals
X- Termination of Coverage of Qualified Individuals.
XI – Other Substantive Requirements

Attestations for all the standards in VI, VII, VIII, IX, X and XI will be accepted.

Non-Pediatric Dental Benefits

Discussion
The working group was charged with coming to consensus on the offering of non-pediatric dental benefits in QHPs and stand-alone plans.

The following are allowed EHB dental plans under DC law:

a. QHP that includes pediatric dental EHB (called "embedded")
b. Standalone dental plan that includes pediatric dental EHB (QDP)
c. QHP in conjunction with a QDP. In this case:
   i. The plans are priced separately
   ii. The plans are made available for purchase separately at the same price.

A QHP is not required to provide pediatric dental benefits if:

i. There is at least one QDP available and

ii. The carrier discloses there are no pediatric dental benefits in the plan and those benefits are available on the HBX.

The Secretary has expressly stated that stand-alone dental plans can offer additional benefits, including non-pediatric coverage. (Federal Register, Vol. 78, No. 37, Feb. 15, 2013, p. 12853). However, DC law does not require it.

Consensus Recommendation

The working group reached consensus recommendation that licensed District of Columbia issuers offering stand-alone pediatric dental plans may also offer non-pediatric dental benefits.

Reasonable Out-of-Pocket Maximums

Discussion

The Working Group was charged with coming to consensus on what a reasonable out-of-pocket maximum (OOP) (dollar amount) would be for a stand-alone pediatric dental plan. According to 45 CFR 156.150, the HBX must establish such a reasonable OOP. In a draft March 1 letter, the Center for Consumer Information and Insurance Oversight (CCIIO) stated that a $1,000 OOP would be considered reasonable (i.e. a safe harbor). However, it was not clear in the letter if that was per plan, or whether it could be applied to each child covered in the plan. Our neighbor jurisdiction, Maryland, has set the OOP at $1,000 if there is one child in the plan, and $2,000 if there are two or more children in the plan.

The dental issuers strongly support a $1,000 per child OOP and maintain that if it is less, premiums, deductibles and other cost-sharing will be higher. They maintain that at $1,000 per child, about 2% of children would reach the OOP. If the OOP were dropped to $500, then about 4% reach the OOP. One reason for the low percentages is that only medically necessary orthodontia is covered as an EHB, and according to the experts, the handicapping criteria to reach that threshold are extremely difficult. A pediatric dentist reported that children who reach the threshold have significant deformities.

Generally speaking, consumer advocates think a $1,000 per child OOP is too high, and even more so if there are several children in the plan. This creates a barrier to purchasing a plan because the pediatric dental benefit, although a required offer, is not a mandated purchase for childless adults and may result in less coverage. An actuarial study circulated by Milliman[1] that indicated the premium rise for a lower OOP was not significant (about $2-$3 to go from $1,000 to $270), but various parties disputed the age of the report and the assumptions used.

[1] *Out of Pocket Maximum for Pediatric Dental and Orthodontia Benefit Plan to Prevent Catastrophic Dental Cost*. Milliman, November 5, 2012.

A working group member thought that CCIIO was going to revisit the $1,000 safe harbor, and a few working group members wanted to follow the federal safe harbor, whatever it turned out to be.

Non-Consensus Recommendation
The issue of the out-of-pocket maximum was discussed at both working group meetings, and the working group was unable to reach consensus on the OOP issue.

Subsequent to the working group meetings, on April 5, 2013, CCIIO released a revised letter that set the stand-alone dental OOP safe harbor at $700 per child, and $1,400 if there are two or more children covered by the plan.

Separate Pricing of Pediatric Dental Benefit Embedded in QHP

Discussion
The Working Group was charged with coming to consensus on whether an issuer offering QHP with the EHB pediatric dental benefit embedded in the plan should be required to display the cost of the pediatric dental benefit portion separately from the cost of the rest of the plan. The discussion of this issue showed that stand-alone dental plans and QHPs with an embedded have polar opposite views. Stand-alone dental plans insist they will be at a competitive disadvantage if the QHP is not required to separate out and display the pediatric EHB portion. QHP issuers are equally adamant that it is impossible to do since the pricing of the plan covers so many benefits and is spread among people who will never use the pediatric dental benefit. The Department of Insurance, Securities, and Banking also confirmed that separating the cost of dental benefits in these plans would not be feasible for comparison purposes.

Consensus Recommendation
In what can be considered a compromise, the working group reached consensus that a QHP should clearly label whether it does, or does not, include the pediatric dental EHB.

<u>Working Group Members</u>

The Dental Plan Advisory Working Group is comprised of representatives from dental plans, health plans and consumer advocates. Two meetings were held, on March 26 and April 2, 2013, both with in-person and conference call participation.

Leighton Ku	The George Washington University Center for Health Policy Research (DC HBX Board)
Katherine Stocks	The Goldblatt Group
Anupama Rao Tate	Children's National Medical Center
Mark Haraway	DentaQuest
Guy Rohling	UHC Dental

Jim Mullen, Kevin Wrege	Delta Dental
Louisa Tavakoli	Care First
Colin Reusch	Children's Dental Health Project
Amy Hall	DC resident
Tiffany	Kaiser Permanente
Jim Sefcik	Consultant
Mike Hickey	MetLife
Dean Rodgers	Dominion Dental
Jonathan Zuck	United Concordia
Meg Booth	CDHP
Claire McAndrew	Families USA

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a reasonable out-of-pocket maximum for Qualified Dental Plans.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, § 1311(d)(2)(B)(ii) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) ("ACA"), 45 CFR § 155.1065, and § 5(b) of the Act (D.C. Official Code § 31-3171.04(b)) permit a health carrier to offer a limited scope dental benefit either separately or in conjunction with a Qualified Health Plan, if the plan provides essential pediatric dental benefits meeting the requirements of §1302(b)(1)(J) of the ACA;

WHEREAS, § 10(e) of the Act (D.C. Official Code § 31-3171.09(e)) applies the certification requirements of the Act to Qualified Dental Plans to the extent relevant and permits health carriers to jointly offer a comprehensive plan through the exchanges in which the dental benefits are provided by a health carrier through a Qualified Dental Plan and the other benefits are provided by a health carrier through a Qualified Health Plan; provided, that the plans are priced separately and are also made available for purchase separately at the same price;

WHEREAS, the Dental Plan Working Group, which included ten dental and health carriers, consumer groups, and a DC resident, met on April 2, 2013and reached consensus on three recommendations and did not reach consensus on one recommendation;

WHEREAS, on April 15, 2013, the Insurance Market Working Committee deliberated on the non-consensus recommendation regarding an out of pocket maximum for the pediatric dental essential health benefit in a stand-alone dental plan;

WHEREAS, 45 C.F.R. §156.150 requires a stand-alone dental plan covering the pediatric dental essential health benefit to demonstrate that it has a reasonable annual limitation on cost-sharing as determined by the Exchange;

WHEREAS, on April 5, 2013, the Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services, issued a letter of guidance for federally facilitated and partnership exchanges defining a reasonable out-of-pocket maximum for the pediatric dental essential health benefit from 45 C.F.R. §156.150 as at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees; and

WHEREAS, the Insurance Market Working Committee in a 3-0 vote recommends an out-of-pocket maximum that is not greater than $1000 for one child, increasing to $2000 for two or more children for the pediatric dental essential health benefit in Qualified Dental Plans.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves an out-of-pocket maximum for Qualified Dental Plans that is not greater than $1000 for one child, increasing to $2000 for two or more children for the pediatric dental essential health benefit.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**18th**___ day of _**April**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish effective dates for eligibility redeterminations resulting from changes reported during the benefit year.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.330(f)(2) permits the Exchange to determine a reasonable point in a month after which an eligibility change captured through a redetermination will not be effective until the first day of the second month after the redetermination is made; and

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated on this topic and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

For those individuals enrolled in a QHP who experience a change in eligibility during a benefit year, but who do not lose their eligibility for enrollment in a QHP, the District of Columbia Health Benefit Exchange will implement eligibility changes determined on or before the 15th day of the month to be effective the first day of the following month. For those eligibility

changes made on the 16th day or thereafter, the effective date of the change will be the first day of the second month following the date of the redetermination notice.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish default termination rules for Individual Exchange marketplace enrollees who are determined eligible for Medicaid.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange ("Exchange") for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, according to 26 U.S.C. §36B(c)(2)(B), individuals eligible for Minimum Essential Coverage are not eligible for the Advanced Premium Tax Credits used to lower premium costs for coverage in the Individual Exchange marketplace;

WHEREAS, according to 26 U.S.C. §5000A(f))(1)(A)(ii), Medicaid coverage is considered Minimum Essential Coverage;

WHEREAS, 45 C.F.R. §155.330(d)(ii) requires the Exchange to proactively and regularly monitor Medicaid eligibility determinations;

WHEREAS, the Authority is establishing a unified eligibility determination system in partnership with the Department of Health Care Finance (State Medicaid Agency) and will have knowledge of Medicaid eligibility determinations;

WHEREAS, Medicaid coverage in the District of Columbia offers a comprehensive benefit package at little or no cost-sharing for the enrollee; and

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated regarding this situation and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

Default Termination of QHP Coverage Based on Medicaid Eligibility Determination:

The District of Columbia Health Benefit Exchange will terminate an enrollee's QHP enrollment upon notification of Medicaid eligibility with the effective date dependent on the date of the Medicaid eligibility determination. Determinations made on or before the 15th of the month would have a default termination effective the first day of the next month, determinations made after the 15th would have a default effective date of the first day of the second month following the determination. An individual can request to continue enrollment in their QHP, without any subsidies, before the scheduled default QHP termination date. Individuals will be advised of their default termination date in the redetermination notice sent following the Medicaid eligibility determination. Default terminations do not alter an individual's right to terminate under 45 C.F.R. §155.430.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To define "exceptional circumstances" permitting a Special Enrollment Period.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (9)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including the establishment of enrollment periods, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.420(d)(1) – (8) establishes a series of circumstances in which QHPs must permit qualified individuals to receive a 60-day special enrollment period (SEP) to enroll in the Individual Exchange marketplace outside an Open Enrollment Period;

WHEREAS, 45 C.F.R. §155.420(d)(9) permits the Exchange to define "exceptional circumstances" establishing additional SEPs; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated on this topic and reached consensus recommendations to the Executive Board;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations presented by the Eligibility, Enrollment, and Churn Working Group:

The District of Columbia Health Benefit Exchange will consider it an exceptional circumstance, permitting a new special enrollment period, when an applicant or enrollee does not select a plan during Initial Enrollment, Open Enrollment, or an SEP granted on other grounds, due to one of the following circumstances if the individual does not otherwise qualify for an SEP under the categories in 45 C.F.R. §155.420(d)(1) – (8):

1) Based on the individual's self-attestation, he/she is eligible for Medicaid but the eligibility determination is pending paper verification of an eligibility factor and the

individual is ultimately determined ineligible for Medicaid after the enrollment period has expired. The first day of the SEP shall be the date of the notice of Medicaid ineligibility. This SEP would exclude Medicaid applicants who were denied due to their failure to timely provide the requested documentation.

2) An individual misses the Individual Exchange enrollment period while waiting for their employer to be approved for the SHOP. Under this scenario, an individual's employer applies to participate through SHOP during the individual open enrollment period and is ultimately denied due to not meeting minimum participation requirements. By the time the employee is notified that he/she cannot enroll through the SHOP, the individual's enrollment period has passed.

3) The individual's enrollment or non-enrollment in a QHP was unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a QHP issuer, or its instrumentalities as evaluated and determined by the D.C. Department of Insurance, Securities, and Banking. In such cases, the Exchange may trigger the SEP and take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To require Qualified Health Plan (QHP) issuers to establish polices that address transition of care for enrollees in the midst of active treatment at the time of transition into a QHP.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (19)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, there is a consensus among public health researchers that a substantial portion of individuals in the Individual Exchange marketplace will experience changes in eligibility during the benefit year causing them to move or "churn" between Medicaid, and coverage in a Qualified Health Plan (QHP);

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group discussed strategies to address "churn" and developed consensus recommendations.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations presented by the Eligibility, Enrollment, and Churn Working Group:

<u>Establishment of Care Transition Plans by QHP Issuers:</u>

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

Counseling by In-Person Assisters and Brokers:

In-Person Assisters under contract with the District of Columbia Health Benefit Exchange shall counsel individuals about transition risk upon changes in program eligibility. The training available to In-Person Assisters and Brokers shall include information on risks associated with transitioning from one form of coverage to another during a course of active treatment.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish outreach strategies to promote tobacco cessation programs and other preventive benefits that are covered without cost sharing.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and a Small Business Health Options Program (SHOP) Exchange (collectively the District of Columbia Health Benefit Exchange or DC HBX) and maintain a publicly available website with information available to enrollees and prospective enrollees, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, on December 12, 2012, the Executive Board established the Plan Management Advisory Committee to advise on qualified health plan (QHP) requirements, dental plan requirements, certification processes, QHP enrollment, and other issues as requested by the Executive Board or Authority staff;

WHEREAS, on April 8, 2013, the Executive Board requested that an appropriate advisory committee provide recommendations to the Executive Board on approaches for promoting outreach to beneficiaries on tobacco cessation programs and other preventive benefits provided without any cost sharing; and

WHEREAS, that responsibility was assigned to the Plan Management Advisory Committee, which met on April 11 and 24, 2013 to review these issues and developed a series of consensus recommendations.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendations presented by the Plan Management Advisory Committee to encourage the use of tobacco cessation programs and other preventive benefits by enrollees in the DC HBX:

1) As part of the general information on the DC HBX website, provide descriptive information on the ACA covered preventive services including tobacco cessation and, when feasible, link to carrier websites which describe the availability of their tobacco cessation/preventive benefits.

2) Recognizing that carriers now communicate with new enrollees, ensure that carriers include information about tobacco cessation and other preventive services in their new member communication. Note: this recommendation is not intended to duplicate existing communication or add to costs.

3) Recognizing that carriers now communicate with providers, ensure that carrier communications to their providers include up to date information on the preventive benefits and tobacco cessation programs to be provided with no cost sharing. Note: this recommendation is not intended to duplicate existing communication or add to costs.

4) As part of training for navigators, in-person assistors (IPAs), and certified application counselors (CACs), the DC HBX should provide descriptive materials on the availability of no cost preventive services including tobacco cessation for use in enrollment counseling sessions. These counselors should stress the importance of enrollees speaking directly with their carrier to obtain more information on these benefits.

5) Utilize alternative vehicles for communication, other than carriers, including providing educational materials to small business owners and benefit administrators on the availability of preventive services including tobacco cessation.

6) Maintain ongoing discussions with key stakeholder groups to identify additional opportunities to increase the use of preventive services including tobacco cessation. Stakeholder groups should include at least carriers, providers, and community organizations.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date

District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To establish an automatic enrollment policy for the Individual Exchange marketplace and to define "exceptional circumstances" permitting a Special Enrollment Period.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (9)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including the establishment of enrollment periods, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.410(g) enables the Exchange to enable individuals to be automatically enrolled into Qualified Health Plans(QHP), "subject to the Exchange demonstrating to HHS that it has good cause to perform such automatic enrollments."

WHEREAS, under 45 C.F.R. §155.335(j) an enrollee who remains eligible for coverage in a QHP upon annual redetermination will remain in the QHP selected the previous year unless such enrollee terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP;

WHEREAS, 45 C.F.R. §155.420(d)(1) – (8) establishes a series of circumstances in which QHPs must permit qualified individuals to receive a 60-day special enrollment period (SEP) to enroll in the Individual Exchange marketplace outside an Open Enrollment Period;

WHEREAS, 45 C.F.R. §155.420(d)(9) permits the Exchange to define "exceptional circumstances" establishing additional SEPs;

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated the issue and did not reach a consensus recommendation on the topic of auto-enrollment for existing enrollees whose plan was not going to be offered in the subsequent plan year. This non-consensus recommendation was referred to the Executive Board's IT Infrastructure and Eligibility Working Committee; and

WHEREAS, on May 3, 2013, the Executive Board's IT Infrastructure and Eligibility Working Committee discussed the topic of auto-enrollment for existing enrollees whose plan was not going to be offered in the subsequent plan year, and developed consensus recommendations for Executive Board consideration.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following recommendations presented by the Executive Board's IT Infrastructure and Eligibility Working Committee:

Auto-Enrollment in Similar Plan; Allow an Additional SEP:

The District of Columbia Health Benefit Exchange (DCHBX) will enable an individual to be automatically enrolled if he or she does not select a new plan, and does not terminate such coverage when their existing plan is no longer offered in a subsequent plan year, into a similar plan, if available. A similar plan is defined as same carrier, metal tier, and provider network.

Additionally, a new 60-day SEP is established. The triggering date is the effective date for the plan in which the individual has been automatically enrolled. This provides the individual an additional opportunity to change plans.

No Auto-Enrollment if Similar Plan Not Available; Allow an Additional SEP to select new plan:

There is no automatic enrollment if there is no similar plan available.

Additionally, a new 60-day SEP is established. The triggering date is the first day coverage is terminated. This provides the individual an additional opportunity to select a new plan.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To allow a good faith extension of the period to resolve eligibility factor inconsistencies for eligibility or enrollment in the Individual Exchange marketplace

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.315(f)(3) allows Exchanges to extend the 90-day period provided to individuals to resolve inconsistencies regarding eligibility factors between data sources available to the Exchange and the individual's self-attestation when there has been a good faith effort; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated the issue and reached a consensus recommendation;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

Extension of Inconsistency Period for Good Cause:

Individuals who make a good faith effort shall be provided an additional 30 days, beyond the 90 days mandated in 45 C.F.R. §155.315(f)(2)(ii), to resolve any inconsistencies with Exchange

eligibility verification data sources. Good faith effort shall be defined as an individual requesting the additional 30 days from the Exchange either online, through the call center, in-person at a service center, or by mail.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___**9th**___ day of _**May**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a strategy for the DC Health Benefit Exchange to improve the quality of care offered by Qualified Health Plans, including through quality reporting requirements.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, § 1311(c), (g), and (h) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) ("ACA") and § 5(a)(6) of the Act (D.C. Official Code § 31-3171.09(a)(6)) require the DC Health Benefit Exchange promote quality through quality improvement strategies, accreditation, and program investments by Qualified Health Plans and § 1001 of ACA which amends § 2717 (a) of the Public Health Services Act specifies quality reporting requirements to be used by Qualified Health Plans;

WHEREAS, on March 27, 2012, the Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services, promulgated a final rulemaking requiring states to establish a timeframe and standards for the accreditation of a Qualified Health Plan based on quality standards (77 Fed. Reg. 59 (27 March 2012). pp. 18310 – 18475); and

WHEREAS the Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services has stated in Guidance on State Partnership Exchange dated January 3, 2013 that CMS will issue future rulemaking on *"quality reporting requirements related to all QHP issuers (other than accreditation reporting) [that will] become a condition of QHP certification beginning in 2016 based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act sections 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h). States may collect additional quality data (and collect data prior to 2016) directly from issuers or third party entities (such as accrediting entities) for use in applying the consumer interest standard of QHP certification under 45 CFR 155.1000, making*

QHP certification determinations, conducting QHP performance monitoring, and providing consumer education and outreach."

WHEREAS, on March 13, 2013, the Executive Board voted to adopt the recommendation of the Issuer Certification Process Working Group, which included Qualified Health Plan accreditation requirements and reporting of a quality improvement strategy for any plan not already accredited;

WHEREAS, during March and May 2013, the Quality Working Group, which included representatives from health plans, providers, small businesses, community and consumer advocates, brokers, and representatives from the Exchange Board and Standing Advisory Committee, met three times to discuss health plan quality improvement strategies and establish a strategy to improve the quality of care offered by Qualified Health Plans;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the consensus recommendations regarding the quality improvement strategies and quality reporting activities of the District of Columbia Health Benefit Exchange Authority that are in the attached document titled "Quality Working Group Report" dated May 29, 2013.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this ___6**th**___ day of **_June**____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish requirements for employees of health insurance carriers serving as Certified Application Counselors (CACs) on DC Health Link.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, § 1311of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) ("ACA") provides for the introduction of consumer choices and insurance competition through health benefit exchanges in each state;

WHEREAS, the Centers on Medicare and Medicaid Services enacted regulations (45 CFR – Part 155.225) requiring exchanges to implement a Certified Application Counselor program in compliance with the requirements of this regulation;

WHEREAS, the Consumer Assistance and Outreach Advisory Committee met on June 26 and July 28, 2013 to discuss and develop recommendations regarding the federally-required Certified Application Counselor Program and did not reach consensus on one recommendation regarding requirements for employees of health insurance carriers serving as CACs;

WHEREAS, on July 31, 2013 the Executive Board Marketing and Consumer Outreach Working Committee deliberated and voted unanimously on the non-consensus recommendation regarding requirements for employees of health insurance carriers serving as CACs.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the consensus recommendation from the Executive Board Marketing and Consumer Outreach Working Committee regarding requirements for employees of health insurance carriers serving as CACs as follows:

- Health Insurance Carrier staff can be CACs with the following requirements:
    - They can only help current clients and those who contact them directly
    - They must let people they are helping know about all plan options for all carriers
    - They must disclose any potential conflicts of interest
    - They must ask if the person they are helping has worked with a broker in the past and if he or she would rather work with that person again to help select a plan
- The policy decision will be revisited in one year

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 13**th** day of **August**, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To adopt a recommendation regarding whether health carriers offering qualified health plans in DC Health Link will be required to offer plan options that do not include the pediatric essential dental benefit.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(d)(2)(b) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) ("ACA") allows an "issuer of a plan that only provides limited scope dental benefits… to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan);"

WHEREAS, for plan year 2014, the Department of Insurance, Securities and Banking (DISB) did not approve stand-alone pediatric dental plans for sale in the exchange marketplace, citing duplication of benefits since all qualified health plans ("QHPs") embedded the pediatric dental essential health benefit;

WHEREAS, on February 12, 2014, the Executive Board re-established the Dental Plans Advisory Working Group ("Dental Working Group") to consider requiring QHPs to provide plan options that do not include the pediatric dental benefit, separate deductibles for the pediatric dental benefits, employer choice of qualified dental plans, employer contribution methodology and requirements for qualified dental plans, and transparency of dental plan offerings on DC Health Link;

WHEREAS, on March 7, March 14 and March 28, 2014, the Dental Working Group met and reviewed technical capabilities of DC Health Link, policies for qualified health plans as a comparison for decisions pertaining to qualified dental plans, and the approaches of other state marketplaces;

WHEREAS, the majority of the Dental Working Group's members, primarily the major medical carriers and consumers groups, voted to let the market determine whether health carriers offer QHPs that include pediatric dental benefits;

WHEREAS, dental carriers on the working group submitted a minority report titled "DC Health Benefit Exchange – Dental Workgroup II Minority Report" dated April 18, 2014 to express the reasons to have a requirement for health carriers to offer QHPs that do not include pediatric dental benefits;

WHEREAS, on April 27, 2014, the Insurance Market Executive Board Working Committee deliberated on the topic of QHPs inclusion of pediatric dental benefits at a meeting open to the public, and approved a recommendation for Board consideration in a two to one vote to allow the market to determine whether health carriers offer QHPs that include or exclude pediatric dental benefits; and

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the majority recommendation by the Insurance Market Executive Board Working Committee that health carriers have the choice to embed, or not embed, the pediatric essential health benefits in the qualified health plans being offered in DC Health Link.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 14th day of May, 2014, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To adopt a recommendation regarding whether health carriers offering qualified health plans in DC Health Link will be required to offer plan options that do not include the pediatric essential dental benefit.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §1311(d)(2)(b) of the Affordable Care Act of 2010 (P.L. 111-148 & P.L. 111-152) ("ACA") allows an "issuer of a plan that only provides limited scope dental benefits… to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan);"

WHEREAS, for plan year 2014, the Department of Insurance, Securities and Banking (DISB) did not approve stand-alone pediatric dental plans for sale in the exchange marketplace, citing duplication of benefits since all qualified health plans ("QHPs") embedded the pediatric dental essential health benefit;

WHEREAS, on February 12, 2014, the Executive Board re-established the Dental Plans Advisory Working Group ("Dental Working Group") to consider requiring QHPs to provide plan options that do not include the pediatric dental benefit, separate deductibles for the pediatric dental benefits, employer choice of qualified dental plans, employer contribution methodology and requirements for qualified dental plans, and transparency of dental plan offerings on DC Health Link;

WHEREAS, on March 7, March 14 and March 28, 2014, the Dental Working Group met and reviewed technical capabilities of DC Health Link, policies for qualified health plans as a comparison for decisions pertaining to qualified dental plans, and the approaches of other state marketplaces;

WHEREAS, the majority of the Dental Working Group's members, primarily the major medical carriers and consumers groups, voted to let the market determine whether health carriers offer QHPs that include pediatric dental benefits;

WHEREAS, dental carriers on the working group submitted a minority report titled "DC Health Benefit Exchange – Dental Workgroup II Minority Report" dated April 18, 2014 to express the reasons to have a requirement for health carriers to offer QHPs that do not include pediatric dental benefits;

WHEREAS, on April 27, 2014, the Insurance Market Executive Board Working Committee deliberated on the topic of QHPs inclusion of pediatric dental benefits at a meeting open to the public, and approved a recommendation for Board consideration in a two to one vote to allow the market to determine whether health carriers offer QHPs that include or exclude pediatric dental benefits; and

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the majority recommendation by the Insurance Market Executive Board Working Committee that health carriers have the choice to embed, or not embed, the pediatric essential health benefits in the qualified health plans being offered in DC Health Link.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 14th day of May, 2014, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To define additional "exceptional circumstances" permitting a Special Enrollment Period.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (9)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including the establishment of enrollment periods, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.420(d)(1) – (8) & (10) establishes a series of circumstances in which QHPs must permit qualified individuals to receive a 60-day special enrollment period (SEP) to enroll in the Individual Exchange marketplace outside an Open Enrollment Period;

WHEREAS, 45 C.F.R. §155.420(d)(9) permits the Exchange to define "exceptional circumstances" establishing additional SEPs;

WHEREAS, on May 9, 2013, the Executive Board defined several "exceptional circumstances" SEPs;

WHEREAS, after open enrollment ended, Authority staff conducted a survey of "exceptional circumstances" SEPs established by the federally-facilitated and other state-based American Health Benefit Exchanges and compiled a list of recommendations of additional "exceptional circumstances" for consideration and debate by the Standing Advisory Board; and

WHEREAS, on May 30, 2014, the Standing Advisory Board received the staff recommendations, deliberated on this topic, and unanimously approved recommendations to the Executive Board;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby adopts the following:

The District of Columbia Health Benefit Exchange Authority will consider it an "exceptional circumstance", permitting a new special enrollment period (SEP), when an applicant or enrollee does not select a plan during Initial Enrollment, Open Enrollment, or an SEP granted on other grounds, due to one of the following circumstances. Unless otherwise indicated, effective dates follow the rules established in 45 C.F.R. §155.420(b)(1) and the length of the SEP shall be in accordance with 45 C.F.R. §155.420(c).

1) A natural disaster such as an earthquake, massive flooding, or hurricane prevented the consumer from enrolling during open enrollment or their special enrollment period. The triggering event shall be day of the disaster of the event, to include the last day in circumstances involving multi-day disasters.

2) A serious medical condition, such as an unexpected hospitalization or temporary cognitive disability prevented the consumer from enrolling during open enrollment or a special enrollment period for which they were otherwise eligible. The triggering event shall be based on the circumstances of the medical condition as determined by the Authority.

3) A DC Health Link system outage or an outage of federal or local data sources, around the plan selection deadline prevented a consumer from enrolling during open enrollment or a special enrollment period for which they were otherwise eligible. The triggering event shall be the day of the outage.

4) If a person is leaving an abusive spouse. The triggering event shall be the date the individual leaves the spouse.

5) If an individual receives a certificate of exemption from the individual mandate based on the eligibility standards described in 45 C.F.R. §155.605 for a month or months during the coverage year, and based on the circumstances attested to, or changes reported under 45 C.F.R. §155.620(b), he or she is no longer eligible for a exemption within a coverage year, but outside of an open enrollment period. The triggering event shall be 30 days prior to the date of ineligibility for the exemption.

6) If an individual is a current COBRA enrollee, he/she shall have until November 15, 2014 to voluntarily drop COBRA coverage and enroll in a DC Health Link plan.

7) If an individual is a member of AmeriCorps State and National, Volunteers in Service to America (VISTA), and National Civilian Community Corps (NCCC). The triggering event is either the day the individual begins or ends service with one of the three programs.

8) Getting divorced or legally separated. The triggering event is the date of the divorce or legal separation. Effective dates shall mirror those available based on marriage under 45 CFR §155.420(b)(2)(ii).

9) Entering into a domestic partnership, as permitted or recognized in D.C. Official Code § 32-702. The triggering event shall be the date the partnership is entered into. Effective

dates shall mirror those available based on marriage under 45 CFR §155.420(b)(2)(ii).

10) Being court-ordered to obtain health insurance coverage (a.k.a. "medical insurance coverage order"). This circumstance shall include when a person other than the applicant/enrollee is being ordered to obtain coverage for the applicant/enrollee. The triggering event shall be the date of the court order.

11) Losing access to employer-sponsored coverage because the employee is enrolling in Medicare. The triggering event is the date of the loss of coverage. Effective dates shall follow the rules under 45 C.F.R. 155.420(b)(2)(iv).

12) Losing access to COBRA because an employer that is responsible for submitting premiums fails to submit them on time. The triggering event shall be the date of the loss of coverage. The length of the SEP shall be based on circumstances as determined by the Authority. The effective date of coverage shall be based on circumstances as determined by the Authority with the intent of preventing gaps in health coverage for the consumer.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this __**11th**____ day of _**June**___, 2014, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

DC Health Benefit Exchange Authority

RESOLUTION

EXECUTIVE BOARD OF THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY

To define additional "exceptional circumstances" permitting a Special Enrollment Period.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq*.) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (9)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including the establishment of enrollment periods, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.420(d)(1) – (8) & (10) establishes a series of circumstances in which QHPs must permit qualified individuals to receive a 60-day special enrollment period (SEP) to enroll in the Individual Exchange marketplace outside an Open Enrollment Period;

WHEREAS, 45 C.F.R. §155.420(d)(9) permits the Exchange to define "exceptional circumstances" establishing additional SEPs;

WHEREAS, on May 9, 2013, the Executive Board defined several "exceptional circumstances" SEPs;

WHEREAS, after open enrollment ended, Authority staff conducted a survey of "exceptional circumstances" SEPs established by the federally-facilitated and other state-based American Health Benefit Exchanges and compiled a list of recommendations of additional "exceptional circumstances" for consideration and debate by the Standing Advisory Board; and

WHEREAS, on May 30, 2014, the Standing Advisory Board received the staff recommendations, deliberated on this topic, and unanimously approved recommendations to the Executive Board;

WHEREAS, on June 11, 2014, the Executive Board defined additional "exceptional circumstances" SEPs;

WHEREAS, on June 20, 2014, the Standing Advisory Board deliberated further on the topic, and unanimously approved the following amendments to their prior recommendations to the Executive Board;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby amends the special enrollment period exceptional circumstances definitions adopted on June 11, 2014 as follows:

Additional language is underlined.

4) If a person is leaving an abusive spouse or domestic partner. For purposes of this SEP, the term "domestic partner" shall include persons in a domestic partnership recognized by D.C. Official Code §32-702. The triggering event shall be the date the individual leaves the spouse or domestic partner.

8) Getting divorced or legally separated. This circumstance shall apply equally to the termination of a domestic partnership recognized under D.C. Official Code §32-702. The triggering event is the date the divorce, legal separation, or partnership termination. Effective dates shall mirror those available based on marriage under 45 CFR §155.420(b)(2)(ii).

I HEREBY CERTIFY that the foregoing Resolution was adopted on this __**9th**____ day of __**July**_____, 2014, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____ _____

Khalid Pitts, Secretary/Treasurer Date
District of Columbia Health Benefits Exchange Authority

Appendix G

DCHBX Carrier Integration Manual

CARRIER INTEGRATION MANUAL

June 5, 2015

Version 1.8

Revision History

Date	Version	Changes	Author	Reviewed By
05/28/2013	0.1	Initial Draft	Apurva Chokshi	
07/17/2013	1.0	Draft, Reset document version to 1.0 to coordinate across all guides.	Sara Cormeny Dan Thomas	Saadi Mirza Yeshwanth Somashekhara David Sloand Gautham Palani Apurva Chokshi
08/30/2013	1.7		Dan Thomas	Sara Cormeny
06/105/2015	1.8	Updates to reflect changes since the previous version and some restructuring of the document	Saadi Mirza	Brendan Rose Alix Pereira

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1 Introduction

1.1 Purpose and Scope

The purpose of this document is to provide Health Insurance Carriers ("Carriers") with a comprehensive guide to the services offered by the District of Columbia Health Benefit Exchange ("DC Exchange" or DCHBX) that allow them to fully participate in the Exchange.

This document describes the supported business processes, overview of operational and technical integration requirements, testing processes, and certification requirements for the Carriers. This document is meant to provide an overview only and detailed information for each area are provided in the respective documents listed in the "Related Resources" section of this document.

1.2 Background of DC Health Exchange

On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law. A key provision of the law requires all states to participate in a Health Benefit Exchange beginning January 1, 2014. The District of Columbia declared its intention to establish a state based health benefit exchange in 2011 with the introduction and enactment of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19- 0094).

The Health Benefit Exchange Authority Establishment Act of 2011 establishes the following core responsibilities for the Exchange:

1. Enable individuals and small employers to find affordable and easier-to understand health insurance
2. Facilitate the purchase and sale of qualified health plans
3. Assist small employers in facilitating the enrollment of their employees in qualified health plans
4. Reduce the number of uninsured
5. Provide a transparent marketplace for health benefit plans
6. Educate consumers
7. Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions

The DC Exchange is responsible for the development and operation of all core Exchange functions including the following:

1. Certification of Qualified Health Plans and Qualified Dental Plans
2. Operation of a Small Business Health Options Program
3. Consumer support for coverage decisions
4. Eligibility determinations for individuals and families
5. Enrollment in Qualified Health Plans
6. Contracting with certified carriers
7. Determination for exemptions from the individual mandate

1.3 Intended Audience

This document is written for business users, business analysts, system architects, EDI developers, network engineers and others who are involved in the integration program of Carrier systems with DC Exchange.

1.4 Trading Partner Agreement and Carrier Onboarding Reference Manual

A Trading Partner Agreement (TPA) is created between participants in EDI file exchanges. All trading partners who wish to exchange X12 **5010 EDI** transaction sets electronically to/from DC Exchange and receive corresponding EDI responses, must complete Trading Partner testing to ensure their systems and connectivity are working correctly before any production transactions can be processed.

DC Exchange will comply with the data encryption policy as outlined in the HIPAA Privacy and Security regulations regarding the need to encrypt health information and other confidential data. All data within a transaction that are included in the HIPAA definition of Electronic Protected Health Information (ePHI) will be subject to the HIPAA Privacy and Security regulations, and DC Exchange will adhere to such regulations and the associated encryption rules. All Trading Partners also are expected to comply with these regulations and encryption policies.

For each Trading Partner, the DC Exchange and partner will specifically define interchange components, e.g., machine names, security protocols, security credentials, encryption methods, and field contents. These definitions will be captured and maintained in the DC Exchange Carrier Onboarding Document.

Below is a list of participants in the DC Exchange as of the writing of this document

Table 1: Participants in the DC Exchange

Name	DC Exchange ID
Aetna Health, Inc.	AHI
Group Hospitalization and Medical Services, Inc.	GHMSI
Kaiser Foundation of the Mid-Atlantic States, Inc.	KFMASI
United Healthcare Insurance Company	UHIC
DC Exchange	DC HBX
Dominion Dental	DMND
Dentegra Dental	DTGA
Delta Dental	DDPA

1.5 Glossary

Advance Premium Tax Credit (APTC)	Advance payments of the premium tax credit means payment of the tax credits specified in the Affordable Care Act which are provided on an advance basis to an eligible individual enrolled in a health plan through an Exchange.
Business Requirement (BR)	Specific business element or task which is required by the District of Columbia, business users, legislation, regulation or guidance
Carrier	Refers broadly to any entity licensed to engage in the business of insurance in District of Columbia and subject to District laws regulating insurance. These entities include insurers, health maintenance organizations, non-profit health service plans, dental plan organizations, stand-alone vision carriers, and consumer operated and oriented plans.
CCIIO	Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight
CMS	Center for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
Customer	Individual using DC Exchange to directly acquire health insurance
DC Exchange	District of Columbia based Health Insurance Marketplace
Dependent	A dependent is an individual who is eligible for coverage because of his or her association with a subscriber. Typically, a dependent is a member of the subscriber's family.
DISB	District of Columbia Department of Insurance, Securities and Banking
EDI	Electronic Data Interchange.
Health plans	Health care coverage plans sold on the DC Exchange to individuals, families and small employers. They include Qualified Health Plans (QHPs), Qualified Standalone Dental Plans (QDPs) (which are a subset of QHPs), and Catastrophic Plans
Insured or Member	An insured individual or member is a subscriber or dependent who has been enrolled for coverage under an insurance plan. Dependents of a Subscriber who have not been individually enrolled for coverage are not included in Insured or Member.
Metal Level	Platinum, Gold, Silver, and Bronze - representing available QHPs in descending actuarial value
No Wrong Door	The provision in the Affordable Care Act requiring states to ensure that a customer who approaches the state for health assistance programs is correctly

	directed to the program for which they are eligible including individual affordability programs such as Medicaid or qualified health plans (QHPs)
Qualified Employee/SHOP Employee	Employee of a qualified employer who has been offered coverage through the SHOP Exchange
Qualified Employer/SHOP Employer	An employer with 50 or fewer employees, with a business address in the District of Columbia, which offers QHP(s) to at least all full-time employees working an average of at least 30 hours per week
Qualified Health Plans (QHPs)	The certified health insurance plans and standalone dental plans offered to consumers and small businesses purchasing coverage through the DC Exchange.
Reference plan	A benchmark plan chosen by an employer for purposes of calculating employer contributions. The employee cost to enroll in the reference plan is the same for each coverage tier for every employee regardless of his/her age. If an employee chooses to enroll in a plan other than the reference plan, the employee cost is the cost to enroll in the reference plan plus the difference between the member-level age-rated lists billed premium for the reference plan and the plan in which the individual enrolls.
Small Business Health Options Program	Or SHOP**,** the component of the DC Exchange designed to allow small businesses to shop for QHPs for their employees
Sponsor	A sponsor is the party that ultimately pays for the coverage, benefit, or product. A sponsor can be an individual, employer, union, government agency, association, or insurance agency.
Subscriber	Subscriber is an individual covered by a QHP through the Small Business Health Options Program (SHOP) because of his or her employment by a Qualified Employer, or an individual who purchases a QHP through the DC Exchange individual market.

1.6 Related Resources

This Carrier Integration Manual is one in a series of documents that describes and specifies communication between the DC Exchange and carriers. Below is a list of related guides and specifications. Current versions of these DC Exchange-produced resources may be obtained at the DC Health Benefit Exchange Web site (see How to Contact Us).

Table 1: Related Resources

Document	Description
CMS Companion Guide for the Federally Facilitated Exchange (FFE)	Provides information on usage of 834 transaction based on 005010X220 Implementation Guide and its associated 005010X220A1 addenda
CMS Standard Companion Guide	
Trading Partner Agreements (TPA)	Outlines the requirements for the transfer of EDI information between a Carrier and DC Exchange
DC Exchange Carrier Onboarding Document	Contains all the information including interchange specifications required to onboard a Carrier on DC Exchange
DC Health Benefit Exchange Carrier Reference Manual	Provides policy information on carrier participation in the DC Health Benefit Exchange
DC Exchange Benefit Enrollment Companion Guide	Provides technical information on 834 transactions supported by DC Exchange
DC Exchange Premium Payment Companion Guide	Provides technical information on 820 transactions supported by DC Exchange
DC Exchange Carrier Testing Document	Contains the testing strategy for DC Exchange – Carriers integration
DC Exchange Transaction Error Handling Guide	Provides details on exchange message validation and error handling
DC Exchange Broker and Employer Demographic Data Exchange Guide	Provides technical information on Broker and Demographic Data file exchanges supported by the DC Exchange.

1.7 How To Contact Us

The DC Exchange maintains a Web site with Carrier-related information along with email and telephone support:

- **Web**: http://dchbx.com/page/carrier-information
- **Email**: carriersupport@dchbx.com
- **Web**: http://dchbx.com/page/carrier-information
- **Email**: carriersupport@dchbx.com
- **Phone**:
    - (202) 317-0287 - Concierge, general Carrier EDI support
    - (202) 320-7308 - technical Carrier EDI support

2 DC Exchange Overview

2.1 Functional Overview

Below sections provide a functional overview of the DC Exchange in relation to data exchange between DCHBX and the Carriers

2.1.1 Enrollment

The DC Exchange offers health care coverage to residents of DC and eligible employees of small businesses that elect purchase health coverage through DCHBX.

Enrollment transactions carry necessary and sufficient information for the Carriers so they can enroll prospective applicant in particular health care coverage. This includes, but is not limited to,

- demographics of the subscriber and their dependents (if any),
- the Qualified Health Plan (QHP) for which the coverage is being sought,
- premium amount calculations for each member,
- date when the coverage is expected to begin, and
- Any subsidies (APTC or CSR information in the Individual market, employer contribution in the SHOP market).

All transactions from DC Exchange, including enrollment transactions, carry unique identifiers that are issued by the DC Exchange for each member (subscriber or dependent) and unambiguously identify a person. These identifiers are invariant as they are based on the identity of a person and are never reused.

2.1.1.1 SPECIAL ENROLLMENT PERIOD (SEP) ENROLLMENTS

Under special conditions, an individual or an employee may be allowed to enroll in a health plan outside of the assigned open enrollment period. Such enrollments are called Special Enrollment Period (SEP) enrollments and the rules governing such enrollments are specified in DC Exchange Carrier Reference Manual.

- Moving to the District of Columbia;
- Having a baby, adopting a child, or having a child placed for adoption;
- Getting married, entering a legally-recognized domestic partnership, getting divorced, or legally separating;
- Losing health coverage during the year;
- Becoming a citizen or gaining a new immigration status;
- Experiencing a change in eligibility for premium tax credits or cost-sharing reductions, or the amount of premium tax credits or cost-sharing reductions, if already enrolled in a DC Health Link plan;
- An employee getting hired after the Open Enrollment has closed for the employer;
- Not enrolling during the open enrollment period was unintentional, inadvertent, or erroneous and was the fault of a DC Health Link employee or the enrollment error was the result of misconduct by someone providing enrollment assistance, or an insurance company representative; or
- An exceptional circumstance as defined by the DC Health Benefit Exchange Authority.

2.1.2 Changes

The DC Exchange is the System of Record regarding any enrollee or employer information. This means that any changes to enrollee or employer information can only be initiated by the DC Exchange. Such types of changes include, but are not limited to

- Change of Address
- Demographic information correction (e.g. DOB correction)
- Change to demographic information (e.g. change of last name)
- Change of QHP plan choice
- Adding or removing of dependents from coverage

2.1.3 Disenrollment

Disenrollment is the termination or cancellation of QHP coverage for an individual or an employee. For an enrollee, disenrollment causes coverage to end in case of termination or lose effect in case of a cancellation. Disenrollment can originate either from the DC Exchange or a Carrier under the following conditions

- In the Individual market,
    - Carriers collect payments for Individual market enrollees and are allowed to originate Cancellations and terminations for reasons of Non-payment, death, or fraud
    - DC Exchange can originate a cancellation or termination based on any valid reason
- In the SHOP market
    - DC Exchange collects all the payments and is the sole source of any disenrollment transactions
    - Carriers may not send any disenrollment transactions to DC

2.1.4 Employer Termination

In the SHOP market, an employer may decide to withdraw coverage for a valid reason. In such a situation, all of the active enrollees for that employer are dis-enrolled and any carriers that the employer selected plans for will be notified through appropriate data exchange that the employer is no longer offering coverage

2.1.5 Renewal

In an effort to ensure continuity of coverage, DC Exchange facilitates renewals for both SHOP and Individual market enrollees in to a subsequent plan year. There are two ways in which an enrollee may renew on the DC Exchange

- Passive Renewal: A passive renewal is where an active enrollee takes no action during open enrollment, in which case the DC Exchange automatically renews coverage for them and all of their existing dependents based on the QHP choice that is currently in effect. In case the same plan is no longer available, the DC Exchange will renew coverage under a similar or ‘comparable’ plan
- Active Renewal: In situations where a currently enrolled member wishes to select a different QHP for the next plan year, the DC Exchange will facilitate the renewal of their enrollment under a plan of their choice for them and any of their dependents

Renewal transactions are transmitted throughout the open enrollment period as members are allowed to alter any plan choice during this period

2.1.6 Payments

Payments are collected either by the DC Exchange or the Carrier. In the small business (SHOP) insurance market, the DC Exchange collects all payments. In the individual market, consumers make all premium payments directly to the Carriers.

Advance Premium Tax Credit (APTC) payments are sent directly to the Carriers by the Federal Government (i.e. the APTC is not sent to the DC Exchange).

After a payment is received, payment information must be sent from the receiving entity to the other. After the DC Exchange receives payment, twice monthly the DC Exchange will remit the amounts and send the payment remittance information via an EDI transaction to the Carrier.

2.1.7 Reconciliation

2.1.7.1 ENROLLMENT RECONCILIATION

The Enrollment reconciliation process is designed to ensure that Carrier and DC Exchange databases correctly and completely process transactions and accurately reflect the insured population. As detailed in the DC Health Benefit Exchange Benefit Enrollment Companion Guide, the report structure and format will follow the Reconciliation Report Template format. Any issues identified by Carriers must be reported to the DC Exchange in a manner and within a time period defined by the DC Exchange.

Enrollment reconciliation is designed to be a monthly process. The intention is to identify anomalies and exceptions scenarios as early as possible, in an effort to respond quickly and minimize the impact of issues. Under certain conditions, DC Exchange may need to run off-cycle special purpose reconciliation with carriers to address any immediate issues, which will be coordinated with the relevant carrier staff with appropriate notice.

2.1.7.2 PAYMENT RECONCILIATION

In the initial stages of the DC Exchange operation, payment reconciliation will take place on an as-needed basis, but no less that once per month. The intention is to identify anomalies and exceptions scenarios as early as possible, in an effort to respond quickly and minimize the impact of issues.

DC Exchange requires that a Carrier reconcile payment files with the Exchange no less than once a month. DC Exchange will send one payment file containing all SHOP payment data in ASC X12 820 format to the Carrier for reconciliation purposes on monthly basis. This file will contain the cumulative payment information between the DC Exchange and Carrier at any given point of time for a benefit year.

Carriers must analyze and reconcile the files with the data in their systems. Carriers will contact DC Exchange Business Process Support if there are any questions or discrepancies.

2.2 High Level Architecture Overview

Figure 1 provides a high level architectural view of the DC Exchange. The users on the top part of the diagram access the DC Exchange functionality through various means as depicted in the diagram.

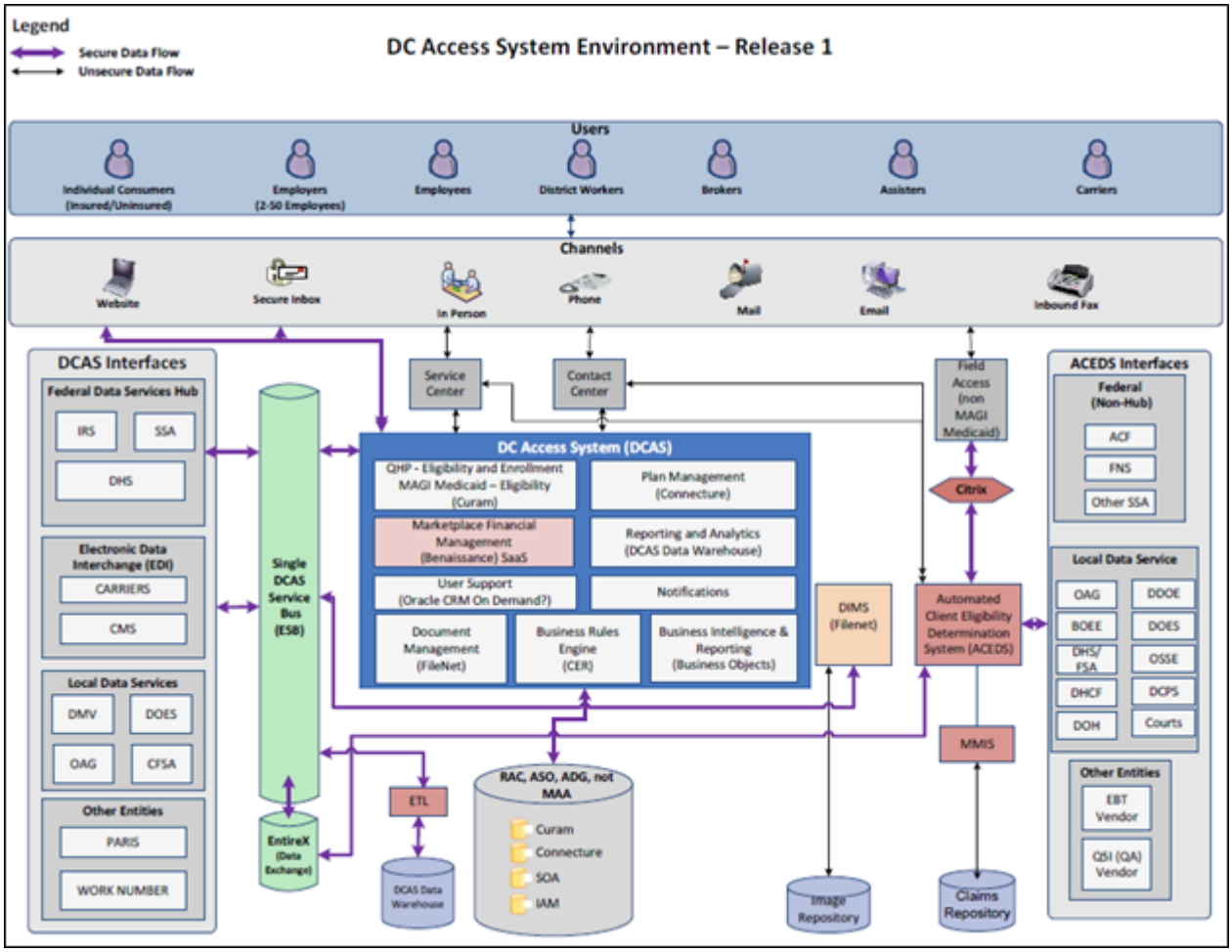

Figure 1: DC Exchange DCAS System Architecture

3 Data Exchange Model

Data exchange between the DC Exchange and its trading partners will take the form of EDI and non-EDI (e.g. XML) files. The EDI format is defined by the ASC X12 organization and is the primary form of communication for enrollment data exchange between the DC Exchange and carriers.

All files exchange between the carriers and DC Exchange is performed using the SSH File Transfer Protocol (SFTP) using servers hosted by the DC Exchange. In other words, files will be "pulled" by carriers from DC Exchange servers instead of being "pushed" by DC Exchange to carrier systems.

In addition, DC Exchange will leverage standard encryption mechanisms to ensure security of data "at-rest", in addition to the "in motion" security provided via SFTP. DC Exchange will set up a credential based account or "Drop Zone" for each trading partner using a pre-defined folder structure as outlined in the DC Exchange Benefit Enrollment guide.

Following figure illustrates different payment and enrollment data transactions and direction of flow between the DC Exchange and Carriers.

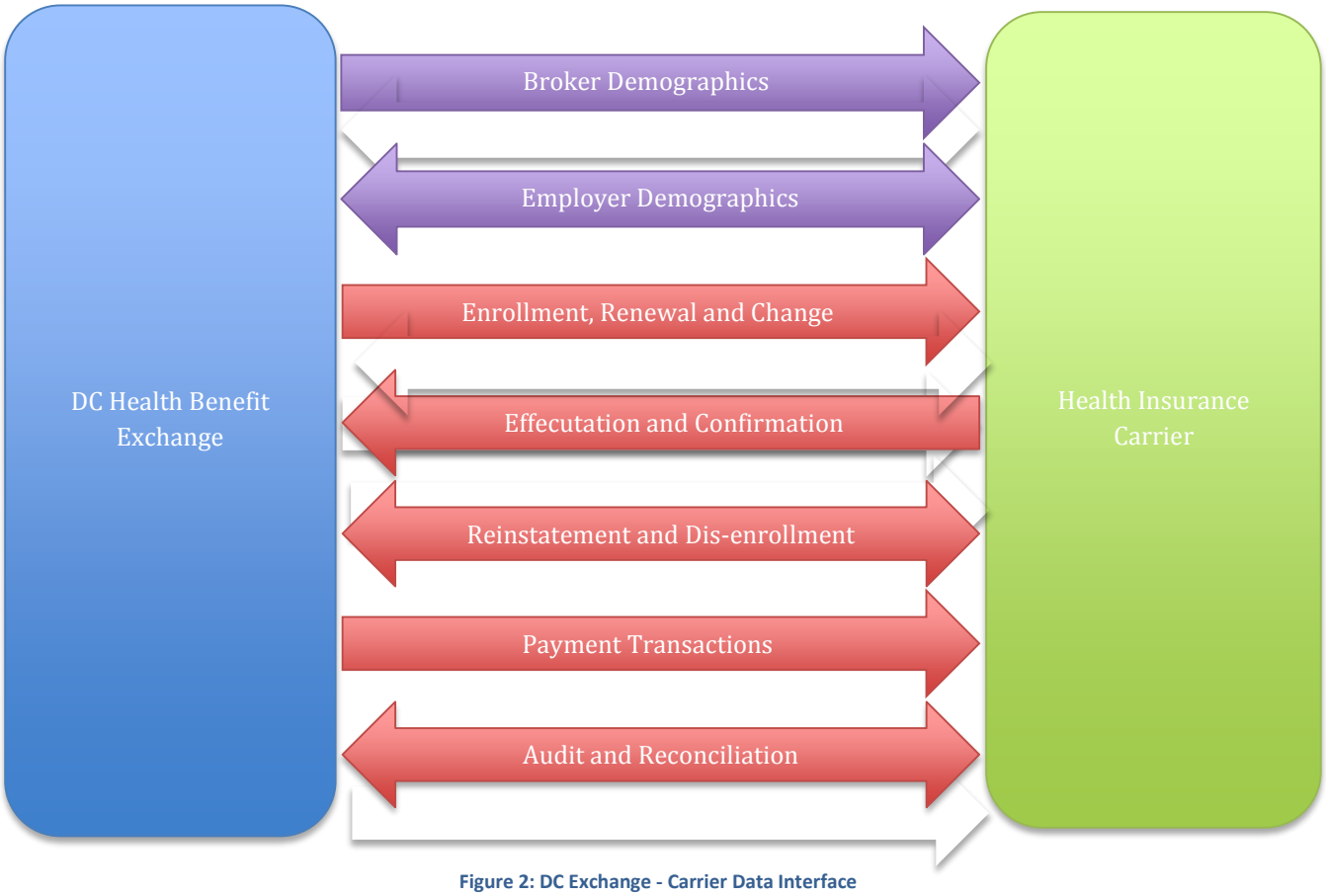

Figure 2: DC Exchange - Carrier Data Interface

3.1 File Exchange Activity Sequence

3.1.1 Inbound Activity Sequence (DC Exchange to Carrier)

Below is the sequence of activities for an inbound file transfer from the DC Exchange to a Carrier. All inbound files to Carriers are encrypted and are available for them to retrieve from their respective INBOUND folders.

1. Carrier authenticates self and establishes a secure connection with the DC Exchange.
2. Carrier downloads the encrypted inbound file from the respective INBOUND folder.
3. Carrier decrypts the inbound file.
4. In case of an EDI file
    a. Carrier sends an encrypted transport acknowledgement (TA1) accept/reject file to the respective OUTBOUND folder
    b. If file transport was successful, Carrier functionally processes the inbound file payload.
    c. Based on the result of the functional processing, Carrier encrypts and sends functional acknowledgement (999) accept/reject file to the respective OUTBOUND folder
5. In case of a non-EDI file, carrier decrypts and processes the file. Any errors in processing the file are communicated to DC via secure email or custom spreadsheet on the SFTP server
6. DC Exchange decrypts and evaluates the TA1 and 999 files

3.1.2 Outbound Activity Sequence (Carrier to DC Exchange)

Below is the sequence of activities for an outbound file transfer from a Carrier to the DC Exchange. All outbound files from a Carrier are encrypted and are available for DC Exchange in their respective OUTBOUND folder to process.

1. Carrier authenticates self and establishes a secure connection with DC Exchange.
2. Carrier pushes the encrypted outbound file to the respective OUTBOUND folder on the DC Exchange SFTP server.
3. DC Exchange decrypts the file.
4. In case of an EDI file
    a. DC Exchange sends an encrypted transport acknowledgement (TA1) accept/reject file to the respective INBOUND folder for the Carrier
    b. If file transport was successful, DC Exchange functionally processes the inbound file payload.
    c. Based on the result of the functional processing, DC Exchange encrypts and sends functional acknowledgement (999) accept/reject file to the respective INBOUND folder for the carrier
5. Carrier retrieves and decrypts the TA1 and 999 acknowledgment/error files from the INBOUND folder
6. Carrier evaluates the TA1 and 999 acknowledgment/error files.

4 Data Exchange Details

Below is the list of different transactions that occur between DC Exchange and Carriers:

- Employer and Broker Demographic data exchange
- Enrollment transactions
- Payment transactions
- Audit and reconciliation transactions

The subsequent sections provide more information on all of the above exchanges and transactions. The functional business process flows identify the responsible partner (either DC Exchange or Carrier), frequency (e.g.; daily, weekly) and time-of-day. The frequency values assume business days: Monday through Friday except for District of Columbia holidays. The time-of-day values are representative-only to illustrate the processing window. Carriers will receive actual time-of-day assignments as part of the onboarding process.

4.1 Employer and Broker Demographic Data Exchange

DC Exchange sends employer/group and broker demographic data to Carriers via a batch process. Carriers must set up employer/group data and broker data before any related enrollment or payment transactions corresponding to the brokers or employers included in these transactions can be processed.

DC Exchange uses an XML file format based on well-defined XSD schemas for these demographic files. Details are documented in the DC Exchange Benefit Enrollment Companion Guide.

4.1.1 Employer Demographic Data

Employer demographic data XML file is provided to carriers in following scenarios:

- New employer/group being on-boarded on DC Exchange
- Updates to existing employer/group data
- Employer/Group termination
- Employer/Group renewal

Please note that carriers are expected to respond back to DC with the same employer demographic XML with enriched data such as Carrier assigned identifiers for employers.

4.1.2 Broker Demographic Data

Broker demographic data XML file is provided to carriers in following scenarios:

1. New broker being on-boarded on DC Exchange
2. Updates to existing broker data
3. Broker termination

4.2 EDI Error Transactions

When an EDI file (820, 834) cannot be processed and errors are determined either by DC Exchange or Carrier, appropriate X12-compliant TA1 or 999 acknowledgments will be sent rejecting the transaction in error.

When an EDI file has Interchange Level errors:

1. Receiver rejects the entire EDI file.
2. Receiver generates the TA1 file with errors and posts the file back to sender
3. Sender corrects the errors and reposts the EDI file to the receiver.

When an EDI file has standard syntax errors or Implementation Guide (IG) level errors:

1. Receiver rejects the transactions in the EDI file that have standard syntax errors or IG errors.
2. Receiver generates the 999 file with errors and posts the file for the sender.
3. Sender reviews the errors, corrects, and reposts the transactions for the receiver

For more details on EDI errors, please refer to the DC Exchange Transaction Error Handling Guide.

4.3 Enrollment Transactions

Table 5 depicts the supported enrollment transactions in the DC Exchange based on the CMS FFE Standard Companion Guide. The table depicts the allowed transactions and the authorized senders.

Table 2: 834 Transactions

Transaction Type	DC Exchange to Carrier	Carrier to DC Exchange
Initial Enrollment	X	-
Effectuation	-	X
Change	X	-
Disenrollment (Cancellation/Termination)	X	X (*Individual market only*)
Confirmation (*Renewal only*)	-	X
Reinstatement	X	-
Audit	X	-
Reconciliation	X	X
TA1/999	X	X

Following are the details for each type of transaction

4.3.1 Initial Enrollment/Effectuation -- Individual

An initial enrollment transmission is created by the Exchange and sent to the Carrier after an application has been determined eligible, and a health plan has been selected. Carriers effectuate enrollees after payment has been verified.

EDI Business Process Flow

1. **Whenever available, DC Exchange** posts 834 individual initial enrollment file to Carrier drop box each business day **by 10am.**
2. **Carrier** downloads 834 individual initial enrollment file from DC Exchange
3. **Carrier** decrypts and submits the 834 file for X12 Compliance and Syntax Validation and uploads the resulting TA1/999 acknowledgements within one business day of receiving the files
4. **Carrier** processes 834 file records that pass validation and posts 834 effectuation record to DC Exchange **within five business days of receipt of binder payment for the policy**
5. When available, **Carrier** posts 834 individual effectuation file to DC Exchange on a business day **by 9am**
6. If **Carrier** fails to post 834 individual effectuation files within the SLA window
    a. **DC Exchange** notifies designated DC Exchange technical contact **by 11am**
    b. **Carrier** corrects error and posts records (along with new transactions) in 834 change file **next business day**
7. **DC Exchange** accesses Carrier 834 individual effectuation file
8. **DC Exchange** decrypts and submits the 834 file for X12 Compliance and Syntax Validation and uploads the resulting TA1/999 acknowledgements within one business day of receiving the files from the Carrier

Flow of Events

1. A valid DCAS user shops, selects plan and submits
2. User chooses to be billed by the carrier
3. **DC Exchange** posts an 834 initial enrollment record (using extended 834 2750 loop directing Carrier to issue invoice) **within one business day**
4. **Carrier** invoices/processes payment
5. If binder premium payment clears,
    a. Carrier posts 834 effectuation record to DC Exchange within five business days
6. If premium payment doesn't clear **within calendar 90 days**
    a. **Carrier** posts 834 cancellation record to DC Exchange

4.3.2 Initial Enrollment/Effectuation – SHOP

Group Information Assumptions

- DC Exchange will use XSD for Employer/Broker Demographic information

- DC Exchange will transmit initial enrollment for SHOP employees in a group-specific 834 add file
- Failure to process XML will result in failure to process any corresponding records in 834

Flow of Events

1. Whenever needed**, DC Exchange** will post the employer demographic XML file to Carrier drop box on a business day **by 10am**
2. **Carrier** downloads XML file from the DC Exchange
3. **Carrier** decrypts and validates XML data file against the Employer demographic XSD as defined by the DC Exchange
4. If XSD validation fails
    a. **Carrier** notifies the DC Exchange via secure email or spreadsheet on the SFTP server
    b. **DC Exchange** corrects and reposts the employer demographic XML file **within three business days**
5. Whenever available, DC Exchange posts 834 initial enrollment for SHOP employer groups to the Carrier drop zone on a business day by 10am.
6. **Carrier** downloads 834 initial enrollment for SHOP group file from DC Exchange
7. **Carrier** submits 834 file for X12 Compliance and Syntax Validation
8. **Carrier** processes 834 file records that pass validation and posts 834 effectuation record to DC Exchange **within five business days**
9. **Carrier** posts 834 effectuation file for SHOP group to DC Exchange each business day **by 9am**
10. If **Carrier** fails to post 834 effectuation file
    a. **DC Exchange** notifies designated Carrier technical contact **by 11am**
    b. **Carrier** corrects error and posts records (along with new transactions) in 834 change file **next business day**
11. **DC Exchange** accesses Carrier 834 effectuation file for SHOP group
12. **DC Exchange submits** 834 file for X12 Compliance and Syntax Validation (see below)

4.3.3 Change Transaction

DC Exchange is the system of record for enrollee information and any updates or corrections to such information are conveyed through an 834 EDI Change transaction. Please refer to section (reference needed) for more details. Below you will find the flow of the data exchange.

Flow of Events

1. Whenever available, **DC Exchange** posts 834 maintenance (or change) file to Carrier drop zone on a business day **by 10am.**

2. **Carrier** downloads 834 individual maintenance file from the DC Exchange
3. **Carrier** decrypts and submits the 834 maintenance file for X12 Compliance and Syntax Validation
4. **Carrier** uploads the resulting TA1/999 accept/reject acknowledgements within one business day of receiving the files
5. **Carrier** processes any records that pass validation
6. **DC Exchange** evaluates any resulting error TA1/999 acknowledgments and resubmits the corrected change transaction(s) within three business days

4.3.4 Disenrollment Transaction

An 834 EDI Disenrollment transaction is used in a situation where specific individual or SHOP market coverage is being cancelled (i.e. no coverage) or terminated (i.e. some coverage).

Assumptions

- DC Exchange may issue disenrollment to Carrier for situations such as:
    - Individual obtaining coverage through employment
    - Employee leaving employment
    - Individual moving out of area
    - Bounced payments in the SHOP market
    - Death
    - Fraud
- Carriers may dis-enroll for the following reasons (Individual market only):
    - No binder payment received – 30 days (non-APTC) or 90 days (APTC eligible)
    - Death of individual
    - Fraud
    - Carriers **may not** originate disenrollment transactions in the SHOP market

Flow of Events (DC Exchange to Carrier)

1. **Event** occurs that causes **DC Exchange** to determine a user should be dis-enrolled
2. **DC Exchange** posts 834 maintenance file to Carrier drop box on a business day **by 10am.**
3. **Carrier** downloads 834 maintenance file from DC Exchange
4. **Carrier** decrypts and submits the 834 maintenance file for X12 Compliance and Syntax Validation

5. **Carrier** uploads the resulting TA1/999 accept/reject acknowledgements within one business day of receiving the files
6. **Carrier** processes any records that pass validation
7. **DC Exchange** evaluates any resulting error TA1/999 acknowledgments and resubmits the corrected dis-enrollment transaction(s) within three business days

Flow of Events (Carrier to DC Exchange)

1. **Event** occurs that causes **Carrier** to determine an enrollee in the Individual market must be disenrolled
2. **Carrier** posts 834 maintenance file to Carrier drop zone on a business day **by 10am**
3. **DC Exchange** downloads 834 maintenance file from Carrier
4. **DC Exchange** decrypts and submits the 834 maintenance file for X12 Compliance and Syntax Validation
5. **DC Exchange** uploads the resulting TA1/999 accept/reject acknowledgements within one business day of receiving the files
6. **DC Exchange** processes any records that pass validation
7. **Carrier** evaluates any resulting error TA1/999 acknowledgments and resubmits the corrected dis-enrollment transaction(s) within three business days

4.3.5 Confirmation Transaction

As of the publishing of this guide, DC Exchange does not require or collect 834 confirmation files (except in the case of renewals – see above) from Carriers. This decision may be evaluated in the future.

Confirmation transaction flow for renewals work is identical to the initial enrollment/effectuation flow except that instead of an initial enrollment, the carrier will receive a maintenance file from DC with the renewal transaction and much like an effectuation transaction, the carrier will respond with the confirmation for this renewal file.

Please note that for renewals in the Individual market, carriers do not require a binder payment resulting in a different wait period before an enrollee is dis-enrolled for non-payment.

4.3.6 Eligibility Re-determinations – Individual market

An individual or family may report a life event change to the DC Exchange that will require the re-determination of eligibility to purchase insurance on the Exchange, or a re-determination of APTC eligibility/APTC amount eligibility, or CSR eligibility.

DC Exchange will report elected APTC amount to health plan issuers in the 834 Member Reporting Categories Loop using the mechanism identified in the CMS Companion Guide for the Federally Facilitated Exchange (FFE). The CSR variant is part of the HIOS Plan id in the 834 Coverage loop and any changes to CSR variants are communicated as a dis-enrollment followed by a new enrollment with the updated CSR variant.

Please note that DC Exchange does not transmit CSR amounts in the 834 Member Reporting Categories Loop.

Specific instructions for reporting these values can be found in Sections 9.5 and 9.6 of the CMS Companion Guide.

EDI Process Flows

1. **DC Exchange** posts 834 maintenance file to Carrier drop box on a business day **by 10am**
2. If **DC Exchange** fails to post 834 maintenance enrollment file **by 10am**
    a. **Carrier** notifies designated DC Exchange technical contact **by noon**
    b. **DC Exchange** corrects error and posts records (along with new transactions) in 834 change file **next business day**
3. **Carrier** downloads 834 maintenance file from DC Exchange
4. **Carrier** submits 834 file for X12 Compliance and Syntax Validation (see below)
5. **Carrier** processes 834 file records that pass validation

Flow of Events

1. A valid, enrolled user reports a life change to **DC Exchange**
2. **DC Exchange** performs eligibility redetermination
3. If **DC Exchange** determines user is no longer eligible to participate in the exchange
    a. DC Exchange produces 834 dis-enrollment transaction within one business day
4. If DC Exchange determines change in APTC
    a. **DC Exchange** produces 834 maintenance file with new APTC amount **within one business day**
5. If DC Exchange determines change in CSR
    a. **DC Exchange** produces a dis-enrollment for the plan with the old CSR variant with the expected end date
    b. **DC Exchange** sends an initial enrollment with the new CSR variant reflecting the begin date when the new CSR variant is effective from

4.3.7 Re-Enrollment Transaction - Individual Market

A re-enrollment transaction is generated by DC Exchange when an enrollee who has been terminated is re-enrolled. For instance, the main subscriber on an account becomes ineligible, and the dependent(s) elect to continue coverage.

Flow of Events

1. A valid, enrolled user becomes ineligible to participate in exchange
2. User's dependent requests continued participation in DC Exchange
3. **DC Exchange** performs eligibility redetermination on dependent(s)
4. If **DC Exchange** determines dependent is eligible to participate in exchange

a. **DC Exchange** produces 834 re-enrollment record with APTC amount **within one business day**

4.3.8 Reinstatement Transaction – DC Exchange to Carrier – SHOP and Individual Markets

A Reinstatement transaction is generated by DC Exchange when an enrollee who has been terminated is being reinstated.

Flow of Events

1. A valid, enrolled Individual market consumer or SHOP enrollee is terminated or cancelled
2. DC Exchange determines that the enrollee should be reinstated back to the original coverage
    a. **DC Exchange** produces 834 reinstatement record(s) **within three business days of such a determination**
3. Remaining flow of events is identical to the sequence as outlined in the section for Change transactions [4.3.3]

4.3.9 Reinstatement Transaction – Carrier to DC Exchange – Individual Market

A Reinstatement transaction is generated by the Carrier when an enrollee who has been cancelled or terminated is determined to be eligible for a reinstatement.

Flow of Events

1. A valid, enrolled Individual market consumer is cancelled or terminated
2. **Carrier** determines that the member should be reinstated back to the original start date
3. Carrier produces 834 reinstatement record within one business day
4. Carrier posts 834 maintenance file to Carrier drop box each business day by 10am
5. **DC Exchange** downloads the 834 maintenance file from Carrier drop zone
6. **DC Exchange** decrypts and submits the 834 maintenance file for X12 Compliance and Syntax Validation
7. **DC Exchange** uploads the resulting TA1/999 accept/reject acknowledgements **within one business day of receiving the files**
8. **DC Exchange** processes any records that pass validation
9. **Carrier** evaluates any resulting error TA1/999 acknowledgments and resubmits the corrected dis-enrollment transaction(s) **within three business days**

4.3.10 Reconciliation/Audit Transaction

On a periodic basis, the DC Exchange sends to each a Carrier a standard 834 “audit or full” file which contains enrollment data for all the active enrollments (Individual and/or SHOP) for that carrier.

In response the Carrier sends a reconciliation report with any identified issues in the same format as defined for errors in the DC Exchange Error Handling Guide.

Flow of Events

1. The audit files are generated on the **15th of every month** (or first business day after if falls on weekend or holiday)
2. **SHOP** and **Individual** market audit files will be separate physical files
3. The audit file will contain all active enrollments with a cutoff for coverage start dates to be the end of the prior month. For instance, a file produced on May 15th will have all active enrollments that have a start date of 4/30 or prior
4. For the first few cycles, **DC Exchange** will also include terminated or cancelled records
5. **DC Exchange** will post the 834 audit file to Carrier drop box on a business day **by 10am**
6. If **DC Exchange** fails to post 834 audit file **by 10am**
    a. **Carrier** notifies designated DC Exchange technical contact **by noon**
7. **Carrier** downloads 834 audit file from DC Exchange
8. **Carrier** submits 834 file for X12 Compliance and Syntax Validation
9. **Carrier** processes 834 file records that pass validation and posts reconciliation report in the format outlined above to the DC Exchange **within five business days**.

4.4 Payment Transactions

The following table depicts the supported transactions in the DC Exchange based on the CMS Standard Companion Guide. Table 3 depicts the allowed transactions and the authorized senders.

Please note that DC Exchange does not collect any binder or ongoing payments for Individual market consumers

Table 3: SHOP 820 Transactions

Transaction Type	DC Exchange to Carrier	Carrier to DC Exchange
SHOP Payment	X	-
TA1/999	-	X

The sub-sections below provide instructions for the content of EDI files for payment related data operations.

4.4.1 SHOP Payment

SHOP payments are always collected by the DC Exchange and then transferred from the DC Exchange to the Carrier. The Exchange will send one 820 file per carrier.

4.4.2 820 Error Transaction

When an 820 cannot be processed and errors are determined either by the Carrier, Carriers will use the TA1/999 Interchange Acknowledgement and EDI X12 999 Implementation Acknowledgement. The flow has been outlined in a previous section (ADD REFERENCE).

More details can be found in the DC Exchange Error Handling Guide.

5 Testing

In order to interface with the production systems of DC Exchange, all data interfaces have be tested and certified in a testing environment.

5.1 Testing Process

The DC Exchange defines the testing process in the following high-level phases:

1. Test Planning and Preparation
2. Test Execution and Support
3. Test Validation and Technical Certification

5.2 Test Planning and Preparation

During the planning phase, the DC Exchange and participating Carriers will identify resources to support the testing effort. The DC Exchange envisions the following type of high-level roles/responsibilities.

Table 4: Testing Roles and Responsibilities

Role	Responsibility	Carrier Will Identify	DC Exchange Will Identify
Test Manager	The DC Exchange will provide a Test Manager. The Test Manager will be the primary point of contact throughout the testing effort. The Test Manager will coordinate and oversee the entire testing effort. Responsibilities include: Coordination of the test schedule. Organizing and facilitation of conference calls and meetings. Management of issues, risks, action items. Management of the defect resolution process, coordinating the review, remedy, and disposition, of defects and/or anomalies. Management and assurance of timely reporting of the overall test effort Facilitation of the definition and acceptance of go/no-go criteria. Facilitation of final technical validation as part of overall certification.		X

Role	Responsibility	Carrier Will Identify	DC Exchange Will Identify
Test Specialist	Both the DC Exchange and participating Carriers will provide Test Specialists. The Test Specialists will collaborate to: Develop scenarios and test use cases Execute test plan Identify and document defects and anomalies Perform retesting and regression testing as appropriate Validate reporting functions with DC Exchange based on reporting requirements Contribute to status and management reporting on the overall test effort	X	X
Developer	Both the DC Exchange and the participating Carriers will make available technical development staff to support the testing effort. Through Test Planning and Preparation, the specific roles and responsibilities for the DC Exchange development staff and the participating Carrier development staff will be elaborated and more clearly defined. At a high level, the DC Exchange developers and participating Carrier developers are responsible for researching and resolving defects and/or anomalies, as appropriate. Developers are also responsible for managing testing environments, technical access and security, and applicable interface support.	X	X

The Test Manager will support the participating Carriers in understanding of the testing process by creating a framework for collaborative development of:

5.2.1 Testing Roadmap

The Roadmap is a simple document outlining the various steps, and the testing timeline that the Carrier Test Specialist will need to follow to self-test their changes in DC Exchange with the DC Exchange Test Specialist.

5.2.2 Testing Roles and Responsibilities

In greater detail, the roles/responsibilities will be defined and shared between DC Exchange and the Carrier.

The Test Manager will communicate the expectations for turnaround time for the items on the Roadmap.

5.2.3 Test Cases and/or Scenarios

The DC Exchange will provide a guide on how to develop test cases and scenarios that map back to the approved requirements.

Test case scripting will be a collaborative effort between the DC Exchange and the participating Carriers.

5.2.4 Defect Reporting Process

Applicable access to tools and/or forms for documenting defects will be provided.

Detailed guidelines regarding how to report and disposition defects.

5.2.5 Validation and Technical Certification

The DC Exchange will provide detailed information regarding test entrance / exit criteria, pass / fail criteria, and how to meet the overall technical requirements necessary for review and certification.

5.3 Test Execution Process and Support

During the Testing phase itself, the DC Exchange will provide a testing environment for the participating Carriers to submit and validate various testing scenarios. It is during the execution phase that the Test Manager will coordinate testing sessions with each of the participating Carriers to schedule send/receive/response testing time in order to validate that the interfaces are functioning according to approved requirements. The Test Manager will work in concert with the Carriers to create an overall schedule, facilitate co-located and remote testing as appropriate, and manage the defect report/resolution process.

Test Specialists will execute the test scenarios and report findings. Defects and/or anomalies will be researched, documented, aligned with requirements, resolved if appropriate or deferred to a future release. Technical staff will participate in the research and resolution process. Test Specialists will perform retesting and disposition of the defect and/or anomaly, as applicable.

5.4 Test Validation and Technical Certification

As part of the overall process to be certified in their selected Program, the participating Carriers will be required to validate their technical solutions with the DC Exchange.

The Test Manager will work with each participating Carrier to schedule time for the Carrier and the DC Exchange to conduct the necessary tests, reviews, and evaluation for technical certification. During this time, all required scenarios will be validated and findings documented. Upon successful completion of this process, and following a separate review of the applicable business requirements necessary to perform the selected Program, the Carrier will be granted official certification from the DC Exchange for the interfaces that have been tested.

6 Carrier Program Support

As DC Exchange transitions from a development project into a functional program, it recognizes that new specific levels of support must be available to participating Carriers. To that end, specific post-project-implementation services will be retained to assure continuity and continuous operational improvement.

Specifically, the DC Exchange will retain specific support services for:

- Production Support and Maintenance / Operations
- Help Desk Support
- Call Center Support

The support information is included in the DC Exchange Carrier Onboarding Document.

7 File Archival

As per the HIPAA mandates, DC Exchange retains all the transaction files for a period of 6 years effective from the date of creation. Files are archived on the SFTP server shared with the Carriers and also on a separate secured network.

While the archived files on the SFTP server will be removed after a pre-determined retention period, the archived files on the secured network will be retained for 6 years.

Appendix H

DCHBX 834 Enrollment Companion Guide

BENEFIT ENROLLMENT (834) COMPANION GUIDE

November 18, 2013

Version 1.9

Revision History

Date	Version	Changes	Author	Reviewed by
05-22-2013	1.0a	Baseline	Vik Kodipelli	
05-28-2013	1.1a	Made changes to few sections to include DC specific information	Yesh Somashekhara	
06/21/2013	1.2a	Made several generic changes and added to Trading Partner, File Types and Frequency, EDI Acknowledgements and Confirmations, Error File – DC Exchange to Carrier, Carrier to DC Exchange, File Handling, Error Handling, and Encryption	Sara Cormeny	
07/16/2013	1.0	Draft, Reset document version to 1.0 to coordinate across all guides.	Sara Cormeny Dan Thomas	Saadi Mirza Yeshwanth Somashekhara David Sloand Gautham Palani Apurva Chokshi Trunal Kamble
07/26/2013	1.0.1	Added email/phone contacts. Corrections to File naming conventions	Dan Thomas	Sara Cormeny
08/06/2013	1.0.3	Added SFTP folder structures, time standard, sentinel file requirement, reasons for file rejection. Elaborated 2700/2750 Loop instructions for Carrier-collected binder payments. Updated EDI ISA/GS header specification. Clarified Individual vs SHOP market sponsor identification and encoding. Removed requirement for confirmation transactions.	Dan Thomas	Sara Cormeny
08/12/2013	1.5	Added 2750 reporting category instructions. Updated to enable multiple employer groups within a single physical file.	Dan Thomas Stuart Beaton	Sara Cormeny Bonnie Norton Hannah Turner Brendan Rose
08/20/2013	1.6	Added seconds units to file naming convention timestamp component, CSR to 2750 Loop, and Member Health Information to 2100A Loop. Added requirement for Carrier cancellation response on initial enrollment. `	Dan Thomas Stuart Beaton	Sara Cormeny Hannah Turner
09/10/2013	1.7	Rearranged sections for more logical flow. Clarified Exchange file structure. Added delimiter section. Modified GS02 envelope to distinguish inbound carrier files. Provided additional detail on Broker and Employer demographic interchange. Updates to 834 transaction specifications as a result of Carrier testing and CMS requirements. Extended seconds value to 5 digits in filename convention timestamp and examples.	Dan Thomas	Stuart Beaton Susan Tuite
10/08/2013	1.8	Updated Employer Demographic EFT section to reflect version 1.0 XSD. Added requirement for pgp encryption in ASCII Armor format	Dan Thomas	
11/18/2013	1.9	Added ACK file type. Specified folder location for Enrollment Error Report. Updated Employer demographic file to document added properties. Elaborated Loop 2000, INS06=15 (Ward) and elaborated valid values. Added Loop 2000, INS08=TE to termination spec.	Dan Thomas	

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1 Introduction

1.1 Purpose and Scope

This document provides information about Carrier Integration when the District of Columbia Health Benefit Exchange (referred to as "DC HBX" or "DC Exchange") is the aggregator of enrollment data for carriers or the recipient of enrollment data from carriers.

This document describes the use and exchange of member enrollment, change and termination messages that will be used for both the Individual and Small Business Health Options Program (SHOP) markets.

1.2 Intended Audience

This document is written for system architects, EDI developers, network engineers and others who are involved in the integration program of Carrier systems with DC Exchange.

1.3 Background of DC Health Exchange

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. A key provision of the law requires all states to participate in a Health Benefit Exchange beginning January 1, 2014. The District of Columbia declared its intention to establish a state based health benefit exchange in 2011 with the introduction and enactment of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19-0094).

The Health Benefit Exchange Authority Establishment Act of 2011 establishes the following core responsibilities for the Exchange:

1. Enable individuals and small employers to find affordable and easier-to-understand health insurance
2. Facilitate the purchase and sale of qualified health plans
3. Assist small employers in facilitating the enrollment of their employees in qualified health plans
4. Reduce the number of uninsured
5. Provide a transparent marketplace for health benefit plans
6. Educate consumers
7. Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions

The DC Exchange is responsible for the development and operation of all core Exchange functions including the following:

1. Certification of Qualified Health Plans and Qualified Dental Plans
2. Operation of a Small Business Health Options Program (SHOP)
3. Consumer support for coverage decisions
4. Eligibility determinations for individuals and families
5. Enrollment in Qualified Health Plans
6. Contracting with certified carriers
7. Determination for exemptions from the individual mandate

1.4 Trading Partner Agreement

A Trading Partner Agreement (TPA) is created between participants in Electronic Data Interchange (EDI) file exchanges. All trading partners who wish to exchange 5010 transaction sets electronically to/from DC Exchange via the ASC X12N 834,

Benefit Enrollment and Maintenance (Version 005010X220A1) and receive corresponding EDI responses, must execute a TPA and successfully complete Trading Partner testing to ensure their systems and connectivity are working correctly prior to any production activity.

1.5 Regulatory Compliance

The DC Exchange will comply with the data encryption policy as outlined in the HIPAA Privacy and Security regulations regarding the need to encrypt health information and other confidential data. All data within a transaction that are included in the HIPAA definition of Electronic Protected Health Information (ePHI) will be subject to the HIPAA Privacy and Security regulations, and DC Exchange will adhere to such regulations and the associated encryption rules. All Trading Partners also are expected to comply with these regulations and encryption policies. (Please refer to the DC Health Link Carrier Onboarding Document for additional information).

1.6 Key Terms

The following are definitions for acronyms used in this document.

Table 1: Acronyms

Acronym	Definition
ACA	Affordable Care Act
APTC	Advance Payments of the Premium Tax Credit
ASC	Accredited Standards Committee
Cancellation of Health Coverage	End health coverage prior to the health coverage effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
CCIIO	Center for Consumer Information and Insurance Oversight
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
EDI	Electronic Data Interchange
EDS	Enrollment Data Store
EFT	Enterprise File Transfer
FEPS	Federal Exchange Program System
FF-SHOP	Federally Facilitated Small Business Health Option Program
FFE	Federally Facilitated Exchange operated by HHS
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
Hub	Data Services Hub Referred to as the Hub
IG	Implementation Guide
PHS	Public Health Service
QHP	Qualified Health Plan
MEC	Minimum Essential Coverage
SBE	State-Based Exchange
SFTP	Secure File Transfer Protocol
SHOP	Small Business Health Option Program
Termination of Health Coverage	Terminate (end-date) health coverage after the health coverage effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
Companion Guide Technical Information (TI)	The Technical Information (TI) section of the ASC X12 Template format for a Companion Guide which supplements an ASC X12 Technical Report Type 3 (TR3)
TR3	Type 3 Technical Report
XOC	eXchange Operational Support Center

1.7 Related Resources

This Benefit Enrollment Companion Guide is one in a series of documents that describes and specifies communication between the Exchange and carriers. Below is a list of related guides and specifications. Current versions of these resources may be obtained at the DC Health Benefit Exchange Web site (see How to Contact Us).

Table 2: Related Resources

Resource	Description
CMS Companion Guide for the Federally Facilitated Exchange (FFE)	Provides information on usage of 834 transaction based on 005010X220 Implementation Guide and its associated 005010X220A1 addenda
Trading Partner Agreements (TPA)	Outlines the requirements for the transfer of EDI information between a Carrier and DC Exchange
DC Health Link Carrier Onboarding Document	Contains all the information required for Carrier to connect and communicate with the DC Exchange, i.e. machine addresses, security protocols, security credentials, encryption methods
DC Health Link Carrier Integration Manual	Provides a comprehensive guide to the services offered by DC Exchange
DC Health Link Premium Payment Companion Guide	Provides technical information on 820 transactions supported by DC Exchange
DC Health Link Carrier Testing Document	Contains the testing strategy for DC Exchange – Carriers integration
DC Health Link Transaction Error Handling Guide	Provides details on exchange message validation and error handling
DC Health Link Billing and Enrollment Timelines	Explains enrollment and premium billing timelines for plans sold on the DC Exchange.
Employer Demographic XSD	XML schema definition for exchanging Employer Demographic information
Broker Demographic XSD	XML schema definition for exchanging Broker Demographic information
Reconciliation Report Template	Excel file template for Carriers to report and resolve discrepancies between Carrier and DC Exchange subscriber databases

1.8 How to Contact Us

The DC Exchange maintains a Web site with Carrier-related information along with email and telephone support:

- **Web**: http://dchbx.com/page/carrier-information
- **Email**: carriersupport@dchbx.com
- **Phone**:
  - (202) 317-0287 - Concierge, general Carrier EDI support
  - (202) 320-7308 - technical Carrier EDI support

2 Electronic Communication with the DC Exchange

2.1 Connecting to the DC Exchange

The DC Exchange publishes secure Internet resources that a Carrier may access to exchange electronic information. Under the Trading Partner setup process, a Carrier completes the DC Health Link Onboarding Document.

The Onboarding Document collects information about Carrier technical contacts, network details and other information necessary to establish secure communication. Based on this information, the DC Exchange will configure networks; establish service accounts and credentials; and exchange keys with Carriers to enable connectivity to DC Exchange resources.

2.2 PGP Encryption

The DC Exchange uses Pretty Good Privacy (PGP) to encrypt information shared with trading partners. Using PGP, sensitive information in electronic files is protected during transmission over the open Internet and while stored on messaging servers.

The DC Exchange and Carriers will exchange public keys under the onboarding process. Files will be encrypted with the receiver's public key (either the DC Exchange or Carrier) and signed by the sender's private key. The encrypted data must be encoded in ASCII Armor format rather than binary form.

2.3 Secure Email

The DC Exchange will support SSH SMTP services. Carriers and the Exchange may use this service to send email messages that contain private or sensitive content.

2.4 SFTP Server

The DC Exchange provides a secure landing zone for Carriers to post and retrieve transaction files. SSH FTP protocol is used to transfer files to and from the landing zone server. Files persisted on the landing zone server are encrypted to protect private and sensitive information.

2.5 File Types and Frequency

As shown in Table 3, there are four types of files that will support member enrollment and change information under the Individual and SHOP markets:

1. **Change File**: A file containing any changes. Any new record or maintenance to a membership record will be included on the appropriate change file.
2. **Audit File**: An audit file containing the current view of the membership. So whether a member has been involved in a change or not, the file is sent to Carriers.
3. **Interchange Acknowledgement**: file header verification
4. **Functional Acknowledgement**: file content syntactic verification

Table 3: File Types and Frequency

Market	File Type	File Content	Frequency
Individual	Change File	Initial Enrollment 834	Daily*
	Change File	Effectuation 834	Upon processing of Initial Enrollment 834 EDI file or Maintenance 834 additions
	Change File	Maintenance 834	Daily*
	Change File	Confirmation 834 EDI**	Upon processing of Maintenance 834 EDI file
	Audit	Full File 834	Monthly
	Interchange Acknowledgement	TA1	Upon receipt of 834
	Functional Acknowledgement	999	Upon processing of 834
SHOP	Change File	Initial Enrollment 834	Daily*
	Change File	Effectuation 834	Upon processing of Initial Enrollment 834 EDI file or Maintenance 834 additions
	Change File	Maintenance 834	Daily*
	Change File	Confirmation 834 EDI**	Upon processing of Maintenance 834 EDI file
	Audit	Full File 834	Monthly
	Interchange Acknowledgement	TA1	Upon receipt of 834
	Functional Acknowledgement	999	Upon processing of 834

* Throughout this document, "Daily" means business days; files will not be exchanged on weekends or Federal and District holidays.

** As of Oct. 1, 2013, the DC Exchange will not require Confirmation 834 EDI's from Carriers. We will revisit this policy in the future.

Table 4 lists 834 transactions by type and direction of message travel.

Table 4: 834 Transactions and Exchange Flow

Transaction Type	DC Exchange to Carrier	Carrier to DC Exchange
Initial Enrollment	X	
Effectuation		X
Change	X	
Cancellation	X	X
Termination	X	X
Reinstatement	X	X
Audit	X	
Reconciliation		X
Error 999 / TA1	X	X

2.6 File Naming

Files follow a naming convention as follows, broken down into identifying parts that enable interpretation of its content type, vintage, source, etc. Each file name part is separated by an underscore "_" to allow parsing. See Table 5 for explanation and values of each file name part, ordered as follows:

FileStandard_DateTime_IssuerID_FilePurpose_FileContent_ExchangeMarket_ProcessFlag.Encryption

For example:

File name	Meaning
834_20130514142206000Z_PYR_C_EF_I_1.asc	834 file, produced May 14, 2013 at 2:22pm GMT, issuer identified by "PYR", purpose is database update, content is effectuation notices, market is individual subscribers, file contains one or more records and is PGP ASCII armor encrypted.

Table 5: File Naming Convention

File Name Part	Description	Acceptable Values	
File Standard	Structure: X12 specification	834 TA1 999	Enrollment & Maintenance Technical Acknowledgement Functional Acknowledgement
Date Time	Timestamp: UTC date and time	yyyyMMddHHmmssssZ	
Issuer ID	Carrier: DC Exchange-assigned unique identifier for Carrier that created file.	<CarrierID>	IDs are established though trading partner agreements
File Purpose	Purpose: Whether content is intended for database update or comparison/reconciliation.	C A	Change File Audit File
File Content	Content: Whether this is an Initial Enrollment file, Maintenance File, Full File	E EF ACK M F	Initial Enrollment File Effectuation file Acknowledgement File Maintenance File Full File
Exchange Market	Market: Whether content is Individual Exchange or SHOP Exchange	I S	Individual Exchange SHOP Exchange
Sentinel Flag	Flag: Presence of file is positive acknowledgement that exchange partner has successfully completed processing. Flag value indicates whether file contains new content to exchange or is empty (no new messages).	1 0	File has content to process File is empty
Encryption	Encryption type	.pgp or .asc	PGP encrypted in ASCII armor format

2.7 Acknowledgement Files

The DC Exchange limits one interchange (ISA-IEA) per file and one single functional group per interchange (GS-GE), therefore one 999 functional acknowledgement file will be produced for each physical file exchanged.

The entire submission will be rejected under the following situations:

- Submission of files that don't comply with file name specification defined herein
- Submission of data that is not valid based on the TR3
- Submission of a segment or data element specified in the TR3 as "Not Used"
- Submission of non-unique values in the GS06, or non-unique combinations of GS06 and ST02

2.8 Sentinel Files

The Exchange business model requires successful process execution and coordinated inter-organization information exchange to ensure members receive entitled coverage and updates on a timely basis. The EDI interchange between Carriers and the Exchange is a critical point in that process to recognize and recover from errors. One such error is the failure to post interchange files for a partner organization to process. For instance, how should a Carrier interpret the situation when an 834 file isn't found during daily inspection of the new enrollments folder? The lack of a file could signal: 1) no new data, 2) delay in DC Exchange processing, or 3) failure in DC Exchange processing.

In order to detect process failures, the DC Exchange uses sentinel files. A sentinel file provides a mechanism for the sender to positively inform the receiving party that no data is available to process. For daily interchanges, both the DC Exchange and Carriers will always post a file, indicating via the file's sentinel flag (as specified in the File Naming section), whether the file has content to process. Files names with a sentinel flag indicating no content shall be 0-length.

The DC Exchange and Carriers will post sentinel files when there's no content to process for the following exchanges:

- Individual Market 834 initial enrollment file
- Individual Market 834 effectuation file
- Individual Market 834 maintenance file
- SHOP Market 834 initial enrollment file
- SHOP Market 834 effectuation file
- SHOP Market 834 maintenance file

When the receiving party encounters a sentinel file, they will not produce a TA1/999 acknowledgement for the interchange.

2.9 Landing Zone Folders

Folders and file name conventions are used on the landing zone to organize and distinguish between file types and instances used on the Exchange. Since Carriers may elect to offer QHPs in Individual, SHOP or both markets, folders are organized first by market type.

Following is a detailed description of each market folder hierarchy. Folders are named from the Carrier perspective. Inbound holds files for Carrier to download, outbound files are uploaded by the Carrier. **Note**: The receiving party is responsible for deleting landing zone server interchange and acknowledgement files from their respective folders once they are successfully transferred and processed.

2.9.1 INDIVIDUAL MARKET FOLDER STRUCTURE

Carriers who offer Individual Market QHPs will use a folder structure like that shown in Figure 1 to exchange transactions.

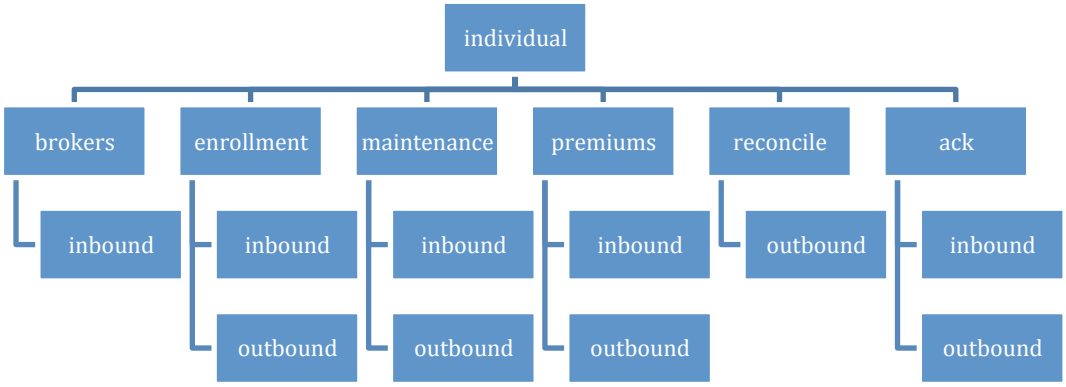

Figure 1: SFTP Folder Structure for Individual Market

Carriers may retrieve new and updated broker demographic information in the **brokers/inbound** folder. Broker files are non-EDI with uni-directional flow from the Exchange to Carriers.

Individual initial enrollment 834's are accessed in the **enrollment/inbound** folder. Carriers post effectuation files in the **enrollment/outbound** folder.

The **maintenance** folder is for Individual market 834 change files. Carriers pick up 834 files, including periodic 834 audit files, from the **maintenance/inbound** folder. Carriers post 834 change files to the **maintenance/outbound** folder.

The **premiums** folder enables 820 premium payment exchanges. Carriers collect Individual binder payment 820's from the **premiums/inbound** folder and post ongoing payment 820 remittance advice to the **premiums/outbound** folder.

The **reconcile/outbound** folder is for Carriers to post Enterprise File Transfer (EFT) files, including Enrollment and Premium Error Reports (see Transaction Error Handling Guide) and 834 audit reconciliation files.

The DC Exchange posts TA1/999 acknowledgement files to the **ack/inbound** folder for Carrier consumption. Carriers post TA1/999 acknowledgement files to the **ack/outbound** folder for DC Exchange consumption.

2.9.2 SHOP MARKET FOLDER STRUCTURE

Carriers who offer SHOP Market QHPs will use a folder structure like that shown in Figure 2 to exchange transactions.

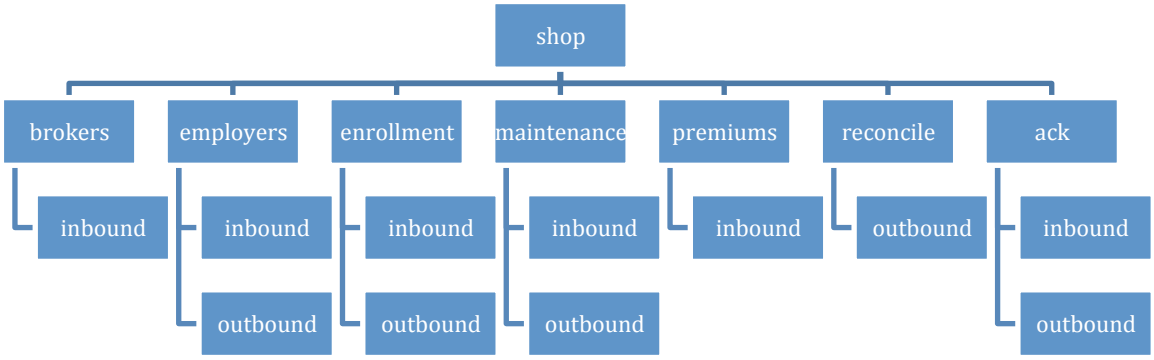

Figure 2: SFTP Folder Structure for SHOP Market

Carriers may retrieve new and updated broker demographic information in the **brokers/inbound** folder. Broker files are non-EDI with uni-directional flow from the Exchange to Carriers.

Employer demographic information is handled similar to that of brokers. Carriers may retrieve new and updated employer demographic information in the **employers/inbound** folder. Carriers will post Group ID response files to the **employers/outbound** folder.

SHOP initial enrollment 834's are accessed in the **enrollment/inbound** folder. Carriers will post effectuation files in the **enrollment/outbound** folder.

The **maintenance** folder is for SHOP market 834 change files. Carriers pick up 834 files, including periodic 834 audit files, from the **maintenance/inbound** folder. Carriers post 834 change files to the **maintenance/outbound** folder.

The **premiums** folder enables 820 premium payment exchanges. Carriers pick up SHOP 820's from the **premiums/inbound** folder.

The **reconcile/outbound** folder is for Carriers to post Enterprise File Transfer (EFT) files, including Enrollment and Premium Error Reports (see Transaction Error Handling Guide) and 834 audit reconciliation files.

The DC Exchange posts TA1/999 acknowledgement files to the **ack/inbound** folder for Carrier consumption. Carriers post TA1/999 acknowledgement files to the **ack/outbound** folder for DC Exchange consumption.

3 EDI Implementation

3.1 Standards Supported

The DC Exchange uses the EDI ASC X12N standard formats for exchanging benefit enrollment and premium payment remittance information. The specifications and versions are as follows:

Specification	Version
EDI X12 834	005010X220A1
EDI X12 820	005010X306
EDI X12 TA1	005010X231A1: Interchange Acknowledgement
EDI X12 999	005010X231A1: Implementation Acknowledgement

3.2 WEDI SNIP Validation

EDI transactions submitted to the DC Exchange pass through compliance checks before processing. The DC Exchange and Carriers will validate to a minimum of WEDI SNIP types 1 and 2.

WEDI SNIP Type 1: EDI Syntax Integrity Checking. Validates the basic syntactical integrity of EDI submission. This tests the EDI for valid segments, segment order, element attributes, etc. When EDI submissions fail this validation, the entire file will be rejected back to the submitter. Examples of these errors include, but are not limited to:

- Invalid date or time
- Invalid character or data element
- Invalid data element length

WEDI SNIP Type 2: HIPAA Syntactical Requirement Validation. This level validates the file for conformance to HIPAA Implementation Guide syntax, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. When EDI submissions fail this validation, failing transactions will be rejected back to the submitter. Examples of these errors include, but are not limited to:

- Missing/Invalid Enrollee information
- Patient's city, state, or zip is missing or invalid

3.3 Character Set

- As specified in the TR3, the basic character set includes uppercase letters, digits, space, and other special characters with the exception of those used for delimiters.
- All HIPAA segments and qualifiers must be submitted in UPPERCASE letters only.
- To avoid syntax errors hyphens, parentheses, and spaces should not be used in values for identifiers. (Examples: Tax ID 123654321, SSN 123456789, Phone 8001235010)
- The DC Exchange coordinate with trading partners to determine delimiters. Delimiters for the transaction are specified in Delimiters section herein

3.4 Delimiters

The DC Exchange will use the separators listed in Table 6 in all outbound files and prefers the same for inbound files. The 'at' (@) character is prohibited as email addresses are included in interchanges.

Table 6: Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

3.5 Time Zone

Unless otherwise noted, all date and time values refer to Coordinated Universal Time (UTC). The DC Exchange and Carrier will verify use of Network Time Protocol (NTP) to synchronize system clocks between respective communicating servers.

3.6 834 Control Segments/Envelope

Trading partners should follow the Interchange Control Structure (ICS) and Functional Group Structure (GS) guidelines for HIPAA that are located in the HIPAA Implementation Guides. The following sections address specific information needed by the DC Exchange in order to process the ASC X12N/005010X220A1-834 Benefit Enrollment and Maintenance Transaction.

The DC Exchange will accept:

- Single ISA-IEA envelope within a single physical file
- Single GS-GE envelopes within a single ISA-IEA interchange
- Multiple ST-SE envelopes within a single GS-GE functional group

Table 7 specifies use of 834 ISA and GS headers for interchange with the DC Exchange.

Table 7: Control Segments

Element	Description	Length	Acceptable Values	Instructions
ISA	Interchange Control Header	1		
ISA01	Authorization Information Qualifier	2	00	
ISA02	Authorization Information	10		Space characters
ISA03	Security Information Qualifier	2	00	
ISA04	Security Information	10		Space characters
ISA05	Interchange Sender ID Qualifier	2	30	
ISA06	Interchange Sender ID	9	NNNNNNNNN	Sender's Federal Tax ID
ISA07	Interchange ID Qualifier	2	30	
ISA08	Interchange Receiver ID	9	NNNNNNNNN	Receiver's Federal Tax ID
ISA09	Interchange Date	6	YYMMDD	

Element	Description	Length	Acceptable Values	Instructions
ISA10	Interchange Time	4	HHMM	
ISA11	Repetition Separator	1	^	Default value
ISA12	Interchange Control Version Number	5	00501	
ISA13	Interchange Control Number	9	NNNNNNNNN	Unique 9-digit number with leading zeroes.
ISA14	Interchange Acknowledgment Requested	1	1	The DC Exchange requires TA1 file acknowledgement
ISA15	Interchange Usage Indicator	1	P = Production Data T = Test Data	
ISA16	Component Element Separator	1	:	Default value
GS	Functional Group Header	1		
GS01	Functional Identifier Code	2	BE	
GS02	Application Sender's Code	3	DC0 = DC Exchange IND = Carrier, Individual Market SHP = Carrier, SHOP Market	
GS03	Application Receiver's Code	3	DC0 = DC Exchange IND = Carrier, Individual Market SHP = Carrier, SHOP Market	
GS04	Date	8	CCYYMMDD	CURRENT-DATE
GS05	Time	4	HHMM	CURRENT-TIME
GS06	Group Control Number	9	NNNNNNNNN	Send only one GS per file. This Control Number must be unique
GS07	Responsible Agency Code	1	X = Accredited Standards Committee X12	
GS08	Version Identifier Code	12	005010X220A1	

3.7 Interchange File Structure

Individual Market transactions are exchanged either as batched or single transaction files. Batched files include one or more interchanges in a single physical file. They use a single GS-GE envelope and segregate enrollment group transactions using one or more ST-SE envelopes as follows:

```
ISA
   GS
      ST
         1000A Enrollment Group 1
         2000s Members in Enrollment Group 1
      SE
      ST
         1000A Enrollment Group 2
         2000s Members in Enrollment Group 2
      SE
      ST
         1000A Enrollment Group 3
         2000s Members in Enrollment Group 3
      SE
   GE
IEA
```

Individual Market single transaction files contain one interchange per file. They use a single GS-GE envelope and single ST-SE envelope.

Similarly, SHOP Market transactions may be exchanged either as batched or single transaction files. Batched files include one or more employer groups, each containing one interchange. They use a single GS-GE envelope and nested ST-SE envelopes separate employer group/enrollment group transactions as follows:

```
ISA
   GS
      ST
         1000A Employer 1
         2000s Members in Employer 1 Group 1
      SE
      ST
         1000A Employer 1
         2000s Members in Employer 1 Group 2
      SE
      ST
         1000A Employer 2
         2000s Members in Employer 2 Group 1
      SE
      ST
         1000A Employer 2
         2000s Members in Employer 2 Group 2
      SE
   GE
IEA
```

SHOP Market single transaction files contain one interchange—one employer group and one enrollment group—per file. They use a single GS-GE envelope and single ST-SE envelope.

The DC Exchange recommends single transaction file model for both Individual and SHOP markets, however will configure batched file transactions at Carrier request.

3.8 Individual Market Plan Sponsor

For all individual market subscribers, the DC Exchange is considered the sponsor with a group identifier of "DC0" (CMS designation for the DC Exchange). Thus, for individuals, as shown in Table 8, use code N101="P5" along with N102 ="DC0" and use code N103="FI" along with the DC Exchange's federal tax ID. According to the file name convention, reference "DC0" as the file name component GroupID value.

Table 8: Loop 1000A for Individual Market

Loop	Element	Element Name	Code	Instruction
1000A	N101	Entity Identifier Code	P5	"Plan Sponsor"
	N102	Plan Sponsor Name	DC0	DC Exchange ID as designated by CMS
	N103	Identification Code Qualifier	FI	"Federal Taxpayer's Identification Number"
	N104	Identification Code	NNNNNNNNN	DC Exchange Tax ID

3.9 SHOP Market Plan Sponsor

The employer is the sponsor in the SHOP market. The DC Exchange uses Loop ID-1000A to identify the plan sponsor. Given Loop Repeat = 1 restriction, it's necessary to create separate transaction (ST-SE) sets for each employer group.

As shown in Table 9, use code N101="P5" along with the employer organization's name, provided in the employer demographic file (see Employer Demographic Data) in N102.

Depending on the Employer group's status on the DC Exchange, values for N103 and N104 will vary. For the Initial enrollment and effectuation cycle, the Exchange and Carrier will populate N103="FI", along with the employer's Federal Employer Identification Number (FEIN). For future transactions, including additional SHOP employee Initial enrollments, the Exchange and Carrier will set N103="94" and N104 to the Carrier-assigned employer group identifier.

Employer group transactions within a single physical interchange file will be sent in separate transaction sets (ST-SE).

Table 9: Loop 1000A for SHOP Market

Loop	Element	Element Name	Code	Instruction
1000A	N101	Entity Identifier Code	P5	"Plan Sponsor"
	N102	Plan Sponsor Name		SHOP Employer free form name
	N103	Identification Code Qualifier	FI 94	Initial enrollment, use code FI and "Federal Employer Identification Number" in N104. Following receipt of Carrier-assigned Employer group identifier via EFT (see Employer Demographic Data section), use code 94 and group identifier value in N104.
	N104	Identification Code	NNNNNNNNN	IRS-assigned Employer EIN for initial enrollment. Following receipt of Carrier-assigned Employer group identifier, use this Employer Group ID.

4 Enterprise File Transfer

This section covers special circumstances where the DC Exchange has turned to Enterprise File Transfer (EFT) non-EDI message exchange to support requirements beyond those envisioned under the ASC X12 standards.

4.1 Broker Demographic Data

The broker demographic EFT transaction provides Carriers with contact information for DC-certified brokers via a batch process. Broker demographics are communicated one way, from DC Exchange to Carriers. All Broker information is broadcast to all Carriers daily, if additions, updates or removals occur. The DC Exchange compiles broker data in an XML file under the following scenarios:

- New broker is accepted to the DC Exchange
- Updates to existing broker data
- Broker termination

The Broker XML file structure is defined in an XML Schema Definition (XSD) file that may be obtained from the DC Exchange. The XML file's content may include one or more Brokers along with their demographic information as indicated in Table 10. The table also shows which of the possible elements the DC Exchange supports.

Table 10: Broker Demographic XML file contents

Element	DC Exchange Supported?	Description
npn	Yes	Broker National Producer Number (license number)
vcard	Yes	Broker contact information using the vcard-4.0 standard serialized in XML format
insurance_expiration_date	No	End date for Broker certification on the DC Exchange
associated_agency_name	No	Name of company that employs broker
associated_agency_fein	No	Federal tax identification number of company that employs broker
license	No	State license number, issuing state and effective date

As shown in Table 11, the DC Exchange provides three interchange elements in the Broker XML file to support Carriers adding and updating Broker information. The **exchange_id** is the Broker's unique identifier in the DC Exchange and will not change between transactions. The **exchange_status** element indicates the Broker's certification status with the DC Exchange. The **exchange_status** value will be "Active" for Brokers with a current certification, and "Inactive" for those who do not. The **exchange_version** element increments each time the Broker record changes on the DC Exchange.

Table 11: Broker Demographic Data Interchange Elements

Element	Description
exchange_id	DC Exchange key for the Broker
exchange_status	Broker status on the DC Exchange, either Active or Inactive
exchange_version	DC Exchange version number for this Broker record

Carriers must download and process this content before processing the 834 EDI files, as the 834s may contain references to the new broker information. Table 12 shows specifications related to this transaction.

Table 12: Broker Demographics Transaction Details

Interaction Model	Batch
File Name	BrokerData_yyyyMMddHHmmssssZ.xml.pgp
Frequency	Daily
Inbound File Format	XML file containing the Broker demographics data
Outbound File Format	N/A
Exchange Process	DC Exchange compiles data of all newly added brokers as well as of updated data of existing brokers into an XML file. The Carriers pick up the file and process it without need for acknowledgement response to DC Exchange.
Success	N/A
Failure	N/A
Error Handling	Carrier contacts DC Exchange support

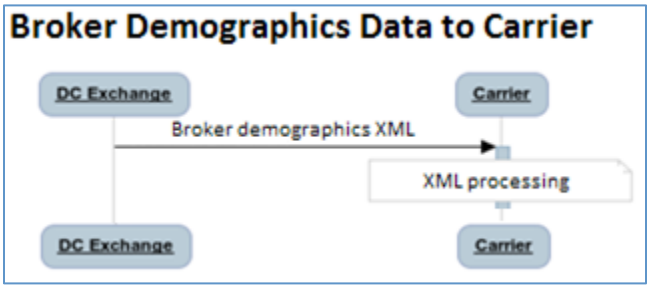

Figure 3: Broker Demographics Data to Carrier

Figure 3 Sequence:

1. DC Exchange drops Broker Demographics XML file update to Carrier landing zone folder
2. The Carrier successfully processes the XML before processing the daily 834 initial enrollment
3. In case of issues processing file, Carrier contacts DC Exchange support

4.2 Employer Demographic Data

The employer demographic EFT transaction enables employer demographic and group-related data exchange between the DC Exchange and Carriers. Demographic information is transmitted to Carriers whose plans were selected by the Employer on daily basis, if additions, updates or removals occur. In the case of additions, Carriers must return to the DC Exchange Carrier-assigned employer group and policy numbers. The DC Exchange generates an XML file under the following scenarios:

- New employer/group on boarded to the DC Exchange
- Updates to existing employer/group data
- Employer/Group termination

The DC Exchange will post an Employer demographic file for Carrier access on a daily basis as information becomes available. Carriers must download and import this information in advance of processing SHOP initial enrollments to ensure proper association with any transactions that may reference a new employer. Also, the Carrier must assign a

Group ID to the new employer and upload to the DC Exchange an XML response file (using the same Employer XML schema format) that cross-references the employer's EIN (**fein**) with this new Group ID.

As indicated throughout this companion guide, the Carrier-assigned Employer Group ID (**plan:group_id**) is the primary employer identifier for 834 and 820 information exchange between the DC Exchange and Carriers. However, a Carrier-generated identifier isn't available when an employer first enrolls on the DC Exchange. In order to trade using this Group ID, DC Exchange-collected employer demographic information must be sent to the Carrier and the assigned Group ID transmitted back to the DC Exchange.

During this communication coordination setup, trading partners will use the employer's EIN in lieu of the Group ID as the employer's identifier (e.g. 834 Loop 1000A), to avoid enrollment/payment transaction delays or interruptions. After the DC Exchange processes the Carrier-provided XML response file, all future benefit enrollment and premium payment transactions, and all updates to the employer demographic information, will reference the Group ID.

The Employer XML file structure is defined in an XML Schema Definition (XSD) file that may be obtained from the DC Exchange. The file's content may include one or more Employers along with their demographic information as indicated in Table 13. The table also shows which of the possible elements the DC Exchange supports.

Table 13: Employer Demographic XML file contents

Element	DC Exchange Supported?	Description
name	Yes	Free form name for this Employer
fein	Yes	Federal tax identification number for this Employer
employer_exchange_id	Yes	DC Exchange key for the Employer (same as exchange_id)
sic_code	Yes (optional)	Standard Industrial Code (when known)
fte_count	Yes	Number of full time employees
pte_count	Yes	Number of part time employees
broker:npn_id	Yes (optional)	NPN (license) number of the Broker supporting this Employer (when known)
broker:tpa_ga_fein	No	
open_enrollment_start	Yes	Employer's open enrollment period begin date
open_enrollment_end	Yes	Employer's open enrollment period end date
plan_year_start	Yes	Date Employer plan year begins
plan_year_end	Yes (optional)	Date Employer plan year ends (when known)
continuation_coverage_type	No	
plan:qhp_id	Yes	Qualified Health Plan identifier - HIOS ID
plan:plan_exchange_id	Yes	Exchange-assigned plan identifier
plan:policy_number	Yes	Carrier-assigned policy number (when known)
plan:group_id	Yes	Carrier-assigned Group ID for this Employer (when known)
plan:carrier_id	Yes	Exchange-assigned Carrier ID
plan:carrier_name	Yes	Carrier free-form text name
plan:plan_name	Yes	Carrier-assigned plan name
plan:coverage_type	Yes	Health coverage designation: Health or Dental
plan:original_effective_date	Yes	Effective date coverage begins
plan:renewal_effective_date	No	
plan:out_of_state_flag	No	
plan:metal_level_code	Yes	ACA actuarial level for plan: Bronze, Silver, Gold, Platinum
vcard	Yes	Employer contact information using the vcard-4.0 standard serialized in XML format
notes	Yes	Free form description field (when available)

The DC Exchange will post a new change file whenever a new employer enrolls or a change is made to existing employer information. On days when no changes are made to employer records, no file will be posted.

As shown in Table 14, the DC Exchange provides three interchange elements in the Employer XML file to support Carriers adding and updating Employer information. The **exchange_id** is the Employer's unique identifier in the DC Exchange and will not change between transactions. The **exchange_status** element indicates the employer's enrollment status with the DC Exchange. The **exchange_status** value will be "Active" for employers with a current enrollment, and "Inactive" for those who are not. The **exchange_version** element increments each time the Employer record is changed on the DC Exchange.

Table 14: Employer Demographic Data Interchange Elements

Element	Description
exchange_id	DC Exchange key for the Employer
exchange_status	Employer status on the DC Exchange, either Active or Inactive
exchange_version	DC Exchange version number for this Employer record

Table 15 shows specifications related to this transaction.

Table 15: Employer Demographic Transaction Details

Interaction Model	Batch
File Name	EmployerData_yyyyMMddHHmmssss_<Issuer_ID>.xml.pgp
Frequency	Daily
Inbound File Format	XML file containing the Employer demographics data
Outbound File Format	XML response containing Carrier-assigned Employer Group ID
Exchange Process	DC Exchange compiles data of all newly added employers/groups as well as of updated data of existing employers/groups into an XML file. The Carriers pick up the file and process it and then send subsequent XML response to DC Exchange.
Success	N/A
Failure	N/A
Error Handling	Carrier contacts DC Exchange support

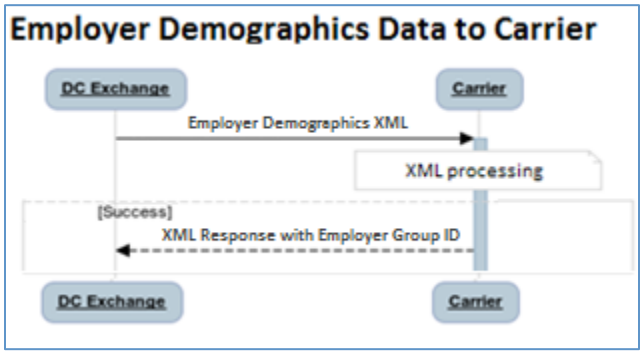

Figure 4: Employer Demographics Data to Carrier

Figure 4 Sequence:

1. DC Exchange drops Employer Demographics XML file update to Carrier landing zone folder
2. The Carrier successfully processes the XML before processing the daily 834 initial enrollments.
3. The Carrier sends DC Exchange Employer Demographics XML response file populated with Carrier-assigned Employer Group ID element

4. DC Exchange processes the response file and begins using the Carrier-assigned Employer ID as identifier
5. In case of issues processing file, Carrier contacts DC Exchange support

5 Detailed Business Scenarios for 834

This section provides the DC Exchange-specific guidance related to the published X12 834 EDI standards, such as extending loop definitions or constraining allowable codes.

5.1 Linking Subscribers and Dependents

The DC Exchange follows ASC X12 5010 Benefit Enrollment and Maintenance (834) guidance for associating dependents with a subscriber within an 834 interchange.

Subscribers and dependents are sent as separate occurrences of Loop 2000 within the same file using the subscriber's unique DC Exchange-assigned identifier as the common key. In the subscriber's—and each dependent's—Loop 2000, include a REF segment and use code "0F" followed by the associated subscriber's Exchange ID. The primary subscriber must appear in a Loop 2000 before any related dependents.

5.2 Initial Enrollment

The DC Exchange will generate separate 834 files for initial enrollments and maintenance of enrollments. The intent is to simplify management and processing of carrier-produced effectuation notifications by separating them from maintenance files, which use a different approach to confirmation where necessary.

The trigger to send an initial enrollment to the Carrier is an applicant is determined eligible by the DC Exchange, a QHP is selected; and the binder payment either settled or flagged for invoice processing by Carrier. Table 16 shows specifications related to this transaction. Figure 5 is a sequence diagram that illustrates the initial enrollment process.

Table 16: Initial Enrollment Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_E_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the companion guide published by DC Exchange.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all enrollment related data corresponding to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

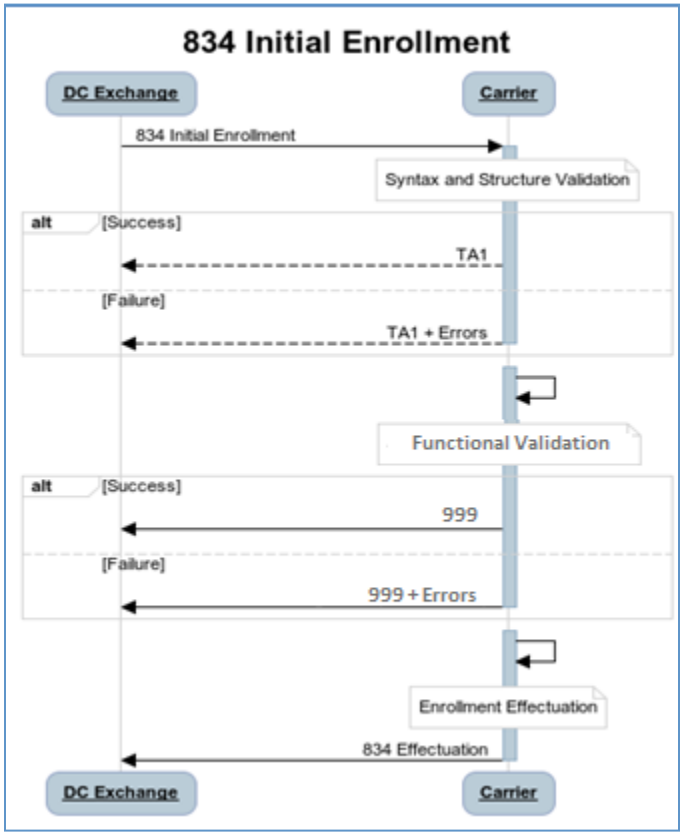

Figure 5: 834 Initial Enrollment Sequence Diagram

Figure 5 Sequence:

1. DC Exchange sends EDI X12 834 Enrollment Data file to Carrier.
2. Carrier sends:
    a. Acknowledgment (TA1) back to the DC Exchange, or
    b. In case of envelope errors, the Carrier sends an acknowledgment (TA1) identifying the errors.
3. Carrier processes the file and sends:
    a. Functional acknowledgment (EDI X12 999) without error codes to the DC Exchange if there are no functional errors in the file, or
    b. In case of error scenario, the Carrier sends a functional acknowledgment (EDI X12 999) along with the error codes.
4. In case of no functional errors, the Carrier carries out enrollment effectuation process and sends an effectuation data file (EDI X12 834) to the DC Exchange.

Subscribers and Dependents must be sent as separate occurrences of Loop 2000 within the same file. The subscriber must appear in Loop 2000 before any dependents.

When a child is the only member covered, the child's information is placed in the Subscriber loop, and the person who is financially responsible will be identified in loop 2100G.

The enrollee's SSN, if known, is transmitted in the NM1 segment on the initial enrollment transactions but is not included in maintenance transactions between Carriers and the DC Exchange.

The DC Exchange has extended the 2700/2750 loops, as required by CMS for State Based Exchanges. As specified in the CMS Companion Guide for the FFE, a number of Member Reporting Category extensions must be transmitted in the 834 under the 2700 Loop – Member Reporting Categories Loop. When the 2700 Loop is present, the 2750 will be sent and the DC Exchange will populate the elements as follows in the 2750 Loop:

- Rating area used to determine premium amounts (premium category). DC does not use rating areas, however for CMS-compliance purposes, all transactions will include the value: R-DC001
- Premium amount (premium category)
- Source Exchange ID. All transactions will use the value: DC0
- Total premium for the health coverage sent at the member level (premium category)
- APTC amount (APTC category) - sent when the member qualifies for APTC. If the member has elected no APTC amount, then zero shall be transmitted
- ~~CSR amount (CSR amount category) sent when the member qualifies for CSR. If the member does not qualify then no CSR amount shall be sent~~. DC HealthLink has request pending with CMS to remove this requirement.
- Total individual responsibility amount (payment category)
- Total employer responsibility amount (payment category) – SHOP

In addition to the above fields, the District Exchange will add: N102 value of "CARRIER TO BILL" that indicates the individual has chosen to the Carrier to collect the binder payment.

Table 17 specifies the 834 initial enrollment message structures for transmission from the DC Exchange to Carrier.

Table 17: Initial Enrollment Supplemental Instructions (DC Exchange to Carrier)

Loop	Element	Element Name	Code	Instruction
Header	BGN	Beginning Segment		
	BGN05	Time Zone Code	UT	Universal Time Coordinate
	BGN08	Action Code	2	"Change" Used to identify a transaction of additions
Header	DTP	File Effective Date		Date the enrollment information was collected by the exchange.
	DTP01	Date Time Qualifier	303	Maintenance Effective
Header	QTY			Will transmit all three iterations of this segment for each for the qualifiers specified in QTY01.
Header	QTY01	Quantity Qualifier	TO	TO = Transaction Set Control Totals
			DT	Dependent Total. Will transmit to indicate that the value conveyed in QTY02 represents total number of INS segments in this ST/SE set with INS01 = "N"
			ET	Employee Total. Will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set with INS01 = "Y"
1000A	N1	Sponsor Name		See Table 8 herein for Individual market and Table 9 for SHOP market
1000B	N1	Payer		Identifies the carrier as indicated in the TPA
	N103	Identification Code	FI	Federal Taxpayer ID. Will transmit until the HPID is required.
			XV	Will transmit after the HPID is required. (Unique National Health Plan Identifier).
1000C	N1	TPA/Broker Name		Loop Repeat = 2
	N101	Entity Identifier Code	BO	Broker. Will transmit Broker in first Loop when Broker is involved in this enrollment
			TV	Third Party Administrator (TPA). Will transmit TPA in second Loop when TPA is involved in this enrollment.
	N102	Name		TPA or Broker Name. Will transmit when Broker or TPA is involved in this enrollment.
	N103	Identification Code Qualifier	94	Broker National Payer Number (NPN) when N101=BO, or

Loop	Element	Element Name	Code	Instruction
			FI	Federal Taxpayer's Identification Number when N101=TV, or
			XV	Centers for Medicare and Medicaid Services Plan ID.
	N104	Identification Code		Code identifying a party or other code. - Will transmit when Broker or TPA is involved in this enrollment.
2000	INS	Member Level Detail	2000	
	INS01	Response Code	Y	Yes – the individual is a subscriber
			N	No – the individual is a dependent
	INS02	Relationship Code	01	Spouse
			15	Ward – sent when aged-off child is still plan-eligible due to disability
			18	Self
			19	Child
	INS03	Maintenance Type Code	021	Addition
	INS04	Maintenance Reason Code	EC	"Member Benefit Selection" Will transmit when member has selected a Carrier.
	INS05	Benefit Status Code	A	Active
	INS08	Employment Status Code	AC	Active (required for non-employment based programs)
2000	REF	Subscriber Identifier		Must be sent for all subscriber and dependent loops
	REF01	Reference Identification Qualifier	0F	Subscriber number
	REF02	Subscriber Identifier		The Exchange Assigned ID of the primary coverage person.
2000	REF	Member Supplemental Identifier		
	REF01	Reference Identification Qualifier	17	Client Reporting Category
	REF02	Member Supplemental Identifier		Exchange Assigned Member ID
2000	DTP	Member Level Dates		Must be sent for all subscriber and dependent loops
	DTP01	Date Time Qualifier	356	Eligibility Begin
	DTP02	Date Format Qualifier	D8	CCYYMMDD
	DTP03	Date Time Period		
2100A	NM1	Member Name		
	NM108	Member Identifier	34	Will transmit the member's SSN when known.
	NM109	Member Identifier		Will transmit the member's SSN when known.
2100A	PER	Member Communications Numbers		
	PER03	Communication Number Qualifier		Will transmit three communication contacts – home phone, work phone, cell phone, or E-mail address when the information is available. Communication contacts will be sent in this order: 1st – Primary Phone ("TE") 2nd – Secondary Phone ("AP") 3rd – Preferred Communication Method ("EM" for E-mail or "BN" for a phone number for receiving text messages). If no preferred communication method is chosen, the third communication contact will not be sent.
	PER05	Communication Number Qualifier		Will transmit three communication contacts – home phone, work phone, cell phone, or E-mail address when the information is available. Communication contacts will be sent in this order: 1st – Primary Phone ("TE") 2nd – Secondary Phone ("AP") 3rd – Preferred Communication Method ("EM" for E-mail or "BN" for a phone number for receiving text messages). If no preferred communication method is chosen, the third communication contact will not be sent.

Loop	Element	Element Name	Code	Instruction
	PER07	Communication Number Qualifier		Will transmit three communication contacts – home phone, work phone, cell phone, or E-mail address when the information is available. Communication contacts will be sent in this order: 1st – Primary Phone (“TE”) 2nd – Secondary Phone (“AP”) 3rd – Preferred Communication Method (“EM” for E-mail or “BN” for a phone number for receiving text messages). If no preferred communication method is chosen, the third communication contact will not be sent.
2100A	N3	Member Residence Street Address		
2100A	N4	Member City, State, ZIP Code		
	N404	Country Code		Will transmit only if not U.S.
2100A	DMG	MEMBER DEMOGRAPHICS		
2100A	HLH	MEMBER HEALTH INFORMATION		Transmitted for all members
	HLH01	Health-Related code		U – Unknown Tobacco Use is only accepted value on DC Exchange
2100A	LUI	MEMBER LANGUAGE		This segment will be transmitted when member language information is available
	LUI01	Identification Code Qualifier	LE	ISO 639-1 language code will be placed in LUI02
2100F		Custodial Parent Loop		The Custodial Parent will be send when known
2100G		Responsible Person Loop		Responsible person information will be sent when known for members below age of 18, as minors are legally incapable of entering into a contract. The responsible person may be parent or guardian.
2100G	PER	Responsible Person Communication Numbers		
	PER03	Communication Number Qualifier		Will transmit three communication contacts – home phone, work phone, cell phone, or email address when the information is available. Communication contacts will be sent in the following order: 1st – Primary Phone (“TE”) 2nd – Secondary Phone (“AP”) 3rd – Preferred Communication Method (“EM” for E-mail or ”BN” for a phone number for receiving text messages). If no preferred communication method is chosen, the 3rd communication contact will not be sent.
	PER05	Communication Number Qualifier		Will transmit three communication contacts – home phone, work phone, cell phone, or email address when the information is available. Communication contacts will be sent in the following order: 1st – Primary Phone (“TE”) 2nd – Secondary Phone (“AP”) 3rd – Preferred Communication Method (“EM” for E-mail or ”BN” for a phone number for receiving text messages). If no preferred communication method is chosen, the 3rd communication contact will not be sent.
	PER07	Communication Number Qualifier		Will transmit three communication contacts – home phone, work phone, cell phone, or email address when the information is available. Communication contacts will be sent in the following order: 1st – Primary Phone (“TE”) 2nd – Secondary Phone (“AP”) 3rd – Preferred Communication Method (“EM” for E-mail or ”BN” for a phone number for receiving text messages). If no preferred communication method is chosen, the 3rd communication contact will not be sent.
2300	HD	Health Coverage		
	HD01	Maintenance Type Code	021	Addition

Loop	Element	Element Name	Code	Instruction
	HD03	Insurance Line Code	DEN HLT	
2300	DTP	Health Coverage Dates		Initial enrollments include “Benefit Begin” and “Last Premium Paid Date”
	DTP01	Date Time Qualifier	348 543	“Benefit Begin” – on initial enrollment the effective date of coverage will be provided “Last Premium Paid Date”
2300	REF	Health Coverage Policy Number		
	REF01	Reference Identification Qualifier	CE	Individual and SHOP. “Class of Contract Code” – Carrier ID Purchased is the Assigned Plan Identifier. This is represented as the HIOS Plan ID Component (14 digits) + subcomponent (2 digits).
			E8	SHOP only. “Service Contract (Coverage) Number” Will transmit Employer Group Number in the associated REF02 element when known
			1L	Will transmit when the Exchange-assigned Policy Identifier will be conveyed in the associated REF02 element.
			X9	Will transmit when the Carrier-assigned Policy Identifier will be conveyed in the associated REF02 element when known
2700		Member Reporting Categories Loop		This loop will be transmitted when additional premium category reporting is appropriate.
2750	N1	Reporting Category		This loop will be transmitted only when the 2700 loop exists
	N101	Entity Identifier Code	75	Participant. This loop will be transmitted only when the 2700 loop exists
	N102	Name		This loop will be transmitted only when the 2700 loop exists **N102** — **REF01** ADDL MAINT REASON — 17 APTC AMT — 9V CARRIER TO BILL — ZZ CSR AMT — 9V OTH PAY AMT 1 — 9V PRE AMT 1 — 9X PRE AMT TOT — 9X RATING AREA — 9X REQUEST SUBMIT TIMESTAMP — 17 SEP REASON — 17 SOURCE EXCHANGE ID — 17 TOT EMP RES AMT — 9V TOT RES AMT — 9V
2750	REF	REPORTING CATEGORY REFERENCE		
	REF01	Reference Identification Qualifier	17 9V 9X ZZ	

5.3 Enrollment Effectuation

An effectuated 834 is created by the Carrier and sent to the DC Exchange for successfully processed 834 initial enrollment transactions. Also, additions of dependent members to an existing subscriber policy will require an Effectuation. Table 18 shows specifications related to this transaction.

The Carrier is required to assign a unique identifier for each individual, Carrier Assigned Member Identifier. The primary member is considered the subscriber, and for that individual, the Carrier Assigned Member Identifier is the same value as the Carrier Assigned Subscriber Identifier. For each individual sent in the 834 Effectuation file, both the Carrier Assigned Member Identifier and the Carrier Assigned Subscriber Identifier are to be returned.

The Carrier must return the original information transmitted on the Initial Enrollment transaction, in addition to the information detailed in Table 19.

Table 18: Enrollment Effectuation Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_EF_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Outbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the companion guide published by DC Exchange.
Exchange Process	Carriers return all the information transmitted on the initial enrollment transaction in addition to effectuation related information. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	DC Exchange sends EDI X12 TA1 to Carrier as an acknowledgement after no errors are found at the interchange level. DC Exchange sends EDI X12 999 to Carrier as an acknowledgement after no errors are found at the functional group level.
Failure	Validation and Error Handling

Table 19: Enrollment Effectuation Instructions (Carrier to DC Exchange)

Loop	Element	Element Name	Code	Instruction
Header	BGN	Beginning Segment		
	BGN06	Original Transaction Set Reference Number		Transmit the value from BGN02 in the initial enrollment transaction when available
	BGN08	Action Code	2	Change
Header	QTY	Transaction Set Control Totals		If the transaction set control totals sent with the Initial Enrollment transaction are not accurate for this confirmation/effectuation, transmit accurate totals instead of the values received in the Initial Enrollment transaction.
	QTY01	Quantity Qualifier	TO	Total - Will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set. It is required for all transactions.
			DT	Dependent Total. - Will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set with INS01 = "N"
			ET	Employee Total – Will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set with INS01 = "Y"
2000	INS	Member Level Detail		
	INS03	Maintenance Type Code	021	"Addition"
	INS04	Maintenance Reason Code	28	"Initial Enrollment"
2000	REF	Member Supplemental Identifier		
	REF01	Reference Identification Qualifier	0F	Exchange-assigned ID of the primary coverage person

Loop	Element	Element Name	Code	Instruction
			23	Transmit with the Carrier Assigned Member ID conveyed in REF02.
			ZZ	Transmit with the Carrier Assigned Subscriber ID conveyed in REF02.
			17	Transmit with the Client Reporting Category from the initial enrollment for the member conveyed in REF02
2100B		Incorrect Member Name Loop		Do not transmit this loop unless it was included in the 834 transaction that is being confirmed.
2300	DTP	Health Coverage Dates		
	DTP01	Date Time Qualifier	348	"Benefit Begin" The Actual Enrollment Begin Date must be transmitted when confirming initial enrollment transactions.
	REF	Health Coverage Policy Number		
	REF01	Reference Identification Qualifier	X9	Transmit with the Carrier assigned Health Coverage Purchased Policy Number conveyed in the associated REF02 element.
2700		Member Reporting Categories Loop		One iteration of this loop is required for all confirmations.
2750	N1	Reporting Category		See Sections 9.5 and 9.6 of the CMS guide for explicit instructions related to the 2750 loop.
	N102	Member Reporting Category Name		"ADDL MAINT REASON"
2750	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	"Client Reporting Category"
	REF02	Member Reporting Category Reference ID		Transmit this text: "CONFIRM"

5.4 Maintenance Files

The DC Exchange will send the full enrollment group with each maintenance interchange.

5.4.1 CANCELLATION

An 834 cancellation transaction will be used when coverage is cancelled prior to the effective date of enrollment. The DC Exchange or the Carrier may initiate a cancellation.

A cancellation may be initiated any time prior to the effective date of the initial coverage. Situations where the DC Exchange may cancel an enrollment include: an individual obtaining coverage through an employer prior to the start of coverage and requesting a cancellation, or an individual moving out of a coverage area before coverage is started.

A Carrier may initiate a cancellation when the applicant member requests billing by the Carrier and doesn't make payment within the grace period. Under the individual market, when an initial enrollment applicant fails to make payment within the grace period as defined in the Billing & Enrollment Timelines document, the Carrier must transmit a cancellation transaction to the DC Exchange.

Table 20 shows specifications related to this transaction. Information specific to the DC Exchange implementation of cancellation transactions is outlined in Table 21.

Table 20: Enrollment Cancellation Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_M_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the companion guide published by DC Exchange.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange/Carrier compiles all cancellation related data corresponding to the Carrier into an EDI X12 834 file format. Data is also customized per the DC Exchange Benefit Enrollment Companion Guide.
Success	Receiving system sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Receiving system sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

Table 21: Enrollment Cancellation Instructions

Loop	Element	Element Name	Code	Instruction
2000	INS	Member Level Detail		
	INS03	Maintenance Type Code	001 024 030	INS03=001 At subscriber level indicates cancellation is occurring at an individual member level, or if multiple plans exist, cancellation is only for one plan. At member level, indicates one of multiple plans is cancelled. Financial changes for enrollment group are reflected at 2700/2750 loops. INS03=024 At subscriber level, indicates entire enrollment group is cancelled. At member level, Indicates member is cancelled INS03=030 Indicates member is not cancelled and none of member's plans are cancelled.
	INS04	Maintenance Reason Code		DC Exchange → Carrier. Any valid Maintenance Reason Code may be used DC Exchange ← Carrier. Carriers may cancel coverage only for 03 Death and 59 Non-Payment.
	INS08	Employment Status Code	TE	Terminated (required for non-employment based programs)
	REF	Subscriber Identifier		

Loop	Element	Element Name	Code	Instruction
	REF02	Subscriber Identifier		The Exchange Assigned ID of the primary coverage person.
	REF	Member Supplemental Identifier		Transmit IDs shown below when they were present on the Initial Enrollment.
	REF01	Reference Identification Qualifier	17	When the Exchange Assigned Member ID is conveyed in REF02.
			23	When the Carrier Assigned Member ID is conveyed in REF02.
	DTP	Member Level Dates		
	DTP01	Date Time Qualifier	357 303	Eligibility End Date for cancelled member Maintenance Effective for non-cancelled members
	DTP03	Status Information Effective Date		The eligibility end date of the termination must be transmitted.
2300	HD	Health Coverage		
	HD01	Maintenance Type Code	024 030	HD01=024 - Cancellation or Termination of plan HD01=030 – Plan is not cancelled or terminated
	HD03	Insurance Line Code	DEN HLT	Dental Health
2300	DTP	Health Coverage Dates		
	DTP01	Date Time Qualifier	349 303	Benefit End (Cancellation/Termination Date) Maintenance Effective for non-cancelled members
	REF	Health Coverage Policy Number		
	REF01	Reference Identification Qualifier	X9	Carrier assigned Health Coverage Purchased Policy Number conveyed in the associated REF02 element.
2700		Member Reporting Categories Loop		Two iterations of this loop are required for all cancellations.
2750	N1	Reporting Category		See Sections 9.5 and 9.6 of the CMS guide for explicit instructions related to the 2750 loop.
	N102	Member Reporting Category Name		”ADDL MAINT REASON”
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	“Client Reporting Category”
	REF02	Member Reporting Category Reference ID		Transmit this Text: “CANCEL”
2750	N1	Reporting Category		See Sections 9.5 and 9.6 of the CMS guide for explicit instructions related to the 2750 loop.
	N102	Member Reporting Category Name		”REQUEST SUBMIT TIMESTAMP”
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	“Client Reporting Category”
	REF02	Member Reporting Category Reference ID		CCYYMMDDHHMMSS

5.5 Termination

Either the DC Exchange or the Carrier can initiate a termination transaction. Termination transactions are initiated in situations when enrollment will end on or after the effective date of coverage.

The DC Exchange may initiate a termination transaction for any valid reason; however the Carrier is only permitted to initiate a termination under certain circumstances: 1) non-payment of coverage, 2) death of the member, 3) plan decertification, or 4) fraud.

In both Individual and SHOP markets, when coverage is terminated, the termination of benefit end-dates is typically prospective – either mid-month (SHOP market only—based on employer rules), the end of the current month or a subsequent month. Terminations can be retrospective, however, when termination is due to nonpayment of premium or fraud. Also, in the SHOP market, terminations can be retrospective due to group termination rules. In the case of death of the member, the benefit end date will be retroactive to the end of the month of death.

Table 22 shows specifications related to this transaction. Information specific to the DC Exchange implementation of termination transactions is outlined in

Table 23.

Table 22: Enrollment Termination Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_M_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the companion guide published by DC Exchange.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange/Carrier compiles all termination related data corresponding to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	Receiving system sends EDI X12 TA1 to the transmitting system as an acknowledgement after no errors are found at the interchange level. Receiving system sends EDI X12 999 to the transmitting system as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

Table 23: Enrollment Termination Instructions

Loop	Element	Element Name	Code	Instruction
2000	INS	Member Level Detail		
	INS03	Maintenance Type Code	024	Termination
	INS04	Maintenance Reason Code	03 59	DC Exchange <-- Carrier. Carriers may terminate coverage only for 03 Death and 59 Non-Payment. Future versions of this guide will include forthcoming CMS Maintenance Reason Codes for Fraud and Plan Decertification
	INS04	Maintenance Reason Code (DC Exchange → Carrier)		Any valid Maintenance Reason Code may be used.
	REF	Subscriber Identifier		
	REF02	Subscriber Identifier		The Exchange Assigned ID of the primary coverage person.
	REF	Member Supplemental Identifier		Transmit IDs shown below

Loop	Element	Element Name	Code	Instruction
	REF01	Reference Identification Qualifier	17	Exchange Assigned Member ID is conveyed in REF02.
			23	Carrier Assigned Member ID is conveyed in REF02.
			0F	Exchange Assigned Subscriber ID is conveyed in REF02
			ZZ	Carrier Assigned Subscriber ID is conveyed in REF02.
	DTP	Member Level Dates		
	DTP01	Date Time Qualifier	357	Eligibility End Date
	DTP03	Status Information Effective Date		The eligibility end date of the termination must be transmitted.
2300	DTP	Health Coverage Dates		
	DTP01	Date Time Qualifier	349	Benefit End Date
2700		Member Reporting Categories Loop		Two iterations of this loop are required for all terminations.
2750	N1	Reporting Category		See Sections 9.5 and 9.6 of the CMS guide for explicit instructions related to the 2750 loop.
	N102	Member Reporting Category Name		”ADDL MAINT REASON”
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	“Client Reporting Category”
	REF02	Member Reporting Category Reference ID		Transmit this Text: “TERM”
	N1	Reporting Category		See CMS Companion Guide for explicit instructions related to the 2750 loop.
	N102	Member Reporting Category Name		”REQUEST SUBMIT TIMESTAMP”
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	“Client Reporting Category”
	REF02	Member Reporting Category Reference ID		CCYYMMDDHHMMSS

5.6 Change Transactions

The DC Exchange will issue a standard 834 Change transaction to update information that has changed. Simple examples are changes in member name and/or contact information. The Exchange will trigger transactions for life change events, such as eligibility changes due to age-out and self-reporting. A special case life change event is adding dependent members to existing policy. This change requires an effectuation response from the Carrier.

Since changes often trigger eligibility redetermination, only the DC Exchange can initiate a Change transaction. If the Carrier receives notice of a change, this information must be communicated directly to the DC Exchange to trigger initiation of an 834 Change transaction.

Table 24 shows specifications related to this transaction.

Table 24: Change Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_M_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the DC Exchange companion guide.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all the changes to enrollment data corresponding to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.

Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

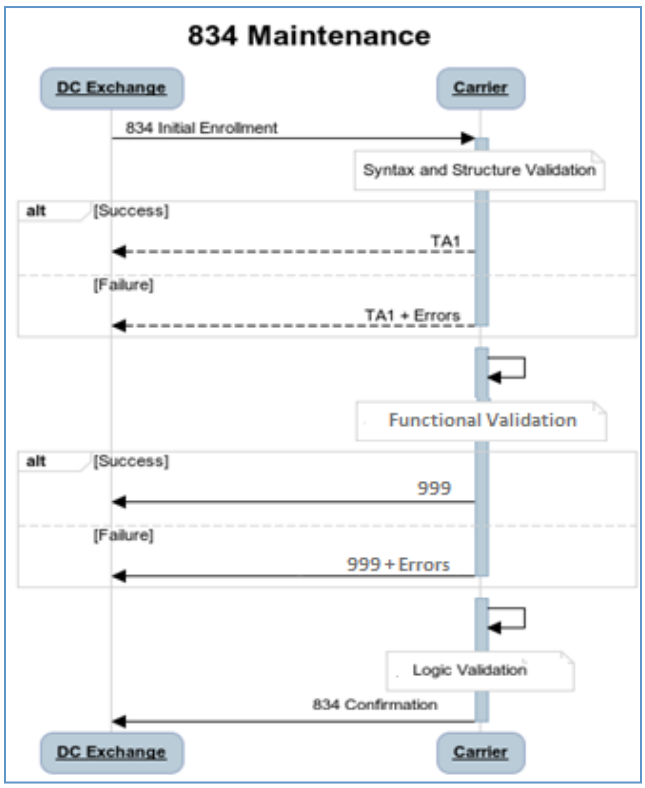

Figure 6: 834 Maintenance Sequence Diagram

Figure 6 Sequence:

1. DC Exchange sends EDI X12 834 Maintenance Data file to Carrier.
2. Carrier sends:
    a. Acknowledgment (TA1) back to the DC Exchange, or
    b. In case of envelope errors, the Carrier sends an acknowledgment (TA1) identifying the errors.
3. Carrier processes the file and sends:
    a. Functional acknowledgment (EDI X12 999) without error codes to the DC Exchange if there are no functional errors in the file, or
    b. In case of error scenario, the Carrier sends a functional acknowledgment (EDI X12 999) along with the error codes.
4. In case of no functional errors the Carrier further processes the file and sends a confirmation file (EDI X12 834) to the DC Exchange.

5.7 Individual Market Re-Enrollment Supplemental Instructions

A re-enrollment transaction is generated when an enrollee who has been terminated needs to be re-enrolled. A potential reason for this transaction would be when the subscriber no longer is eligible and the remaining members of the enrollment group need to be re-enrolled under a new subscriber.

In this situation, the previous Carrier subscriber identifier will be conveyed as a member supplemental identifier, accompanied by the Exchange-generated subscriber identifier for the new subscriber. Only the DC Exchange can initiate Re-Enrollment transactions.

Table 25 shows specifications related to this transaction. Information specific to the DC Exchange implementation of individual market re-enrollment transactions is outlined in Table 26.

Table 25: Individual Market Re-Enrollment Transaction Details

Interaction model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_M_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the DC Exchange companion guide.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all the individual market re-enrollment data corresponding to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

Table 26: Re-enrollment Instructions

Loop	Element	Element Name	Code	Instruction
2000	INS	Member Level Detail		
	INS04	Maintenance Reason Code	41	"Re-enrollment"
	REF	Member Supplemental Identifier		Transmit IDs shown below when they were present on the Initial Enrollment.
	REF01	Reference Identification Qualifier	Q4	"Prior Identifier Number." - When the previous Carrier Assigned Subscriber ID will be conveyed in REF02.

5.8 Reinstatement

A Reinstatement transaction is generated when an enrollee who has been cancelled or terminated needs to be reinstated. For example, eligibility has terminated and the customer appeals after termination has already taken effect. The DC Exchange or the Carrier can initiate Reinstatement transactions. Table 27 shows specifications related to this transaction.

Except as noted in Table 28, the Reinstatement transaction will contain all the information transmitted on the Initial Enrollment Transaction.

Table 27: Reinstatement Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_M_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the DC Exchange companion guide.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all the reinstatement related data corresponding to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

Table 28: Reinstatement Instructions

Loop	Element	Element Name	Code	Instruction
2000	INS	Member Level Detail		
	INS04	Maintenance Reason Code	41	In the context of a Reinstatement, the “Re-enrollment” code will be used.

5.9 Change in Health Coverage

The DC Exchange will send two Coverage Level Change transactions to the Carrier when an enrollee’s health coverage level changes.

The first Coverage Level Change transaction will convey a health coverage termination for the prior coverage level, followed by a second Coverage Level change transaction to convey the enrollment in the new health coverage level (new coverage).

When coverage is terminated in this scenario, the benefit end dates must always be prospective – either the end of the current mount, or a subsequent month. The benefit begins date for the new coverage specified in the new enrollment transaction will be the first of the following month.

Table 29 shows specifications related to this transaction.

Table 29: Change in Health Coverage Transaction Details

Interaction Model	Batch

File Name	E.g. 834_20130514142206000Z_PYR_C_M_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the DC Exchange companion guide.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all the reinstatement related data corresponding to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

5.10 Termination Due to Address Change

The DC Exchange will send two transactions to the Carrier when a change of address results in a termination. The first transaction will communicate the change of address and the second will initiate the termination. Table 30 shows specifications related to this transaction.

Table 30: Termination Due to Address Change Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_C_M_I_1.pgp
Frequency	Daily
Inbound File Format	EDI X12 834 - Benefit Enrollment & Maintenance (005010220A1) as format per the DC Exchange companion guide.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all the data related to coverage termination due to address change in respect to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

6 Audit/Reconciliation

The DC Exchange will periodically generate and send to the Carrier a standard 834 "audit or compare" file that contains a complete, current view of the membership. This file will contain all enrollment data for the active enrollments (all members covered under a current policy) present on that day. Additionally, recently terminated members are included in the audit file for two cycles and noted appropriately. The audit file will include a BGN08 code value of 4, and a Maintenance Type Code of "030" in both INS03 in Loop 2000 and HD01 In Loop 2300.

Carriers will process the 834 audit file, generating and sending back to the DC Exchange a report containing differences between Carrier and DC Exchange's records. The DC Exchange and Carrier will then collaboratively resolve these discrepancies. The report structure and format will follow the Reconciliation Report template.

In practice, the audit and reconciliation process will take place on a monthly basis. Immediately following launch, reconciliations for the Individual Market is scheduled for November 15th. The first SHOP Market audit is tentatively set for December 2nd. The DC Exchange will generate both Individual and SHOP Market audit files on December 16th for final review leading up to January 1st coverage effective date. Starting February 5, 2014, the DC Exchange will produce audit files on the 5th of each month. Carriers will review the audit files and notify the DC Exchange of differences within five business days of receipt.

The DC Exchange has established this schedule to: 1) help mitigate risk by identifying anomalies and exceptions early, and 2) minimize the impact of issues through competent and rapid response. On or around December 2nd, the DC Exchange will review this policy with Carriers and determine reconciliation schedule going forward.

Table 31 shows specifications related to this transaction.

Table 31: Audit/Reconciliation Transaction Details

Interaction Model	Batch
File Name	E.g. 834_20130514142206000Z_PYR_A_F_I_1.pgp
Frequency	Two weeks following launch, monthly thereafter
Inbound File Format	EDI X12 834 – Benefit Enrollment & Maintenance (005010220A1) as per the companion guide published by DC Exchange.
Outbound File Format	Reconciliation report
Exchange Process	DC Exchange compiles data of all enrollees corresponding to the Carrier into an EDI X12 834 file format. Data is also customized *per the DC Exchange Benefit Enrollment Companion Guide*.
Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	*Refer to section 12.2.4 834 Error Transaction*

7 Validation and Error Handling

All EDI transactions on the DC Exchange will use the X12 TA1/999 interchange and implementation acknowledgement protocols. For details on error handling process refer to DC HealthLink Transaction Error Handling Guide.

8 CMS Reporting

8.1 Initial Enrollment and Effectuation to CMS

The DC Exchange will transmit a subset of Individual Market 834 transactions to CMS daily:

- Initial enrollments
- Enrollment effectuations
- Dependent adds
- Dependent add effectuations
- Cancellations
- Terminations

Additionally, the exchange rule requires that Carriers reconcile enrollment files with the DC Exchange at least once per month and that the DC Exchange use that information to reconcile enrollment information with CMS.

The exchanges with DC Exchange and CMS are described below in the following figures.

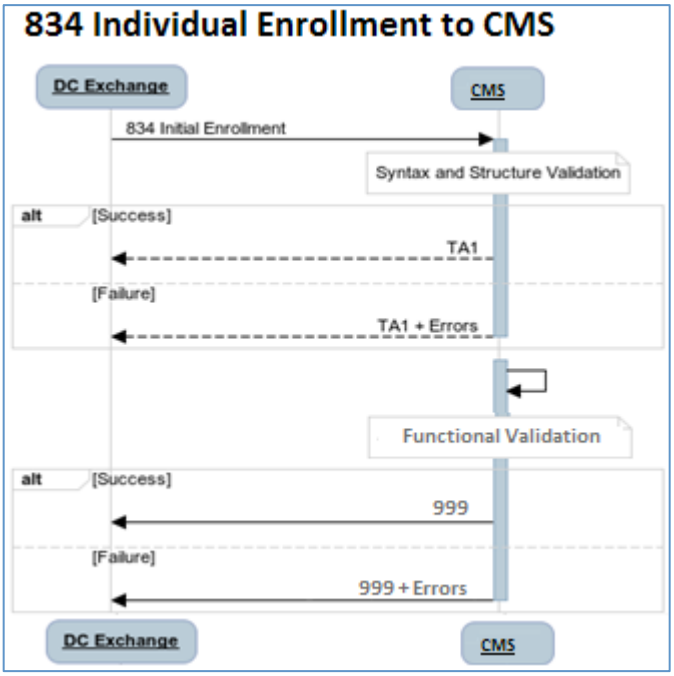

Figure 7: 834 Individual Enrollments to CMS Sequence Diagram

Figure 7 Sequence:

1. DC Exchange sends EDI X12 834 Enrollment Data file to CMS.
2. CMS sends:
    a. Acknowledgment (TA1) back to the DC Exchange, or
    b. In case of envelope errors, the CMS sends an acknowledgment (TA1) identifying the errors.
3. CMS processes the file and sends:

a. Functional acknowledgment (EDI X12 999) without error codes to the DC Exchange if there are no functional errors in the file, or
b. In case of error scenario, CMS sends a functional acknowledgment (EDI X12 999) along with the error codes.

4. In case of no functional errors CMS further processes the file.

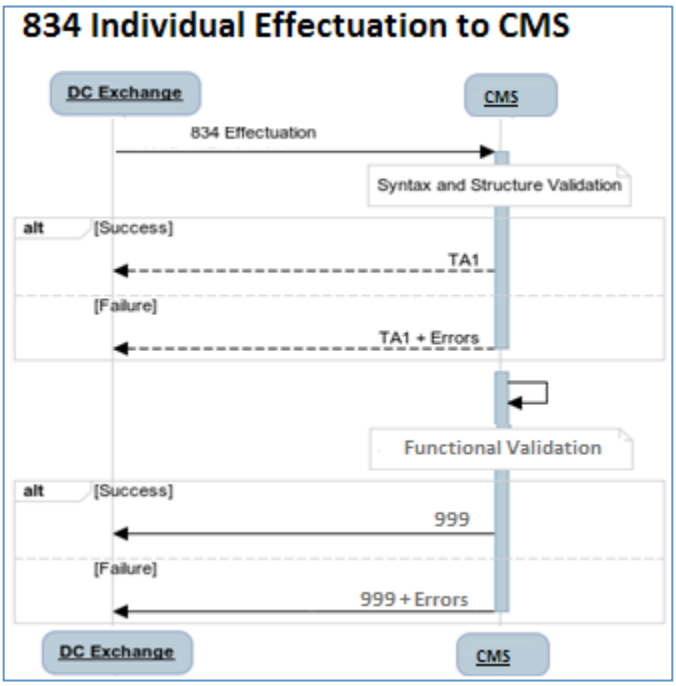

Figure 8: 834 Individual Effectuation to CMS Sequence Diagram

Figure 8 Sequence:

1. DC Exchange receives Effectuation file from Carrier
2. DC Exchange re-envelopes the Effectuation file
3. DC Exchange sends EDI X12 834 Effectuation file to CMS.
4. CMS sends:
   a. Acknowledgment (TA1) back to the DC Exchange, or
   b. In case of envelope errors, CMS sends an acknowledgment (TA1) identifying the errors.
5. CMS processes the file and sends:
   a. Functional acknowledgment (EDI X12 999) without error codes to the DC Exchange if there are no functional errors in the file, or
   b. In case of error scenario, CMS sends a functional a acknowledgment (EDI X12 999) along with the error codes.
6. In case of no functional errors CMS further processes the file.

Appendix I

DCHBX 820 Payment Companion Guide

PREMIUM PAYMENT (820) COMPANION GUIDE

July 17, 2013

Version 1.0

Revision History

Date	Version	Changes	Author	Approved by
05-22-2013	1.0a	Baseline	Vik Kodipelli	
05-28-2013	1.1a	Made changes to few sections to include DC specific information	Yesh Somashekhara	
06/21/2013	1.2a	Made several generic changes and added to Trading Partner, File Types and Frequency, EDI Acknowledgements and Confirmations, Error File – DC Exchange to Carrier, Carrier to DC Exchange, File Handling, Error Handling, and Encryption	Sara Cormeny	
07/17/2013	1.0	Draft, Reset document version to 1.0 to coordinate across all guides.	Sara Cormeny Dan Thomas	Saadi Mirza Yeshwanth Somashekhara David Sloand Gautham Palani Apurva Chokshi Trunal Kamble

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1 Introduction

1.1 Purpose and Scope

This document provides information about Carrier Integration when the District of Columbia Health Benefit Exchange (referred to as "DC HBX" or "DC Exchange") is the aggregator of payment data for carriers or the recipient of payment data from carriers.

This document describes the use and exchange of exchange of premium payment messages that will be used for both the Individual and Small Business Health Options Program (SHOP) markets.

1.2 Intended Audience

This document is written for system architects, EDI developers, network engineers and others who are involved in the integration program of Carrier systems with DC Exchange.

1.3 Background of DC Health Exchange

On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law. A key provision of the law requires all states to participate in a Health Benefit Exchange beginning January 1, 2014. The District of Columbia declared its intention to establish a state-based health benefit exchange in 2011 with the introduction and enactment of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19- 0094).

The Health Benefit Exchange Authority Establishment Act of 2011 establishes the following core responsibilities for the Exchange:

1. Enable individuals and small employers to find affordable and easier-to understand health insurance
2. Facilitate the purchase and sale of qualified health plans
3. Assist small employers in facilitating the enrollment of their employees in qualified health plans
4. Reduce the number of uninsured
5. Provide a transparent marketplace for health benefit plans
6. Educate consumers
7. Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions

The DC Exchange is responsible for the development and operation of all core Exchange functions including the following:

1. Certification of Qualified Health Plans and Qualified Dental Plans
2. Operation of a Small Business Health Options Program
3. Consumer support for coverage decisions
4. Eligibility determinations for individuals and families
5. Enrollment in Qualified Health Plans
6. Contracting with certified carriers
7. Determination for exemptions from the individual mandate

1.4 Trading Partner Agreement

A Trading Partner Agreement (TPA) is created between participants in Electronic Data Interchange (EDI) file exchanges. All trading partners who wish to exchange 5010 transaction sets electronically to/from DC Exchange via the ASC X12N 820, Payroll Deducted and Other Group Premium Payment for Insurance Products (820) (Version 005010X220A1) and receive corresponding EDI responses, must execute a TPA and successfully complete Trading Partner testing to ensure their systems and connectivity are working correctly prior to any production activity.

1.5 Regulatory Compliance

The DC Exchange will comply with the data encryption policy as outlined in the HIPAA Privacy and Security regulations regarding the need to encrypt health information and other confidential data. All data within a transaction that are included in the HIPAA definition of Electronic Protected Health Information (ePHI) will be subject to the HIPAA Privacy and Security regulations, and DC Exchange will adhere to such regulations and the associated encryption rules. All Trading Partners also are expected to comply with these regulations and encryption policies. (Please refer to the DC Exchange Carrier Onboarding Document for additional information).

1.6 Key Terms

The following are definitions for terms and acronyms used in this document.

Table 1: Key Terms

ACA	Affordable Care Act
APTC	Advance Payments of the Premium Tax Credit
ASC	Accredited Standards Committee
Cancellation of Health Coverage	End health coverage prior to the health coverage effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
CCIIO	Center for Consumer Information and Insurance Oversight
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
EDI	Electronic Data Interchange

EDS	Enrollment Data Store
EFT	Enterprise File Transfer
FEPS	Federal Exchange Program System
FF-SHOP	Federally Facilitated Small Business Health Option Program
FFE/FFM	Federally Facilitated Exchange/Marketplace operated by HHS
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
Hub	Data Services Hub Referred to as the Hub
IG	Implementation Guide
PHS	Public Health Service
QHP	Qualified Health Plan
MEC	Minimum Essential Coverage
SBE	State-Based Exchange
SFTP	Secure File Transfer Protocol
SHOP	Small Business Health Option Program
Termination of Health Coverage	Terminate (end-date) health coverage after the health coverage effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
Companion Guide Technical Information	The Technical Information (TI) section of the ASC X12 Template format for a Companion Guide which supplements an ASC X12 Technical Report Type 3 (TR3)

(TI)	
TR3	Type 3 Technical Report
XOC	eXchange Operational Support Center

1.7 Related Resources

This Premium Payment Companion Guide is one in a series of documents that describes and specifies communication between the Exchange and carriers. Below is a list of related guides and specifications. Current versions of these resources may be obtained at the DC Health Benefit Exchange Web site (see How to Contact Us).

Table 2: Related Resources

Resource	Description
CMS Companion Guide for the Federally Facilitated Exchange (FFE)	Provides information on usage of 834 transaction based on 005010X220 Implementation Guide and its associated 005010X220A1 addenda
Trading Partner Agreements (TPA)	Outlines the requirements for the transfer of EDI information between a Carrier and DC Exchange
DC Exchange Carrier Onboarding Document	Contains all the information required for Carrier to connect and communicate with the DC Exchange, i.e. machine addresses, security protocols, security credentials, encryption methods
DC Exchange Carrier Integration Manual	Provides a comprehensive guide to the services offered by DC Exchange
DC Exchange Benefit Enrollment Companion Guide	Provides technical information on 834 transactions supported by DC Exchange
DC Exchange Carrier Testing Document	Contains the testing strategy for DC Exchange – Carriers integration
DC Exchange Transaction Error Handling Guide	Provides details on exchange message validation and error handling
Employer Demographic XSD	XML schema definition for exchanging Employer Demographic information
Broker Demographic XSD	XML schema definition for exchanging Broker Demographic information
Reconciliation Report Template	Excel file template for Carriers to report and resolve discrepancies between Carrier and DC Exchange subscriber databases

1.8 How to Contact Us

The DC Exchange maintains a Web site with Trading Partner-related information along with email and telephone support:

- **Web**: http://dchbx.com/page/carrier-information
- **Email**: XXXX@XXX.com
- **Phone**: 1-XXX-XXX-XXXX

2 Electronic Communication with the DC Exchange

The DC Exchange will use EDI X12 standard formats in combination with non-EDI custom files to support the exchange of necessary information with Carriers.

2.1 EDI Standards Supported

The DC Exchange uses the EDI ASC X12N standard formats for exchanging benefit enrollment and premium payment remittance information. The specifications and versions are as follows:

Specification	Version
EDI X12 834	005010X220A1
EDI X12 820	005010X306
EDI X12 TA1	005010231A1: Interchange Acknowledgement
EDI X12 999	005010231A1: Implementation Acknowledgement

2.2 SNIP Level Validation

The DC Exchange and Carriers will follow the SNIP 1 and SNIP 2 edits mandated by HIPAA.

WEDI SNIP Level 1: EDI Syntax Integrity Validation Syntax errors, also referred to as Integrity Testing, targeted at the file level. This level verifies that valid EDI syntax for each type of transaction has been submitted. The transaction level will be rejected with a TA1 or 999 and sent back to the submitter.

Examples of these errors include, but are not limited to:

1. Date or time is invalid.
2. Telephone number is invalid.
3. Data element is too long.

WEDI SNIP Level 2: HIPAA Syntactical Requirement Validation. This level is for HIPAA syntax errors. This level is also referred to as Requirement Testing. This level will verify that the transaction sets adhere to HIPAA implementation guides.

Examples of these errors include, but are not limited to:

1. Invalid Social Security Number.
2. Missing/Invalid Patient information.
3. Patient's city, state, or zip is missing or invalid.
4. Invalid character or data element.

2.3 Connecting to the DC Exchange

The DC Exchange publishes secure Internet resources that a Carrier may access to exchange electronic information. Under the Trading Partner setup process, a Carrier completes the DC Exchange Onboarding Document.

The Onboarding Document collects information about Carrier technical contacts, network details and other information necessary to establish secure communication. Based on this information, the DC Exchange will configure networks, create credentials, generate keys and forward these to the Carrier along with information necessary to connect to DC Exchange resources.

2.4 File Transfer and Security

The DC Exchange uses Pretty Good Privacy (PGP) to provide a secured method of sending and receiving information between two parties. Using PGP, sensitive information in electronic files is protected during transmission over the open Internet. The DC Exchange will administer and issue PGP keys to Carriers that provide appropriate access to exchange file and enable email-based communications.

The DC Exchange provides a landing zone for the placement of incoming or outgoing files. This landing zone is a secured environment where each Carrier can conduct private transactions with the DC Exchange. The Carrier will use SSH FTP protocol to transfer files to and from the landing zone.

The DC Exchange will also support SSH SMTP services. Carriers and the Exchange can use this to send email messages that contain private or sensitive content.

2.5 File Types and Frequency

This document describes the use of 820 messages that will be used for both the Individual and Small Business Health Options Program (SHOP) markets as outlined below.

- Premium Remittance – 820 Messages used by DC Exchange to notify Carrier regarding receipt of payments of initial binder payments from individuals.
- Premium Remittance – 820 Messages used by Carrier to notify DC Exchange regarding receipt of payments of initial binder payments from individuals.
- Premium Payment Notification – 820 Messages used by a Carrier to notify DC Exchange regarding receipt of payment, other than the initial binder payment, from individuals.
- Premium Payment Notification – 820 Messages used by DC Exchange to notify Carrier regarding receipt of payments for initial and ongoing payments from SHOP employers.

DC Exchange and Carriers can accept binder payments from individuals. Only Carriers can accept subsequent payments from individuals. Only DC Exchange accepts payments from SHOP employers. Enrollment files and Payments are not transferred to the carriers until the payment has been received by DC Exchange and has cleared.

Table 3: Remittance/Notification File Type

DC Exchange	Transaction Type	DC Exchange to Carrier	Carrier to DC Exchange	Frequency
Individual	820 Binder Payment Remittance	X	X	DC Exchange to Carrier: 10th and 24th of every month at 10 AM EST Carrier to DC Exchange: Daily
	820 Ongoing Payment informational		X	Carrier to DC Exchange: Daily
	TA1 Interchange Acknowledgement	X	X	Upon Receipt of 820
	999 Functional Acknowledgement	X	X	Upon Processing of 820
SHOP	820 Binder Payment Remittance	X		DC Exchange to Carrier: 10th and 24th of every month at 10 AM EST
	820 Ongoing Payment Remittance	X		DC Exchange to Carrier: 10th and 24th of every month at 10 AM EST
	TA1 Interchange Acknowledgement	X		Upon Receipt of 820
	999 Functional Acknowledgement	X		Upon Processing of 820

Although broken out in the above table, all SHOP payments will be reported in a single file. Note: this is different than 834 enrollment and change notices, which will be broken out by employer groups.

2.6 File Naming

Files follow a naming convention as mentioned below which provides enough information about the file and its destination. Information is delimited by an underscore "_" to allow parsing.

[FileStandard_DateTime_IssuerID_GroupID_FileType_FileContent_ExchangeType.pgp]

e.g. 820_201305141422Z_CFBCI_INDIV_N_S_I.pgp

Table 4 explains the possible values of each file name part.

Table 4: File Naming Convention

File Name Part	Description	Possible Values
File Standard	File format Standard used	820
Date Time	UTC date and time in the format yyyyMMddHHmm. Suffix Z indicates UTC.	Example: 201305141422Z

File Name Part	Description	Possible Values
Carrier ID	Unique Issuer identifier. Carrier Name will be used here as that is the only common ID across systems.	Carrier IDs are established though trading partner agreements for a given exchange.
Group ID	The Exchange-issued Group ID. Where the file is for the individual market, this ID will be "INDIV"	Still under review
File Type	Whether this relates to non-payment or ACH transfer.	"N" Non-Payment – no money transfer "A" ACH – money is transferred via a separate ACH file
File Content	Whether this is a standard 820 file or an acknowledgement	"S" Standard 820 file "D" Audit file. File Type for audit files must always be N (Non-Payment) TA1 Technical Acknowledgement 999 Functional Acknowledgement
Exchange Type	Whether this is for Individual Exchange or SHOP Exchange	"I" Individual Exchange "S" SHOP Exchange

3 EDI Implementation

3.1 Character Set

1. As specified in the TR3, the basic character set includes uppercase letters, digits, space, and other special characters with the exception of those used for delimiters.
2. All HIPAA segments and qualifiers must be submitted in UPPERCASE letters only.
3. Suggested delimiters for the transaction are assigned as part of the trading partner set up.
4. DC Exchange Representative will discuss options with trading partners, if applicable.
5. To avoid syntax errors hyphens, parentheses, and spaces should not be used in values for identifiers. (Examples: Tax ID 123654321, SSN 123456789, Phone 8001235010)

3.2 820 Control Segments/Envelope

Trading partners should follow the Interchange Control Structure (ICS) guidelines for HIPAA located in the HIPAA Implementation Guides and CMS Guidance. The following sections address specific information needed by DC Exchange to process ASC X12N/005010X306-820 Payment Order/Remittance Advice Transaction Sets.

The DC Exchange will accept:

- ISA-IEA envelopes within a single physical file.
- GS-GE envelopes within a single ISA-IEA interchange.
- Multiple ST-SE envelopes within a single GS-GE functional group.

Table 5 lists information conveyed in the control segment.

Table 5: Control Segments

Element Name	Element	Value
Interchange Control Header	ISA	
Authorization Information Qualifier	ISA01	00 – No authorization information present
Security Information Qualifier	ISA03	00 – No security information present
Security Information	ISA04	This data element will be blank
Interchange ID Qualifier	ISA05	ZZ – Mutually defined
Interchange Sender ID	ISA06	Sender's Federal Tax ID
Interchange ID Qualifier	ISA07	ZZ – Mutually defined
Interchange Receiver ID	ISA08	Receiver's Federal Tax ID
Interchange Date	ISA09	Date of interchange
Interchange Time	ISA10	Time of interchange
Interchange Control Version Number	ISA12	00501

Element Name	Element	Value
Interchange Control Number	ISA13	A unique control number assigned by DC Exchange. Note that manual problem resolution may require the re-transmission of an existing control number.
Acknowledgement Requested	ISA14	1 – A TA1 is requested
Interchange Usage Indicator	ISA15	T – Test P - Production
Functional Identifier Code	GS01	"BE"
Application Sender's Code	GS02	Sender's Code (Usually, but not necessarily, the Sender's Federal Tax ID)
Application Receiver's Code	GS03	Receiver's Federal Tax ID

4 EDI 820 Supplemental Instructions

This section explains where the DC Exchange deviates from the published X12 820 EDI standards, such as extending loop definitions or constraining allowable codes. It also covers special circumstances where the DC Exchange has turned to non-EDI message exchange to support requirements beyond those envisioned under the standards.

Each section includes:

1) Transaction Details
2) Sequence Diagram
3) Header Elements
4) Transaction Detail Elements

This document describes the use of 820 messages that will be used for both the Individual and Small Business Health Options Program (SHOP) markets as outlined below.

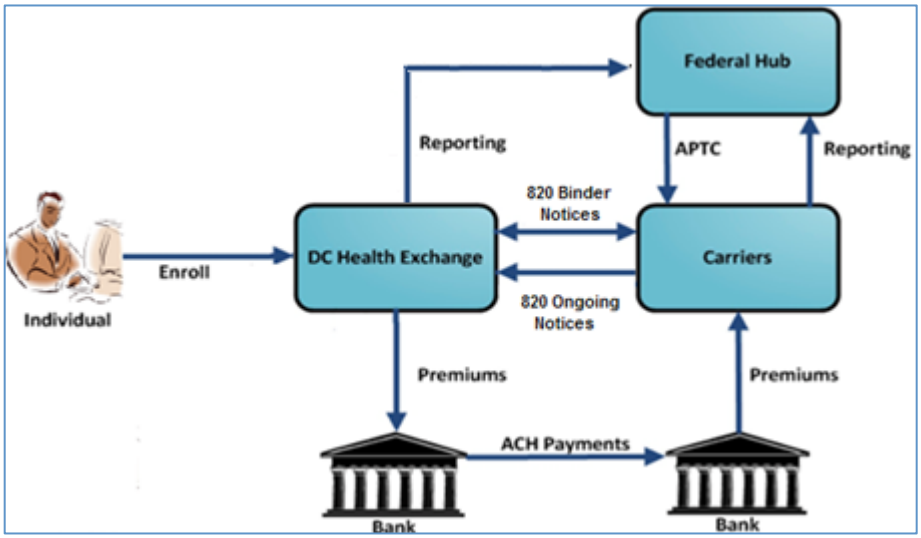

Figure 1: Information Flow - Individual

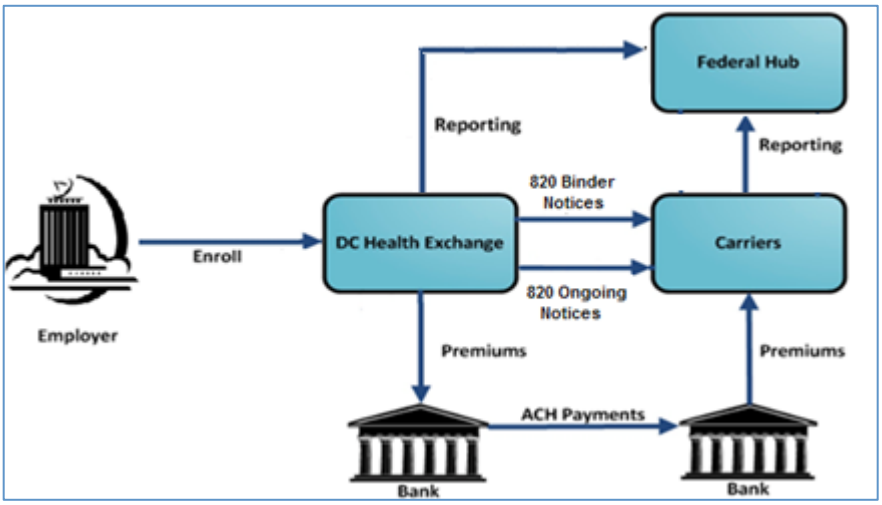

Figure 2: Information Flow - SHOP

4.1 Individual Binder Payments

Individuals always have a choice whether to pay the DC Exchange or carriers directly for the binder payments. When binder payments for individuals are received by DC Exchange, an 834 initial enrollment notice is sent to the Carrier only after full premium has been received and payment has cleared.

820 advice of binder payments for individuals are remitted from the DC Exchange to Carriers twice per month, on the 10th and 24th. Carriers must notify the DC Exchange of cleared binder payments on a daily basis. Table 6 shows specifications related to this transaction.

Table 6: Individual Binder Payment Transaction Details

Interaction Model	Batch
File Name	E.g. 820_201305141422Z_CFBCI_INDIV_N_S_I.pgp
Frequency	Twice Monthly
Inbound File Format	EDI X12 820 - Payment Order/Remittance Advice (5010) as format per the companion guide published by DC Exchange.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all remittance related data corresponding to the Carrier into an EDI X12 820 file format. Data is also customized per the DC Exchange published 820 Companion Guide.
Success	Receiving system sends EDI X12 TA1 to the transmitting system as an acknowledgement after no errors are found at the interchange level. Receiving system sends EDI X12 999 to the transmitting system as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

The sequence diagrams that follow capture the fact that some binder payments are being paid directly to carriers, not the Exchange.

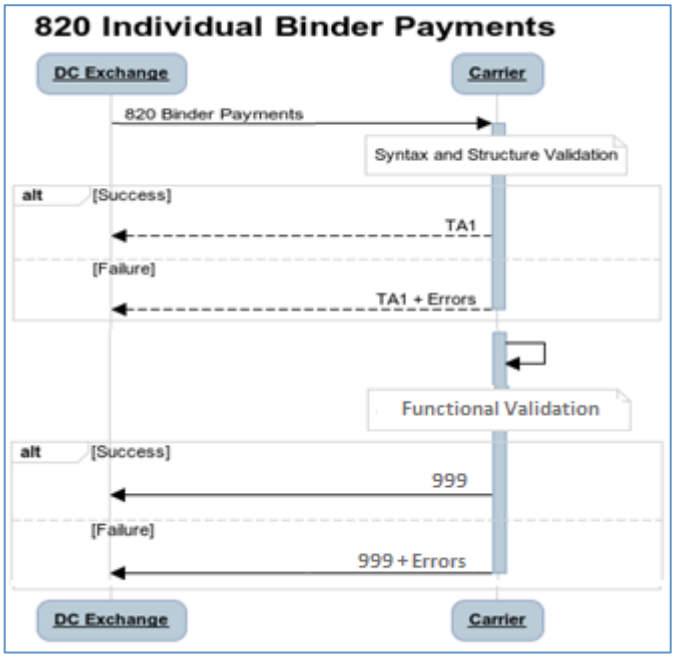

Figure 3: Individual Binder Payment Sequence - DC Exchange to Carrier

Figure 3 **Sequence:**

1) DC Exchange sends EDI X12 820 payment data file to the Carrier.
2) Carrier sends an acknowledgment (TA1) back to DC Exchange.
   a) Carrier sends a TA1 with errors in cases of syntactical errors.
3) Carrier processes file and sends a functional acknowledgment (EDI X12 999) back to the DC Exchange.
   a) Carrier sends a 999 with errors in cases of functional errors

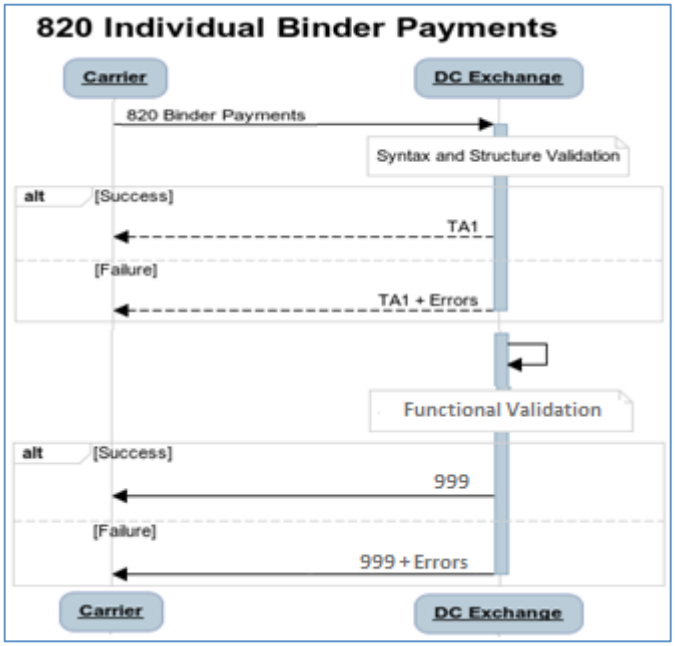

Figure 4: Individual Binder Payments - Carrier to DC Exchange

Figure 4 **Sequence:**

1) Carrier sends EDI X12 820 payments data file to DC Exchange.
2) DC Exchange sends an acknowledgment (TA1) back to the Carrier.
   a) DC Exchange sends a TA1 with errors in cases of syntactical errors.
3) DC Exchange processes the file and sends a functional acknowledgment (EDI X12 999) back to the Carrier.
   a) DC Exchange sends a 999 with errors in cases of functional errors.
4) Below table depicts important information related to this transaction

Table 7: Individual Binder Payment Header Elements

Loop	Element	Element Name	Code	Instruction
Header	ST	Transaction Set Header		
	ST01	Transaction Set Identifier Code	"820"	820 - Remittance Advice
	ST02	Transaction Set Control Number		A unique identifier. For remittance messages, this represents the identifier of the ACH transaction that moved the funds.
	ST03	Implementation Convention Reference	"005010X306"	Used for employer group and individual payments
	BPR	Beginning Segment for Remittance Advice		
	BPR01	Transaction Handling Code	"I"	I – Remittance Information Only.
	BPR02	Monetary Amount		Total amount of money transferred though ACH and detailed in this file.

Loop	Element	Element Name	Code	Instruction
	BPR03	Credit/Debit Flag Code	"C"	C – Credit
	BPR04	Payment Method	Blank	Funds will be transferred though a separate Automated Clearing House (ACH) file. There is an ACH Payment Method Code that is used when a single 820 file contains both the remittance data and the ACH file data. This type of 820 file must be processed by a bank and is not used in the Exchange.
	BPR16	Date		Payment effective date
	REF	Issuer Assigned Qualified Health Plan Identifier		
	REF01	Reference Identification Qualifier	TV	TV –Line of Business. This will be populated with the Employer's Group ID when appropriate.
	REF02	Reference Identification		Group ID.
	DTM	Coverage Period		
	DTM01	Date/Time Reference	"582"	582 – Report Period
	DTM05	Date Time Period Format Qualifier	"RD8"	Range of dates expressed in format CCYYMMDD-CCYYMMDD.
	DTM06	Date Time Period		Start and end dates for the coverage period. Exchange will only offer monthly plans, so date range will be from beginning to end of month for which payment was made.
1000A		Payee Loop		
	N1	Payee Name		This segment represents receipt of payments.
	N101	Entity Identifier Code	"PE"	PE – Payee
	N102	Name		Carrier's organization name.
	N103	Identification Code Qualifier		FI – Federal Taxpayer Identification Number
	N104	Identification Code		Carrier's Federal Taxpayer Identification Number
1000B		Payer Loop		
	N1	Payer's Name		This segment represents originator of the payments.
	N101	Entity Identifier Code	"RM"	Remitter Name
	N102	Name		DC Exchange
	N103	Identification Code Qualifier	"58"	Originating Company Number
	N104	Identification Code		Agreed upon code
	PER	Payer's Administrative Contact Information		
	PER01	Contact Function Code	"IC"	Indicates Contact Information
	PER02	Name		Agreed upon contact name

Loop	Element	Element Name	Code	Instruction
	PER03	Communication Qualifier Number	"TE"	Telephone
	PER04	Communication Number		Contact telephone number
	PER05	Communication Qualifier Number	"EM"	Electronic Mail
	PER06	Communication Number		Contact email address
	PER07	Communication Qualifier Number	"FX"	Facsimile
	PER08	Communication Number		Contact fax number

Table 8: 820 Individual Binder Payment Detail Elements

Loop	Element	Element Name	Code	Instruction
2000	ENT	Remittance Information		
	ENT01	Assigned Number		Sequential Number of the Loop Detail (starting at 1)
2100	NM1	Individual Name		
	NM101	Entity Identifier Code	"IL"	Insured or Subscriber
	NM102	Entity Type Qualifier	"1"	"Person"
	NM103	Last Name		Last name of the subscriber.
	NM104	First Name		First name of the subscriber.
	NM108	Identification Code Qualifier	"C1"	Insured or Subscriber
	NM109	Identification Code		The Exchange assigned Subscriber Identification Number.
2100	REF	Issuer Assigned Qualified Health Plan Identifier		This segment will be transmitted only for payments related to plans for Individuals.
	REF01	Reference Identification Qualifier	"TV"	TV – Line of Business
	REF02	Reference Identification		The Carrier's health plan identifier will be provided here.
2100	REF	Issuer Assigned Employer Group Identifier		This segment will be transmitted only for payments related to SHOP
	REF01	Reference Identification Qualifier	"1L"	1L – Group or Policy Number
	REF02	Reference Identification		For payments related to an Employer Group, the Carrier's Group identifier will be provided here.
2300	RMR	Remittance Detail		

Loop	Element	Element Name	Code	Instruction
	RMR01	Reference Identification Qualifier	"ZZ"	Exchange Payment Type.
	RMR02	Reference Payment Type		Premium Payment
	RMR04	Monetary Amount		Provide amount of payment or adjustment associated with this insured. Note that values corresponding to an adjustment may be negative.
2300	DTM	Individual Coverage Period		This segment will communicate the start and end dates related to the payment.
	DTM01	Date/Time Qualifier	"582"	582 – Report Period.
	DTM05	Date Time Period Format Qualifier		RD8 – CCYYMMDD – CCYYMMDD
	DMT06	Date Time Period		Date range corresponding to the premium payment. This will match the premium payment coverage period.

4.2 Individual Ongoing Payments

Ongoing payments are paid directly to Carrier. Advice of these payments in 820 format must be reported to the DC Exchange on a daily basis. **Error! Reference source not found.** shows specifications related to this transaction.

Table 9: Individual Ongoing Payment Transaction Details

Interaction model	Batch
File Name	E.g. 820_201305141422Z_CFBCI_INDIV_N_S_I.pgp
Inbound File Format	EDI X12 820 - Payment Order/Remittance Advice (5010) as format per the companion guide published by DC Exchange.
Outbound File Format	E EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)DI X12 TA1 -Interchange Acknowledgement (5010)
Exchange Process	Carrier compiles all remittance data related to ongoing payments by the subscribers into an EDI X12 820 file format. Data is also customized per the DC Exchange published 820 Companion Guide.
Success	Receiving system sends EDI X12 TA1 to the transmitting system as an acknowledgement after no errors are found at the interchange level. Receiving system sends EDI X12 999 to the transmitting system as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to Validation and Error Handling

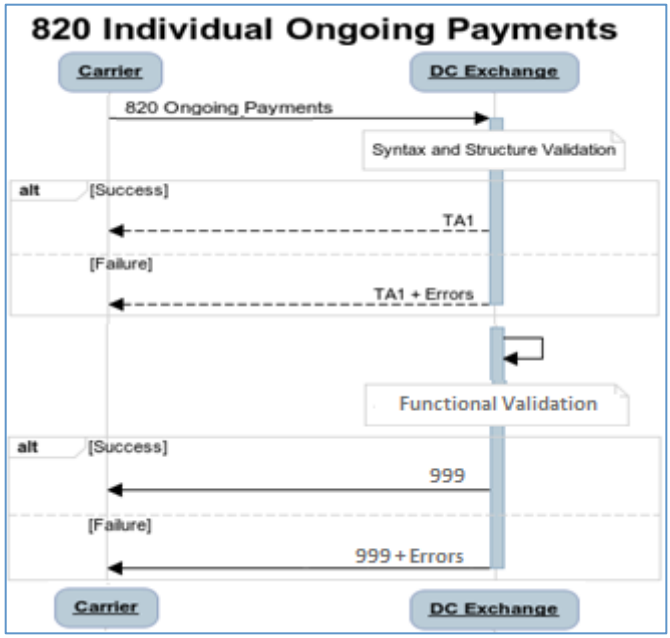

Figure 5: 820 Individual Ongoing Payments Sequence Diagram

Figure 5 **Sequence:**

1) Carrier sends EDI X12 820 payments data file to DC Exchange.
2) DC Exchange sends an acknowledgment (TA1) back to the Carrier.
   a) DC Exchange sends a TA1 (with errors) in cases of syntactical errors.
3) DC Exchange processes file and sends a functional acknowledgment (EDI X12 999) back to the Carrier.
   a) DC Exchange sends a 999 with errors in cases of functional errors.

Table 10: 820 Ongoing Payment Header Elements

Loop	Element	Element Name	Code	Instruction
Header	ST	Transaction Set Header		
	ST01	Transaction Set Identifier Code	"820"	820 - Remittance Advice
	ST02	Transaction Set Control Number		A unique identifier. For remittance messages, this represents the identifier of the ACH transaction that moved the funds.
	ST03	Implementation Convention Reference	"005010X306"	Used for employer group and individual payments
	BPR	Beginning Segment for Remittance Advice		
	BPR01	Transaction Handling Code	"I"	I – Remittance Information Only

Loop	Element	Element Name	Code	Instruction
	BPR02	Monetary Amount	0.00	No money is actually transferred
	BPR03	Credit/Debit Flag Code	"C"	C – Credit
	BPR04	Payment Method	"NON"	Non-Payment data
	BPR16	Date		Payment effective date
	REF	Issuer Assigned Qualified Health Plan Identifier		
	REF01	Reference Identification Qualifier	TV	TV –Line of Business
	REF02	Reference Identification		Group ID
	DTM	Coverage Period		
	DTM01	Date/Time Reference	"582"	582 – Report Period
	DTM05	Date Time Period Format Qualifier	"RD8"	Range of dates expressed in format CCYYMMDD-CCYYMMDD.
	DTM06	Date Time Period		Start and end date for coverage period. Exchange will only offer monthly plans, so this date range will be from beginning to end of the month for which payment was made.
1000A		Payee Loop		
	N1	Payee Name		This segment represents the received of the payments.
	N101	Entity Identifier Code	"PE"	PE – Payee
	N102	Name		DC Exchange
	N103	Identification Code Qualifier		FI – Federal Taxpayer Identification Number
	N104	Identification Code		The Exchange Federal Taxpayer Identification Number
1000B		Payer Loop		
	N1	Payer's Name		This segment represents the originator of the payments.
	N101	Entity Identifier Code	"RM"	Remitter Name
	N102	Name		Carrier's organization name.
	N103	Identification Code Qualifier	"58"	Originating Company Number
	N104	Identification Code		Agreed upon code for Carrier
	PER	Payer's Administrative Contact Information		
	PER01	Contact Function Code	"IC"	Indicates Contact Information
	PER02	Name		Agreed upon contact name

Loop	Element	Element Name	Code	Instruction
	PER03	Communication Qualifier Number	"TE"	Telephone
	PER04	Communication Number		Contact telephone number
	PER05	Communication Qualifier Number	"EM"	Electronic Mail
	PER06	Communication Number		Contact E-mail address
	PER07	Communication Qualifier Number	"FX"	Facsimile
	PER08	Communication Number		Contact fax number

Table 11: 820 Ongoing Payment Detail Elements

Loop	Element	Element Name	Code	Instruction
2000	ENT	Remittance Information		
	ENT01	Assigned Number		Sequential Number of the Loop Detail (starting at 1)
2100	NM1	Individual Name		
	NM101	Entity Identifier Code	"IL"	Insured or Subscriber
	NM102	Entity Type Qualifier	"1"	"Person"
	NM103	Last Name		Last name of the subscriber.
	NM104	First Name		First name of the subscriber.
	NM108	Identification Code Qualifier	"C1"	Insured or Subscriber
	NM109	Identification Code		The Exchange assigned Subscriber Identification Number.
2100	REF	Issuer Assigned Qualified Health Plan Identifier		This segment will be transmitted only for payments related to plans for Individuals.
	REF01	Reference Identification Qualifier	"TV"	TV – Line of Business
	REF02	Reference Identification		The Carrier's health plan identifier will be provided here.
2100	REF	Issuer Assigned Employer Group Identifier		This segment will be transmitted only for payments related to SHOP.
	REF01	Reference Identification Qualifier	"1L"	1L – Group or Policy Number
	REF02	Reference Identification		For payments related to an Employer Group, the Carrier's Group identifier will be provided here.
2300	RMR	Remittance Detail		
	RMR01	Reference Identification Qualifier	"ZZ"	Exchange Payment Type
	RMR02	Reference Payment Type		Premium Payment
	RMR04	Monetary Amount		Provide amount of payment or adjustment associated with this insured. Note that values corresponding to an adjustment may be negative.
2300	DTM	Individual Coverage Period		This segment will communicate the start and end dates related to the payment.
	DTM01	Date/Time Qualifier	"582"	582 – Report Period
	DTM05	Date Time Period Format Qualifier		RD8 – CCYYMMDD – CCYYMMDD

Loop	Element	Element Name	Code	Instruction
	DMT06	Date Time Period		Date range corresponding to premium payment. This will match the premium payment coverage period.

4.3 SHOP Payments

SHOP payments are always paid from the DC Exchange to the Carrier. 820 advice of SHOP payments are remitted from the DC Exchange to Carriers twice per month, on the 10th and 24th. Table 12 shows specifications related to this transaction.

Table 12: 820 SHOP Payment Details

Interaction Model	Batch
File Name	E.g. 820_201305141422Z_CFBCI__GRPID_N_S_S.pgp
Frequency	Twice Monthly
Inbound File Format	EDI X12 820 - Payment Order/Remittance Advice (5010) as format per the companion guide published by DC Exchange.
Outbound File Format	EDI X12 TA1 -Interchange Acknowledgement (005010231A1) / EDI X12 999 – Functional Acknowledgement (005010231A1)
Exchange Process	DC Exchange compiles all the SHOP payment related data corresponding to the Carrier into an EDI X12 820 file format. Data is also customized per the DC Exchange published 820 Companion Guide.
Success	Carrier sends EDI X12 TA1 to DC Exchange as an acknowledgement after no errors are found at the interchange level. Carrier sends EDI X12 999 to DC Exchange as an acknowledgement after no errors are found at the functional group level.
Failure	Refer to section 13.2.4 820 Error Transaction

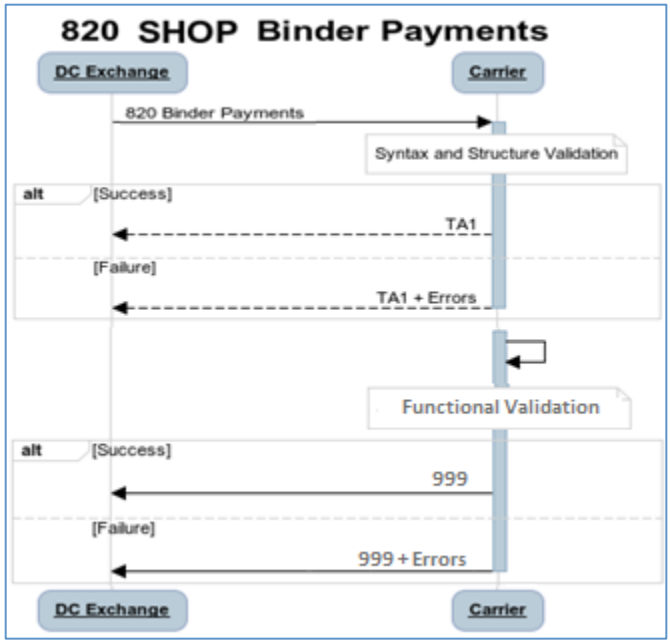

Figure 6: SHOP Binder Payments Sequence Diagram

Figure 6 **Sequence:**

1) DC Exchange sends EDI X12 820 payments data file to Carrier.
2) Carrier sends an acknowledgment (TA1) back to DC Exchange.
   a) Carrier sends a TA1 (with errors) in cases of syntactical errors.
3) Carrier processes file and sends a functional acknowledgment (EDI X12 999) back to DC Exchange.
   a) Carrier sends a 999 with errors in cases of functional errors.

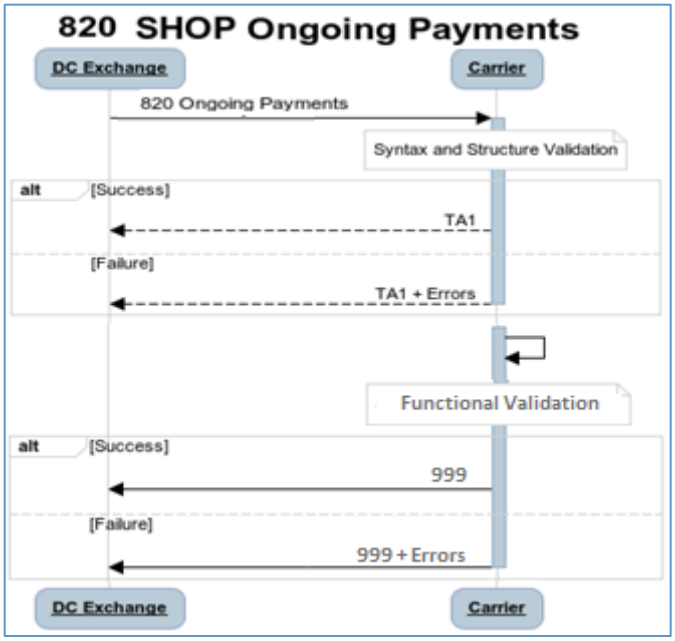

Figure 7: SHOP Ongoing Payments Sequence Diagram

Figure 7 **Sequence:**

1) DC Exchange sends EDI X12 820 payments data file to Carrier.
2) Carrier sends acknowledgment (TA1) back to DC Exchange.
   a) Carrier sends a TA1 (with errors) in cases of syntactical errors.
3) Carrier processes file and sends a functional acknowledgment (EDI X12 999) back to DC Exchange.
   a) Carrier sends a 999 with errors in cases of functional errors.

Table 13: 820 SHOP Payment Header Elements

Loop	Element	Element Name	Code	Instruction
Header	ST	Transaction Set Header		
	ST01	Transaction Set Identifier Code	"820"	820 - Remittance Advice
	ST02	Transaction Set Control Number		A unique identifier. For remittance messages, this represents identifier of the ACH transaction that moved the funds.
	ST03	Implementation Convention Reference	"005010X306"	Used for employer group and individual payments.
	BPR	Beginning Segment for Remittance Advice		
	BPR01	Transaction Handling Code	"I"	I – Remittance Information Only.
	BPR02	Monetary Amount		Total amount of money transferred though ACH and detailed in this file.

Loop	Element	Element Name	Code	Instruction
	BPR03	Credit/Debit Flag Code	"C"	C – Credit
	BPR04	Payment Method	blank	Funds will be transferred though a separate Automated Clearing House (ACH) file. There is an ACH Payment Method Code. This code is used when a single 820 file contains both the remittance data and the ACH file data. This type of 820 file must be processed by a bank and is not used in the Exchange.
	BPR16	Date		Payment effective date
	REF	Issuer Assigned Qualified Health Plan Identifier		
	REF01	Reference Identification Qualifier	TV	TV –Line of Business. This will be populated with the Employer's Group ID when appropriate.
	REF02	Reference Identification		Group ID.
	DTM	Coverage Period		
	DTM01	Date/Time Reference	"582"	582 – Report Period.
	DTM05	Date Time Period Format Qualifier	"RD8"	Range of dates expressed in the format CCYYMMDD-CCYYMMDD.
	DTM06	Date Time Period		This is the start and end date for the coverage period. The Exchange will only offer monthly plans, so this date range will be from the beginning to the end of the month for which payment was made.
1000A		Payee Loop		
	N1	Payee Name		This segment represents the received of the payments.
	N101	Entity Identifier Code	"PE"	PE – Payee
	N102	Name		The Carrier's organization name.
	N103	Identification Code Qualifier		FI – Federal Taxpayer Identification Number
	N104	Identification Code		The Carrier's Federal Taxpayer Identification Number
1000B		Payer Loop		
	N1	Payer's Name		This segment represents the originator of the payments
	N101	Entity Identifier Code	"RM"	Remitter Name
	N102	Name		DC Exchange
	N103	Identification Code Qualifier	"58"	Originating Company Number
	N104	Identification Code		Agreed upon code
	PER	Payer's Administrative Contact		

Loop	Element	Element Name	Code	Instruction
		Information		
	PER01	Contact Function Code	"IC"	Indicates Contact Information
	PER02	Name		Agreed upon contact name
	PER03	Communication Qualifier Number	"TE"	Telephone
	PER04	Communication Number		Contact telephone number
	PER05	Communication Qualifier Number	"EM"	Electronic Mail
	PER06	Communication Number		Contact E-mail address
	PER07	Communication Qualifier Number	"FX"	Facsimile
	PER08	Communication Number		Contact fax number

Table 14: 820 SHOP Enrollment Payment Detail Elements

Loop	Element	Element Name	Code	Instruction
2000	ENT	Remittance Information		
	ENT01	Assigned Number		Sequential Number of the Loop Detail (Starting at 1)
2100	NM1	Group Name		
	NM101	Entity Identifier Code	"IL"	Insured or Subscriber
	NM102	Entity Type Qualifier	"1"	"Person"
	NM103	Last Name		Last name of the subscriber.
	NM104	First Name		First name of the subscriber.
	NM108	Identification Code Qualifier	"C1"	Insured or Subscriber
	NM109	Identification Code		The Exchange assigned Subscriber Identification Number.
2100	REF	Issuer Assigned Employer Group Identifier		This segment will be transmitted only for payments related to SHOP
	REF01	Reference Identification Qualifier	"1L"	1L – Group or Policy Number
	REF02	Reference Identification		For payments related to an Employer Group, the Carrier's Group identifier will be provided here.
2300	RMR	Remittance Detail		
	RMR01	Reference Identification Qualifier	"ZZ"	Exchange Payment Type
	RMR02	Reference Payment Type		Premium Payment
	RMR04	Monetary Amount		Provide amount of payment or adjustment associated with this insured. Note that values corresponding to an adjustment may be negative.
2300	DTM	Group Coverage Period		This segment will communicate the start and end dates related to the payment.

Loop	Element	Element Name	Code	Instruction
	DTM01	Date/Time Qualifier	"582"	582 – Report Period
	DTM05	Date Time Period Format Qualifier		RD8 – CCYYMMDD – CCYYMMDD
	DMT06	Date Time Period		Date range corresponding to the premium payment. This will match the premium payment coverage period.

4.4 Adjustments

Table 15 lists payment codes defined by CMS for Loop 2300 RMR02. None of these codes can be used for adjustments to the premium itself.

Table 15: CMS-Defined Payment Codes (May 2013)

Code	Definition
APTC	Advance Payment of Premium Tax Credit. The RMR 04 segment will be positive.
APTCADJ	Advance Payment of Premium Tax Credit Adjustment. The RMR 04 segment will be positive or negative.
APTCMADJ	APTC Manual Adjustment. Used to show APTC manual adjustment when enrollment group level information is not applicable. The RMR 04 segment will be positive or negative and may be reversed in the future.
BAL	Balancing Amount. Only used when reporting to State-Based Marketplace. The RMR04 segment will be positive.
CSR	Advance Payment of Cost Sharing Reduction. The RMR 04 segment will be positive.
CSRADJ	Advance Payment of Cost Sharing Reduction Adjustment. The RMR 04 segment will be positive or negative.
CSRMADJ	CSR Manual Adjustment. Used to show CSR manual adjustment when enrollment group level information is not provided. The RMR 04 segment will be positive or negative and may be reversed in the future.
CSRN	Cost Sharing Reduction Reconciliation. The RMR 04 segment will be positive or negative.
CSRNADJ	Cost Sharing Reduction Reconciliation Adjustment. The RMR 04 segment will be positive or negative.
DEBTADJ	Payee's debt amount was covered by an affiliate's payment. The RMR04 segment will be positive.
FPLPNT	Used to show offsets for Treasury's Federal Payment Levy Program for Non-Tax related debt. The RMR 04 segment will be a negative amount.
FPLPT	Used to show offsets for Treasury's Federal Payment Levy Program for Tax related debt. The RMR 04 segment will be a negative amount.
INVOICE	Used to show a total amount that will be billed or otherwise collected. Only used when BPR 02 would otherwise be negative.
RA	Risk Adjustment Program payment or charge amount. The RMR 04 segment will be positive or

Code	Definition
	negative.
RAADJ	Risk Adjustment Payment or Charge Adjustment. The RMR 04 segment will be positive or negative.
RAUF	Risk Adjustment User Fee. The RMR 04 segment will be negative.
RAUFADJ	Risk Adjustment User Fee negative. Adjustment. The RMR 04 segment will be positive or negative
RC	Risk Corridor Program payment or charge amount. The RMR 04 segment will be positive or negative.
RCADJ	Risk Corridor Adjustment. The RMR 04 segment will be positive or negative.
REDUCED	Payment reduced to cover an outstanding debt owed by the payee or their affiliates. The RMR04 segment will be negative.
RIC	Reinsurance Contribution Amount. The RMR 04 segment will be negative.
RICADJ	Reinsurance Contribution Adjustment. The RMR 04 segment will be positive or negative.
RIP	Reinsurance Payment Amount. The RMR 04 segment will be positive.
RIPADJ	Reinsurance Payment Adjustment. The RMR 04 segment will be positive or negative.
UF	Federally facilitated Marketplace User Fee. The RMR 04 segment will be negative.
UFADJ	Federally facilitated Marketplace User Fee Adjustment. The RMR 04 segment will positive or negative.
UFMADJ	Federally facilitated Marketplace User Fee Manual Adjustment. Used to show use fee manual adjustment when enrollment group level information is not provided. The RMR 04 segment will be positive or negative and may be reversed in the future.

4.5 Adjustment for Life-Event

This adjustment is used where a member has a life event that caused a change to the premium amount.

Table 16: Sample Premium Adjustment

2100	NM1	Individual Name	Code	Instruction
	NM101	Entity Identifier Code	"IL"	Insured or Subscriber
	NM102	Entity Type Qualifier	"1"	"Person"
	NM103	Last Name	Smith	Last name of the subscriber.
	NM104	First Name	Joe	First name of the subscriber.
	NM108	Identification Code Qualifier	"C1"	Insured or Subscriber
	NM109	Identification Code	99999	The Exchange assigned Subscriber Identification Number.
2100	REF	Issuer Assigned Qualified Health Plan Identifier	X	This segment will be transmitted only for payments related to plans for Individuals.

2100	NM1	Individual Name	Code	Instruction
	REF01	Reference Identification Qualifier	"TV"	TV – Line of Business
	REF02	Reference Identification	X	The Carrier's health plan identifier will be provided here.
2300	RMR	Remittance Detail		
	RMR01	Reference Identification Qualifier	"ZZ"	Exchange Payment Type
	RMR02	Reference Payment Type	"PADJ"	Premium adjustment
	RMR04	Monetary Amount	-999	Reverse the Individual or SHOP employee-only premium amount.
2300	DTM	Individual Coverage Period		This segment will communicate the start and end dates related to the payment.
	DTM01	Date/Time Qualifier	"582"	582 – Report Period
	DTM05	Date Time Period Format Qualifier		RD8 – CCYYMMDD – CCYYMMDD
	DMT06	Date Time Period		Date range for the premium adjustment.
2300	RMR	Remittance Detail		
	RMR01	Reference Identification Qualifier	"ZZ"	Exchange Payment Type
	RMR02	Reference Payment Type	"APTCADJ"	Adjust previous APTC amount.
	RMR04	Monetary Amount	-999	Reverse the original APTC amount.
2300	DTM	Individual Coverage Period		This segment will communicate the start and end dates related to the payment.
	DTM01	Date/Time Qualifier	"582"	582 – Report Period
	DTM05	Date Time Period Format Qualifier		RD8 – CCYYMMDD – CCYYMMDD
	DMT06	Date Time Period		Date range for the premium adjustment
2300	RMR	Remittance Detail		
	RMR01	Reference Identification Qualifier	"ZZ"	Exchange Payment Type
	RMR02	Reference Payment Type	"PREM"	Premium adjustment
	RMR04	Monetary Amount	999	The premium amount
2300	DTM	Individual Coverage Period		This segment will communicate start and end dates related to the payment.
	DTM01	Date/Time Qualifier	"582"	582 – Report Period.
	DTM05	Date Time Period Format Qualifier		RD8 – CCYYMMDD – CCYYMMDD
	DMT06	Date Time Period		Date range for the premium adjustment
2300	RMR	Remittance Detail		
	RMR01	Reference Identification Qualifier	"ZZ"	Exchange Payment Type
	RMR02	Reference Payment Type	"APTC"	Adjust previous APTC amount
	RMR04	Monetary Amount	999	New APTC amount
2300	DTM	Individual Coverage Period		This segment will communicate start and end dates related to the payment.

2100	NM1	Individual Name	Code	Instruction
	DTM01	Date/Time Qualifier	"582"	582 – Report Period.
	DTM05	Date Time Period Format Qualifier		RD8 – CCYYMMDD – CCYYMMDD
	DMT06	Date Time Period		Date range for the premium adjustment

5 Monthly Reconciliation File Processes

In the initial stages of the DC Exchange operation, payment reconciliation will take place on an as-needed basis. The intention is to identify anomalies and exceptions scenarios as early as possible, in an effort to respond quickly and minimize the impact of issues.

DC Exchange requires that a Carrier reconcile payment files with the exchange no less than once a month.

5.1 Payment Reconciliation Process:

DC Exchange will send two separate payment files to the Carrier for reconciliation purposes on monthly basis.

1. File containing all Individual payment data to Carrier.
2. File containing all SHOP payment data to Carrier.

We expect the above file to contain the cumulative payment information between the DC Exchange and a Carrier at any given point of time for a benefit year.

Carriers need to analyze and reconcile the files with the data in their systems. Carriers can contact DC Exchange customer support if there are any questions or discrepancies.

6 Validation and Error Handling

All EDI transactions on the DC Exchange will use the X12 TA1/999 interchange and implementation acknowledgement protocols. For details on error handling process refer to DC Exchange Transaction Error Handling Guide.

Appendix J

DCHBX Enrollment Timeline

Billing & Enrollment Timelines

July 2013
Version 1

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DC Health Link Billing & Enrollment Timelines

1 Introduction and History

In preparation for the launch of DC Health Link on October 1, 2013, the Plan Management Advisory Committee engaged health insurance carriers in a series of discussions regarding enrollment and premium billing timelines for plans sold on the exchange. This document defines these timelines. The District of Columbia will apply these timelines contained in this document to all plans sold in the DC Health Link marketplace in 2014.

Exhibit 1: Definition of Terms

Term	Definition
ACA	"Affordable Care Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended.
APTC	An advanced premium tax credit created by the ACA which takes the form of a Premium subsidy for eligible Individuals who purchase a QHP through the Exchange. The APTC will be paid directly from the US Government to Issuers on behalf of an eligible Individual in order to reduce the Individual's Premium.
Carrier	Insurance issuer that offers qualified health plans on DC Health Link.
CMS	Centers for Medicare and Medicaid Services. CMS is a department within the US Department of Health and Human Services.
Due Date	The date on which the Premium for a month of insurance coverage is due. In DC Health Link, the Due Date for a given Premium month will always be the date immediately preceding the Premium Month (i.e. the Due Date for the July 2014 Premium month will be June 30, 2014). Payment will be considered made on the date that the payment has cleared.
Exchange or DC HBX or DC Health Link	The ACA provides for insurance exchanges in each state known as American Health Benefits (AHB) Exchanges. President Obama describes Exchanges as, "a market where Americans can one-stop shop for a health care plan, compare benefits and prices, and choose the plan that's best for them." In the District, the State's Exchange is named DC Health Link
Employee	An employee and his/her dependents who select health insurance though DC Health Link by virtue of the Employer's participation in the Exchange. The Exchange will invoice Employers for one hundred percent of the Employees' aggregated insurance premiums, and the premiums will be paid by the Employer to the Exchange. Any Employee contributions towards premiums will be accomplished between the Employer and the Employee via payroll deduction.
Employer	A small business with 50 or fewer full-time equivalent employees with at least one place of business in the District of Columbia which participates in DC Health Link in order to allow the Employer's Employees to select health insurance coverage through the Exchange.
FPL	Federal Poverty Level
Grace Period	Grace Periods only apply after an Individual or Employer satisfies the first Premium. A Grace Period is a period of time after the Due Date for a given Premium Month during which an Individual or Employer who fails to pay the given month's Premium by the Due Date may still pay their full Premium to ensure continued coverage. Individuals and Employers who fail to pay a Premium by its Due Date and who enter a Grace Period must pay the entire outstanding Premium(s) due by the end of their Grace Period in order to exit the Grace Period and return to good standing.
Individual or Consumer	An individual (and his/her dependent(s), if any) who purchases health insurance through the Individual & Family Market of DC Health Link.
Open Enrollment	The annual period of time during which Individuals and Employees may shop for

	coverage in DC Health Link.
Plan	An insurance product in which an Individual/Employee and/or his/her family members is enrolled.
Premium	The amount of money owed by an Individual or Employer (on behalf of the Employer's Employees) for a Billing Period to remain covered under a Plan.
Premium Adjustment	A positive or negative dollar adjustment to the premium invoice, based on an enrollment change.
Premium Month	A calendar month of insurance coverage for which a Plan Premium must be paid in order to procure coverage.
Qualified Health Plan (QHP)	A term defined by the ACA that refers to the medical and dental plans offered by an approved carrier on DC Health Link.
Special Enrollment Period (SEP)	A period of time, other than annual open enrollment, during which individuals or employees are eligible to enroll in the Exchange if the experience certain events. <u>Individual Market (45 C.F.R. §155.420)</u> Length of SEP is 60 days from the triggering event. Circumstances triggering an SEP include: 1. Loss of minimum essential coverage (MEC); 2. Gain a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption; 3. An individual who was not previously a citizen, national, or lawfully present gains such status; 4. Newly eligible for APTC due to change in circumstance; 5. Permanent move to the District; 6. An Individual with Indian status; 7. Becomes eligible as a result of an error in the eligibility process at the Exchange or a QHP violates a material provision of its contract; or 8. Other circumstances determined by DC Health Link or by HHS. <u>Small Employer Market (45 C.F.R. §155.725(j)(1))</u> Length of SEP is 30 days from the triggering event (unless otherwise indicated). 1. Loss of minimum essential coverage (MEC); 2. Gain a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption; 3. Permanent move to the District; 4. Gain or Loss of eligibility for Medicaid/CHIP which may include premium assistance towards employer-sponsored coverage (60-day SEP); 5. An Individual with Indian status; or 6. Becomes eligible as a result of an error in the eligibility process at the Exchange or a QHP violates a material provision of its contract. Eligibility for several SEPs are at the discretion of DC Health Link.

1.1 Payment Methods & Processing Time

Electronic payments, including online check and credit/debit card, are processed immediately. Mailed payments, including money orders and cashiers checks, are generally processed as soon as they are received. Personal or business checks submitted by mail will be processed upon receipt but payment will not be considered "cleared" until after a period of 5 business days has elapsed.

2 Individual & Family Market - Enrollment & Billing Timeline

DC Health Link will only collect Individual & Family Market premiums for the initial or "binder" payment to ensure that enrollment in a QHP is effectuated in an efficient and timely manner. The 1st month's premium invoice will be generated upon QHP selection through DC Health Link. This process applies both upon initial plan selection and when an individual changes to another carrier's plan. Individuals will always be able to choose to make the initial payment directly to the Carrier if they choose to do so.

After the initial premium payment is made to DC Health Link, all subsequent payments must be made by an individual to their Carrier, unless the individual changes carriers. Payment grace periods are outlined in a later section.

2.1 Individual & Family Market – Open Enrollment Timeline

The 2014 Open Enrollment Period in the Individual Exchange begins October 1, 2013 through March 31, 2014, for coverage effective no earlier than January 1, 2014. Individuals will be encouraged through all Exchange communications to register for the Exchange and select their QHPs early. In order to ensure that Carriers will have time to fully effectuate coverage by January 1, Individuals will be informed that they should select QHPs and promptly pay the 1st month's premium so that it is received, processed, and cleared no later than December 20, 2013. Individuals who select a QHP and submit 1st month's premium payment after December 20, 2013 will have a later coverage effective date as outlined below.

Exhibit 2: Individual & Family Market Enrollment Timeline – 2014 Open Enrollment Period

Date	Item		
October 1, 2013	Open Enrollment for 2014 plan year begins. Upon selection of a QHP, the individual will be able to immediately pay 1st month's premium online through DC Health Link, or will be able to choose to pay the carrier directly. If the individual chooses to pay the carrier directly, the carrier will send the individual an invoice for the 1st month's premium and effectuate coverage according to the payment receipt schedule outlined below. If the individual chooses to pay through DC Health Link but does not pay online the day of QHP selection, DC Health Link will mail an invoice to the individual for 1st month's premium. DC Health Link will not send enrollment information to Carriers and coverage will not take effect until a QHP has been selected and 1st month's premium payment has be received, processed and cleared.		
	QHP selected:	1st Month Premium Paid By:	Coverage Effective Date
	By December 20, 2013	December 20, 2013	January 1, 2014
	December 21, 2013 - January 20, 2014	January 20, 2014	February 1, 2014
	January 21, 2014 – February 20, 2014	February 20, 2014	March 1, 2014
	February 21, 2014 – March 20, 2014	March 20, 2014	April 1, 2014
	March 21, 2014 – March 31, 2014	April 20, 2014	May 1, 2014

Exhibit 3: Individual & Family Market Enrollment Timeline – 2015 or later Open Enrollment Periods

Date	Item
October 1st	Open Enrollment begins for coverage effective January 1st of the following calendar year. <u>Individuals Already Enrolled in DC Health Link:</u> Current QHP selection will remain in effect unless the individual elects to change QHPs or if the individual's current QHP is no longer available. If the individual changes QHPs to one offered by: • Current carrier, then the individual will continue premium payments directly with the carrier. DC Health Link will not collect any premium payments. • New carrier, then the individual's 1st month's premium must be received, processed, and cleared by December 20th. Payment can be made through DC Health Link or directly to the Carrier. <u>Individuals Newly Enrolling in DC Health Link:</u> Upon selection of QHP, the individual will be able to immediately pay 1st month's premium online through DC Health Link or indicate that he/she would rather pay the Carrier directly. If individual elects to pay Carrier directly, DC Health Link will send the Carrier the individual's enrollment and the Carrier will send an invoice for the 1st month's premium to the individual. If the individual elects to pay DC Health Link but does not pay 1st month's premium by the end of the day the QHP was selected, then DC Health Link will send an invoice for the 1st month's premium to the individual.
December 7th	Last day to select a QHP for the new plan year.
December 20th	Last day to pay 1st month's premium for new plan year, if owed. Payments must be received, processed, and cleared by December 20th in order to be considered timely payment.
December 21st	If payment owed and not received, processed, and cleared by December 20th, notice of non-enrollment generated.

2.2 Individual & Family Market – Open Enrollment Timeline for Individuals with Eligibility Inconsistencies

Pursuant to 45 C.F.R. 155.315(f)(4), individuals whose eligibility cannot be verified will be given conditional eligibility during a 90-day inconsistency period, which can be extended to 120 days upon request. During this period, the inconsistencies must be resolved either through subsequent data matches or through the provision of physical documentation by the enrollee. Based on the information received, an enrollee's eligibility or the amount of their APTC/CSR may change during the inconsistency period. Additionally, once the inconsistency period expires, the Exchange must redetermine eligibility based on the most up-to-date information it has (including information that was provided by the enrollee). If, based on the available information, the individual has not verified residency, citizenship/immigration status, or incarceration status, his/her coverage will be terminated. Additionally, using data sources on income, household size, and access to other coverage, the enrollee may experience a reduction or elimination of APTC/CSR.

Pursuant to DC Health Link policy, redeterminations made on or before the 15th of a month are made effective the 1st day of the next month. Redeterminations made on or after the 16th of the month, will be made effective the 1st day of the month following the next month.

Exhibit 4: Individual & Family Market - Open Enrollment Timeline (Inconsistencies)

Date	Item
October 19, 2013	Individual completes application with a self-attestation that he is a District resident and has an income of 230% of FPL. The data sources do not confirm that he is a District resident and show an income of 330% of FPL. He is conditionally determined eligible for QHP enrollment along with APTC and CSR based on an income of 230%
October 22, 2013	Individual picks Silver-Level Plan A and temporary conditional eligibility notice is sent, confirming plan selection.
October 29, 2013	First Reminder Notice sent, reminding of duty to confirm residency and income.
November 13, 2013	Second Reminder Notice sent, reminding of duty to confirm residency and income.
December 8, 2013	Third Reminder Notice sent, reminding of duty to confirm residency and income.
December 19, 2013	Individual brings income documents into Service Center, which show an income of 270% FPL. Eligibility Redetermination Notice generated indicating APTC will go down and CSR will be eliminated effective January 1, 2014
December 23, 2013	Fourth Reminder Notice sent, reminding of duty to confirm residency.
January 1, 2014	Silver-Level Plan A coverage goes effective
January 15, 2014	Individual asks for, and is automatically granted, a 30-day extension to get his residency documentation. It would have otherwise expired on January 17, 2014
January 25, 2014	Individual submits a copy of a lease via the portal. However, it does not have his name on it.
January 27, 2014	Worker reviews document and rejects it. Sends notice to individual both online and by paper.
February 16, 2014	120-day inconsistency period expires. Notice sent to individual terminating QHP enrollment, along with APTC/CSR effective March 31, 2014. Termination notice also sent to QHP to effectuate termination.
March 31, 2014	Last day of coverage.

2.3 Individual & Family Market –Special Enrollment Period Timeline

During the plan year, individuals are not allowed to enroll in DC Health Link or change plans unless they experience certain life events, as defined in 45 C.F.R. §155.420(d), that trigger a Special Enrollment Period. Individuals generally have 60 days from the date of the triggering event to notify DC Health Link, enroll any new dependents (if applicable), change plans (if applicable), and make 1st month's premium payment (if applicable).

Effective dates of Special Enrollment Period elections depend upon the triggering event.

Exhibit 5: Special Enrollment Period Timeline (Birth)

Date	Item
January 1, 2014	Individual's coverage effective in Carrier 1 Plan A.
April 12, 2014	Individual gives birth to a child, and triggers 60-day special enrollment period
April 16, 2014	Individual reports birth to DC Health Link and notice is generated confirming SEP through June 11, 2014
April 30, 2014	Individual enrolls new child and selects new plan: Carrier 2, Plan B Initial Carrier 2 Premium Invoice generated (including new APTC with baby included) along with notice that if payment not received by May 20, 2014, it could result in non-enrollment.

May 20, 2014	Initial Premium Due Date due to DC Health Link for Carrier 2. This will include the cost for covering baby retrospectively for April and May (without APTC for April) as well as for Individual prospectively for June. Upon receipt of initial premium payment for Carrier 2: • DC Health Link sends notice to Carrier 1 to terminate coverage effective May 31, 2014 for Individual. • DC Health Link sends notice to Carrier 2 to initiate coverage for baby effective April 12, 2014.
May 31, 2014	Carrier 1 Individual coverage ends
June 1, 2014	Coverage under Carrier 2 goes effective for Individual if payment received by May 20, 2014

2.4 Individual & Family Market – Billing Timeline

After the initial premium payment is made to DC Health Link, all subsequent payments will be made by an individual to their Carrier, unless the individual changes carriers.

2.4.1 Individual & Family Market – Late Payment Grace Period (non-APTC Recipients)

For individuals not receiving APTC, the grace period for late payment of premium to the Carriers is 30 days. If payment not received by the end of the grace period, coverage will be terminated retroactive to the last date for which coverage had been paid.

Exhibit 6: Late Payment Grace Period for Non-APTC Recipients

Date	Item
By December 20, 2013	Individual selects a QHP and pays 1st month's premium. Individual is not receiving APTC.
January 1, 2014	Individual's coverage takes effect. Carrier sends monthly invoices to the individual for payment to be made directly to the Carrier for coverage months starting in February.
March 31, 2014	Premium due for April coverage period. Carrier does not receive payment by this due date.
April 30, 2014	If payment still not received for April coverage period, April premium is 30 days overdue. Coverage will be terminated retroactive to the last date for which coverage was paid.

2.4.2 Individual & Family Market – Late Payment Grace Period (APTC Recipients)

The Grace Period for Individuals receiving APTC is defined by CMS as three calendar months, described at 45 CFR §156.270(d). CMS and the Carriers will work together to comply with federal regulations pertaining to grace periods.

2.5 Individual & Family Market – Termination of Coverage

Individuals can terminate their coverage in DC Health Link at any time. Requests for termination of coverage received by the 20th of the month will take effect the last day of that month.

Exhibit 7: Voluntary Termination of Coverage – Timely Notice

Date	Item
January 1, 2014	Individual is enrolled in a QHP and not receiving APTC. Carrier sends monthly invoices to the individual for payment to be made directly to the Carrier.
March 18, 2014	Individual contacts DC Health Link and requests to end his current coverage as soon possible. Because the request was made *before* the 20th day of the month, coverage can be terminated effective the last day of the month.
March 31, 2014	Last day of Individual's QHP coverage.

Exhibit 8: Voluntary Termination of Coverage – No Timely Notice

Date	Item
January 1, 2014	Individual is enrolled in a QHP and not receiving APTC. Carrier sends monthly invoices to the individual for payment to be made directly to the Carrier.
March 28, 2014	Individual contacts DC Health Link and requests to end his current coverage as soon possible. Because the request was made *after* the 20th day of the month, the earliest date that coverage can be terminated is the last day of the following month.
April 30, 2014	Last day of Individual's QHP coverage. If April premium is not paid, this coverage can be retroactively terminated to the last date through which coverage had been paid.

3 Small Employer Market – Enrollment Timeline

3.1 Small Employer Market – Annual Enrollment Timeline

Small employers have a rolling open enrollment that allows them to enroll in DC Health Link at any time during the year. DC Health Link annual enrollment timeline will apply for all small employers, regardless of which month the employer chooses to enter DC Health Link. After the 1st year of DC Health Link coverage, employers renewing coverage in DC Health Link will follow this same timeline except that no binder payment will be collected.

DC Health Link annual enrollment timeline was created with several goals in mind:

1. Provide employers adequate time to review plans, select a method of offering plans to its employees, determine contributions, and make a 1st month's binder payment.

2. Provide employees adequate time to review plan options and make a plan selection as close to the effective date of coverage as possible.

3. Provide Carriers enough time to create a group policy and enroll members by the coverage effective date. Ideally members would receive their ID cards and plan documents from the Carrier before the coverage effective date; however we realize that Carriers may not be able to guarantee this.

Therefore, DC Health Link annual enrollment timeline outlined below provides for:

Employer Election Period:	up to 40 days
Employee Open Enrollment Period:	14 – 40 days
Carrier Administrative Period:	15 days

Exhibit 9: Small Employer Market - Annual Enrollment Timeline

Example: July 1, 2014	Days Prior to Requested Coverage Effective Date	Item
April 1, 2014	90 days prior	Employers can begin to select plan offerings, review employer contributions, and finalize employee eligibility.
May 1, 2014	60 days prior	Earliest day to begin Employee Open Enrollment Period. Employee Open Enrollment Period must last for at least 30 days. (For groups that are enrolling in DC Health Link for first time, employee open enrollment periods of 14 days will be allowed.)
June 10, 2014	10th day of the prior month	Last day to end Employee Open Enrollment Period.
June 15, 2014	15th day of the prior month	Electronic binder payment must be received, processed, and cleared by DC Health Link. Note: Binder payments submitted by mail must be cleared by the 20th of the prior month. Electronic binder payments must be cleared by the 15th. Upon receipt of binder payment and close of employee election period, group information and employee enrollments will be sent to carriers for the requested coverage effective date.
June 20, 2014	20th day of the prior month	Mailed binder payments must be received, processed, and cleared by DC Health Link. Upon receipt of binder payment and close of employee election period, group information and employee enrollments will be sent to carriers for the requested coverage effective date.
July 1, 2014	0 days	Coverage effective. Preliminary invoice generated for 2nd month's premium.
July 15, 2014	15 days after coverage effective date	2nd month's invoice finalized.
July 31, 2014	Last day of 1st month of coverage	Due date for 2nd month's invoice.

For coverage months subsequent to the initial one, Employers will be able to report adjusted Employee enrollment to DC Health Link during a reasonable adjustment period after the generation of an initial invoice for a Premium Month and pay based on the newly adjusted enrollment.

3.2 Small Employer Market –Mid-Year Enrollments

Employers will have a choice of effective dates of coverage for newly eligible employees during the plan year.

Exhibit 10: Small Employer Market - Enrollment for Newly Hired Employee

EXAMPLE Plan Year: January 1, 2014 – December 31, 2014 Eligible Employee Date of Hire: March 23, 2014	
Employer-selected Eligibility Rule	**Coverage Effective**
Date of Hire (DOH)	March 23
1st of Month following DOH	April 1
1st of Month following 30 days	May 1
1st of Month following 60 days	June 1

Exhibit 11: Small Employer Market - Special Enrollment Timeline (Marriage)

Date	Item
January 1, 2014	Beginning of plan year. Employee enrolled in self-only coverage Carrier 1, Plan A.
March 23, 2014	Employee gets married.
April 22, 2014	LAST DAY of 30-day Special Enrollment Period. Employee can: • Add spouse, • Add new child(ren), and • Change carrier / plan; or • Drop coverage (e.g. to enroll in spouse's employer-sponsored coverage). Coverage change effective 1st of the month following the triggering event (**April 1, 2014).**

Exhibit 12: Small Employer Market– Special Enrollment Timeline (Birth/Adoption)

Date	Item
January 1, 2014	Beginning of plan year. Employee enrolled in self-only coverage Carrier 1, Plan A.
March 23, 2014	Employee gains a new dependent due to birth, adoption, or placement for adoption.
April 22, 2014	LAST DAY of 30-day Special Enrollment Period. Employee can: • Add new child, • Add spouse (if not already enrolled), • Add other existing child(ren) (even if not already enrolled), and • Change carrier / plan; Or • Drop coverage (e.g. to enroll in spouse's employer-sponsored coverage). Coverage change effective on the date of the triggering event (**March 23, 2014).**

3.3 Small Employer Market –Billing Timeline

The Small Employer Market billing timeline was created with several goals in mind:

1. DC Health Link must provide a consistent monthly billing cycle with posted and adjusted monthly Premium invoices.

2. DC Health Link will generate an initial invoice and allow Employers a reasonable adjustment period to report adjusted Employee enrollment before a final invoice is generated reflecting the adjustments. Since the full final invoice is due, this adjustment period allows Employers to pay a more accurate amount based on the adjustments made.

3. Provide a reasonable payment grace period for employers that includes newly-required employee notifications with the goal of ensuring payment is made before group is terminated.

Therefore, small employers will have a 60-day grace period before non-payment will cause termination of the group's coverage. Employees' will be notified ~35 days in advance of the potential termination date that their employer is past due in premiums and that coverage may be terminated. If a group's coverage is terminated, the

group will be allowed to reinstate coverage within 30 days as long as all past due and currently owed premiums are paid in full. Reinstatements will be capped at twice in the lifetime of the small employer's participation in DC Health Link.

Exhibit 13: Small Employer Market - Billing Timeline

Example: Employer has paid through May 2014. Invoice being generated for June 2014 coverage period.	
Date	**Item**
May 1, 2014	Preliminary invoice generated for June coverage period.
May 14, 2014	Last day for Employer to report any Employee enrollment changes that would be reflected on an adjusted June invoice on May 15th
May 15, 2015	Exchange generates an adjusted June Premium invoice that reflects any Employer-reported enrollment changes made by May 14th, only if the Employer's preliminary June invoice period has not already been paid. Any enrollment changes reported to the Exchange after the adjusted monthly invoice has been generated (or the preliminary invoice has been paid without adjustments) will be included as Premium Adjustments on the next month's invoice.
May 19, 2014	Employer's June premium payment is received, processed, and cleared by DC Health Link.
May 31, 2014	June Premium Due Date.
June 1, 2014	Preliminary invoice generated for July coverage period.

Exhibit 14: Small Employer Market - Billing Timeline, Failure to Pay

Example: Employer has paid through May 2014. Invoice being generated for June 2014 coverage period.	
Date	**Item**
May 1, 2014	Preliminary invoice generated for June coverage period
May 14, 2014	Last date for Employer to report any Employee enrollment changes that would be reflected on an adjusted June invoice generated on May 15th
May 15, 2015	Exchange generates an adjusted June Premium invoice that reflects any Employer-reported enrollment changes made by May 14th, only if the Employer's preliminary June invoice period has not already been paid. Any enrollment changes reported to DC Health Link after the adjusted monthly invoice has been generated (or the preliminary invoice has been paid without adjustments) will be included as Premium Adjustments on the next month's invoice.
May 31, 2014	June Premium Due Date.
June 1, 2014	Preliminary invoice generated for July coverage period. Invoice includes balance for overdue June Premium.
June 14, 2014	Last date for Employer to report any Employee enrollment changes that would be reflected on an adjusted July invoice generated on June 15th
June 15, 2014	Adjusted July invoice generated based on any enrollment changes reported by June 14th If payment for June coverage period not yet received in full: • First late payment notice sent to Employer
June 25, 2014	If payment for June coverage period not yet received in full: • Second late payment notice sent to Employer, and • Notice of possible cancellation of coverage sent to Employees, sent at least 30 days before effectuation of termination in accordance with 45 CFR §156.270(b)(1).

DC Health Link Billing & Enrollment Timelines

July 1, 2014	Preliminary invoice generated for August coverage period. Invoice includes balance for overdue June and July premiums.
July 14, 2014	Last date for Employer to report any Employee enrollment changes that would be reflected on an adjusted August invoice generated on July 15th
July 15, 2014	Adjusted August invoice generated based on any enrollment changes reported by July 14th If payment for June coverage period not yet received in full: • Final late payment notice sent to Employer
August 5, 2014	If payment for June coverage period not yet received in full: • Notice sent to Employer regarding termination of DC Health Link coverage due to non-payment of premium • Notice sent to Employees that coverage will be terminated retroactive to May 31, 2014, due to Employer's termination of DC Health Link participation • Termination of coverage files sent to Carrier(s) with May 31, 2014 as last day of coverage. *Note: Since payment receipt date is based upon the post-mark date, added 5 calendar days to the final payment due date of July 31 to accommodate for any mail lag.*
August 31, 2014	If employer all past due premiums (June, July, & August coverage) plus currently due premiums (September coverage) are paid and cleared by August 31st, coverage will be retroactively reinstated to June 1, 2014. • Notice sent to Employer regarding reinstatement • Notice sent to Employees regarding reinstatement • Reinstatement file feeds sent to Carrier(s) *Note: Policy currently only allows up to 2 retroactive reinstatements for any Employer in the lifetime of their relationship with DC Health Link.*

Appendix K

DCHBX Plan Management Policy Bulletins

MEMORANDUM

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

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: June 3, 2015

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

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

QHP Terminations

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

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

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

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

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

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

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

Customer initiates Termination with Carrier:

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

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

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

Payment Grace Periods and QHP Terminations

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

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

Mid-Month Terminations

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

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

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

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

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

Termination Grace Periods

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

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

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

Retroactive SHOP Employee Terminations

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

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

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

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

MEMORANDUM

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

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: June 11, 2015

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

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

2015 SHOP Renewals into DC Health Link: Process & Timeline

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

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

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

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

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

MEMORANDUM

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

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: June 12, 2015

SUBJECT: Individual Market Renewal Process Timeline: 2015.0003

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

2015 Individual Market Renewal Process and Timeline

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

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

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

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MEMORANDUM

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

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

DATE: June 22, 2015

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

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

Religious Accommodations

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

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

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

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

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MEMORANDUM

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

FROM: DCHBX Office of Marketplace Innovation, Policy and Operations

DATE: July 22, 2015

SUBJECT: Carrier Reference Manual Update: 2015.0005

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

SHOP Conversion

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

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

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Appendix L

DCHBX SHOP Conversion Employer Technical Guide

2016 EMPLOYER CONVERSION TECHNICAL GUIDE

June 26, 2015

Version 0.2

Revision History

Date	Version	Changes	Author	Reviewed by
06-26-2015	0.2	Baseline	Saadi Mirza	Brendan Rose

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1 Introduction

1.1 Purpose and Scope

Starting in January 2016, any employers that are headquartered in DC and have 50 Full-time employees (FTEs) or less can no longer purchase health insurance directly with health insurance issuers. They must enroll with the District of Columbia Health Benefit Exchange (referred to as "DC HBX" or "DC Exchange") Small Business Health Options Program (SHOP), to purchase health insurance for their eligible employees. Throughout this document such employers will be referred to as "Conversion" employers.

In an effort to provide a seamless transition, DC HBX will work in close coordination with the health insurance carriers currently offering coverage on the DC HBX SHOP market to migrate all of the necessary conversion Employer data and any enrollment data for their eligible employees over to the DC HBX.

This document describes the exchange of any information such as Employer demographic information and enrollment information for eligible employees for conversion employers, between the DC HBX and health insurance issuers.

1.2 Intended Audience

This document is written for business analysts, system architects, developers, and others who are involved in the process of migrating demographic and enrollment data for conversion employers from the health plan issuer to the DC HBX.

1.3 Background of DC Health Exchange

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. A key provision of the law requires all states to participate in a Health Benefit Exchange beginning January 1, 2014. The District of Columbia declared its intention to establish a state based health benefit exchange in 2011 with the introduction and enactment of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19-0094).

The Health Benefit Exchange Authority Establishment Act of 2011 establishes the following core responsibilities for the Exchange:

1. Enable individuals and small employers to find affordable and easier-to-understand health insurance
2. Facilitate the purchase and sale of qualified health plans
3. Assist small employers in facilitating the enrollment of their employees in qualified health plans
4. Reduce the number of uninsured
5. Provide a transparent marketplace for health benefit plans
6. Educate consumers
7. Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions

The DC Exchange is responsible for the development and operation of all core Exchange functions including the following:

1. Certification of Qualified Health Plans and Qualified Dental Plans
2. Operation of a Small Business Health Options Program (SHOP)
3. Consumer support for coverage decisions
4. Eligibility determinations for individuals and families
5. Enrollment in Qualified Health Plans
6. Contracting with certified carriers

7. Determination for exemptions from the individual mandate

1.4 Regulatory Compliance

The DC Exchange will comply with the data encryption policy as outlined in the HIPAA Privacy and Security regulations regarding the need to encrypt health information and other confidential data. All data within a transaction that are included in the HIPAA definition of Electronic Protected Health Information (ePHI) will be subject to the HIPAA Privacy and Security regulations, and DC Exchange will adhere to such regulations and the associated encryption rules. All Trading Partners also are expected to comply with these regulations and encryption policies. (Please refer to the DC Health Link Carrier Onboarding Document for additional information).

1.5 Key Terms

The following are definitions for acronyms used in this document.

Table 1: Acronyms

Acronym	Definition
ACA	Affordable Care Act
APTC	Advance Payments of the Premium Tax Credit
ASC	Accredited Standards Committee
Cancellation of Health Coverage	End health coverage prior to the health coverage effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
CCIIO	Center for Consumer Information and Insurance Oversight
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
EDI	Electronic Data Interchange
EDS	Enrollment Data Store
EFT	Enterprise File Transfer
FEPS	Federal Exchange Program System
FF-SHOP	Federally Facilitated Small Business Health Option Program
FFE	Federally Facilitated Exchange operated by HHS
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
Hub	Data Services Hub Referred to as the Hub
IG	Implementation Guide
PHS	Public Health Service
QHP	Qualified Health Plan
MEC	Minimum Essential Coverage
SBE	State-Based Exchange
SFTP	Secure File Transfer Protocol
SHOP	Small Business Health Option Program
Termination of Health Coverage	Terminate (end-date) health coverage after the health coverage effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
Companion Guide Technical Information (TI)	The Technical Information (TI) section of the ASC X12 Template format for a Companion Guide which supplements an ASC X12 Technical Report Type 3 (TR3)
TR3	Type 3 Technical Report
XOC	eXchange Operational Support Center

1.6 Related Resources

Below is a list of related guides and specifications. Current versions of these resources may be obtained from the DC Health Benefit Exchange (see How to Contact Us).

Table 2: Related Resources

Resource	Description
CMS Companion Guide for the Federally Facilitated Exchange (FFE)	Provides information on usage of 834 transaction based on 005010X220 Implementation Guide and its associated 005010X220A1 addenda
Trading Partner Agreements (TPA)	Outlines the requirements for the transfer of EDI information between a Carrier and DC Exchange
DC Health Link Carrier Onboarding Document	Contains all the information required for Carrier to connect and communicate with the DC Exchange, i.e. machine addresses, security protocols, security credentials, encryption methods
DC Health Link Carrier Integration Manual	Provides a comprehensive guide to the services offered by DC Exchange
DC Health Link Premium Payment Companion Guide	Provides technical information on 820 transactions supported by DC Exchange
DC Health Link Carrier Testing Document	Contains the testing strategy for DC Exchange – Carriers integration
DC Health Link Transaction Error Handling Guide	Provides details on exchange message validation and error handling
DC Health Link Billing and Enrollment Timelines	Explains enrollment and premium billing timelines for plans sold on the DC Exchange.
Employer Demographic XSD	XML schema definition for exchanging Employer Demographic information
Broker Demographic XSD	XML schema definition for exchanging Broker Demographic information
Reconciliation Report Template	Excel file template for Carriers to report and resolve discrepancies between Carrier and DC Exchange subscriber databases

1.7 How to Contact Us

The DC Exchange maintains a Web site with Carrier-related information along with email and telephone support:

- **Web**: http://dchbx.com/page/carrier-information
- **Email**: carriersupport@dchbx.com
- **Phone**:
  - (202) 317-0287 - Concierge, general Carrier EDI support
  - (202) 320-7308 - technical Carrier EDI support

2 Electronic Communication with the DC Exchange

2.1 Connecting to the DC Exchange

The DC Exchange publishes secure Internet resources that a Carrier may access to exchange electronic information. As part of the Trading Partner setup process a Carrier completes the DC Health Link Onboarding Document.

The Onboarding Document collects information about Carrier technical contacts, network details and other information necessary to establish secure communication. Based on this information, the DC Exchange will configure networks; establish service accounts and credentials; and exchange keys with Carriers to enable connectivity to DC Exchange resources.

2.2 PGP Encryption

The DC Exchange uses Pretty Good Privacy (PGP) to encrypt information shared with trading partners. Using PGP, sensitive information in electronic files is protected during transmission over the open Internet and while stored on messaging servers.

The DC Exchange and Carriers will exchange public keys under the onboarding process. Files will be encrypted with the receiver's public key (either the DC Exchange or Carrier) and signed by the sender's private key. The encrypted data must be encoded in ASCII Armor format rather than binary form.

2.3 SFTP Server

The DC Exchange provides a secure landing zone for Carriers to post and retrieve transaction files. SSH FTP protocol is used to transfer files to and from the landing zone server. Files persisted on the landing zone server are encrypted to protect private and sensitive information.

3 Data Migration for Conversion Employers

3.1 File Type

There are two types of files that are used to provide the necessary information for migrating a conversion employer demographic and employee enrollment data to DCHBX

1. **Employer Demographic File**: This file contains the employer's demographic information
2. **Employee Enrollment File**: This file contains all necessary demographic and enrollment data for employees to be migrated over to DCHBX

DC HBX has provided Microsoft Excel templates to the carriers for each of the above files. There is an instruction worksheet in each of the spreadsheets that outlines the validity and optionality criteria (required/situational/optional) for the various data elements.

WARNING: Please adhere to the instructions and ordering of the columns as specified in the spreadsheets. Do not reorder, add, or remove columns in these spreadsheets which will result in automatic rejection of your submission

3.2 Conversion Employer Data Folder Structure

DCHBX will extend the folder structure drop-zone for existing SHOP issuers as in Figure 1 below for facilitating conversion employers' data exchange.

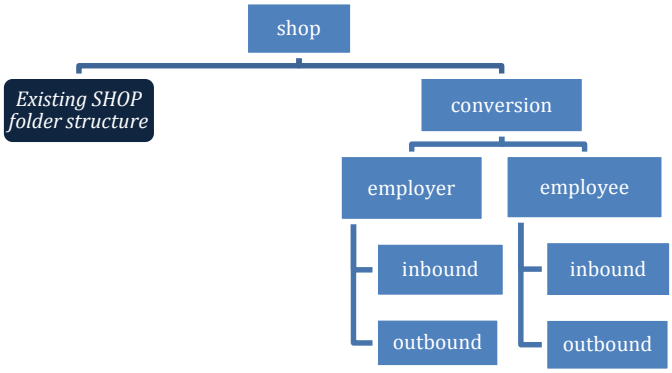

Figure 1: Extension of SFTP Folder Structure for Conversion Employers

Carriers can drop employer demographic information in the **conversion/employer/outbound** folder.

Carriers can drop employee enrollment information in the **conversion/employee/outbound** folder.

3.3 Acceptable File Formats

DCHBX will accept the following formats for the employer and employee data

- Excel (97-2003) Workbook [.xls extension]
- Microsoft Office 2007 and onwards, Excel Workbook [.xlsx extension]
- Comma Separated Values (CSV)

3.4 Naming Convention for Files

3.4.1 FOR EMPLOYER DEMOGRAPHIC DATA

Below is the file naming convention to be used by carriers for naming files with employer demographic data

ConversionEmployerData_<IssuerId>_YYYYMMDDHHMMSS.[xls,xlsx,csv].[pgp,asc]

Examples

`ConversionEmployerData_UHIC_20150625104421.xlsx.asc`

`ConversionEmployerData_UHIC_20150625104421.csv.pgp`

3.4.2 FOR EMPLOYEE ENROLLMENT DATA

Below is the file naming convention to be used by carriers for naming files with employee enrollment data

ConversionEmployeeData_<*IssuerId*>_YYYYMMDDHHMMSS.[xls,xlsx,csv].[pgp,asc]

Examples

`ConversionEmployeeData_AHI_20150626092331.xls.asc`

`ConversionEmployeeData_AHI_20150626092331.csv.pgp`

Where **IssuerId** is the unique identifier assigned by DCHBX to each Carrier as follows. Full list of these identifiers can be found in the DC Exchange Carrier Integration Manual

Table 3: SHOP Participants in the DC Exchange

Name	DC Exchange ID
Aetna Health, Inc.	AHI
Group Hospitalization and Medical Services, Inc.	GHMSI
Kaiser Foundation of the Mid-Atlantic States, Inc.	KFMASI
United Healthcare Insurance Company	UHIC

3.5 File Transfer Process for Conversion Employers

3.5.1 STEP 1: FILE CREATION

Create and populate the appropriate Excel/CSV file for the employee or the employer per provided guidance and using the appropriate naming convention (see earlier)

3.5.2 STEP 2: ENCRYPTION

Encrypt the file using the DCHBX production public key using ASCII Armor format

3.5.3 STEP 3: TRANSMISSION

Upload the file in the appropriate outbound folders using existing production credentials as follows

- **Employer files** → `shop/conversion/employer/outbound`
- **Employee files** → `shop/conversion/employee/outbound`

We advise you to email us whenever you have uploaded any files. Furthermore, it is preferable to not delete any files you have uploaded into these folders.

3.5.4 STEP 4: DC RESPONSE (SITUATIONAL)

In certain situations, DC may post response files in the inbound folders as follows and inform you

- **Employer response files** → `shop/conversion/employer/inbound`
- **Employee response files** → `shop/conversion/employee/inbound`

4 Frequently Asked Questions

What is the format for sending Employer demographic and employee enrollment data to DC?

DC has defined Microsoft Excel templates for populating employer and employee data and these have been published by the DCHBX business team. The acceptable response to these templates are documented elsewhere in this document

What is the mode of transfer of conversion employer data to DC?

DC will utilize the existing SFTP drop zone (same credentials) that the carriers currently use for exchanging EDI and Group data with DC. A separate folder structure has been defined for conversion data and can be found elsewhere in this document

What is the deadline for submitting 2016 employer and employee conversion data?

DCHBX business team has created a detailed calendar with key dates that has been shared with the carriers. Carriers are highly encouraged to submit data ahead of the deadline to prevent delays due to any issues with the submitted data.

What if I have multiple phone numbers for the employee? Currently there is only one field for phone number

Please choose the Home phone number in that situation

There are only two options for Plan selection category in the employer demographic file namely "All Plans" and "Single Plan", what if the employer has selected multiple plans but not all plans with the carrier

Please choose the option of "All Plans" in such a situation

Is the Broker NPN field mandatory?

Yes. The National Producer Number or NPN is a unique identifier for a broker and must be included in the employer demographic file to ensure that the correct broker is credited with the enrollments for that employer

What if we only have the legal name for the business and not the "Doing Business As" (DBA) name?

You can populate the DBA name with the legal name in that instance

Can I reorder the columns in the spreadsheets? How about adding or removing a column?

Please do not alter the ordering of the spreadsheet. You should also not add or remove any columns. This will result in automatic rejection of the file

Can an employer's physical address be outside of DC?

An employer's physical address must be a DC address to qualify for getting health coverage through the DC Exchange. However, it is permissible to have contact and/or mailing address outside of DC.

What if there is an employer with a mid-month start date for Open Enrollment?

DC Exchange only supports start dates at the beginning of a month. Please refer to the policy guidance from the DC HBX business team on this matter to decide which start date with the DC Exchange the employer would map to

How many dependents can an employee have?

Although from a policy perspective there is no upper limit, the employee enrollment spreadsheet contains provision for upto eight dependents. Please let DC HBX if you have such enrollments to process

For an Employee, if the dependents live at the same address as the subscriber, do we still have to fill the address for the dependent?

In the above situation, you can leave the dependent address blank

How can a carrier convey changes to an Employer demographic or Employee enrollment info once it has been sent to DC and accepted?

DC is currently working on the format for this and will address in reconciliation as well.

Appendix M

DCHBX SHOP Conversion File Transfer Process

File transfer process for 2016 conversion employers

Step 1:

Create and populate the appropriate CSV file for the employee or the employer per provided guidance

Step 2:

Encrypt the file using the DCHBX production public key using ASCII Armor format

Step 3:

Upload the file in the appropriate outbound folders using existing production credentials as follows

- Employer files → `shop/conversion/employer/outbound`
- Employee files → `shop/conversion/employee/outbound`

We advise you to email us whenever you have uploaded any files. Furthermore, it is preferable to not delete any files you have uploaded into these folders.

Step 4:

In case of any issues, DC will post any response files in the inbound folders as follows

- Employer files → `shop/conversion/employer/inbound`
- Employee files → `shop/conversion/employee/inbound`