2018 CHECKLIST and WORKSHEET
FOR QUALIFIED HEALTH PLANS IN THE
CALIFORNIA HEALTH BENEFIT EXCHANGE

The Department of Managed Health Care (DMHC) offers the following information to assist Individual and Covered California for Small Business (CCSB) Qualified Health Plans (QHP) filings for the Plan Year 2018, for compliance with the Knox-Keene Act at California Health and Safety Code Sections 1340 et seq. (the Act). References herein to "Section" are to Sections of the Act. References to "Rule" are to the regulations promulgated by the DMHC at California Code of Regulations, title 28.

This checklist and worksheet are not intended to be all-inclusive and represent only what issues, at a minimum, are required to be addressed by a health plan for compliance with the Act and Rules. Additional information as needed may be requested by the DMHC within the course of review of a health plan filing. For health plans licensed pursuant to the Act, the DMHC has primary responsibility for regulatory review and preliminary recommendations with respect to certain selection criteria identified by the California Health Benefit Exchange (Exchange) in evaluation of whether an applicant is in "good standing." All licensure, regulatory and product requirements of the Act and Rules apply to QHPs offered through the Exchange.

Filing Timeframes

Prior to certification, health plans must have DMHC approval of necessary filings, including, but not limited to, licensure, networks, products, and rate filings. Complete filings are due as follows:

	New Applicant; QHP Proposing New: Rating Region, and/or Line of Business	**QHP proposing no changes to Rating Region or Line of Business**
All Other Exhibits as Necessary	No later than March 1	No later than April 1
Provider Network	No later than March 1	No later than June 1
Product Designs	No later than May 2	
Rates Individual and CCSB	Initial: ~~July 18~~ July 17 Finalized: October 3	

Filing Checklist

- Prepare and submit an Amendment or Material Modification pursuant to Sections 1351 and 1352 to a health plan's license to address compliance with the Act, Rules, CA-ACA and ACA laws and regulations related to QHP certification. When submitting your filing, please (1) use the subject title "HBEX QHP Application 2018" and (2) select "QHP" under "Product & Issues - Issues" in the e-File system.
- Product revisions that do not meet the federal Uniform Modification standards should be submitted as a Notice of Material Modification filing.[1]
- Health plans that are not required to file a network pursuant to the Act are not required to file a network for the sole purpose of QHP recertification (see below under "Provider Network.")
- Complete and file the attached QHP DMHC Filing Worksheet(s) as Exhibit E-1. Please provide a narrative and ensure that the description corresponds to the summary provided in the QHP DMHC Filing Worksheet.
- Complete and file the attached QHP Subcontractor Worksheet.
- For each formulary utilized in connection with product(s) required to comply with the 2018 Standard Benefit Design, please submit: (i) an Exhibit T-3 that contains a copy of the formulary, and (ii) an Exhibit T-5 that contains a signed 2018 Prescription Drug Compliance Affidavit, which is attached.

Narrative: Exhibit E-1

Describe the background and purpose of the filing, including, but not limited to:

- Whether the health plan's QHP Application is for individual and/or small group, and identify the region(s) included in the application.
- Whether the product design(s) being proposed have been previously approved by the DMHC including filing numbers of all previously approved product design(s).
- The provider network(s) that will be used to provide health care services to enrollees in the health plan's proposed QHP, including all necessary documentation and filing numbers of all previously approved provider networks, and plan-to-plan arrangements.
- A list of each product (specifying each metal level, market, region and network) offered by the health plan that is required to comply with 2018 Standard Benefit Design (SBD) and an explanation of whether the health plan utilizes the same or different formularies for different products.
- If the health plan is proposing to offer non-standard product(s) on the Exchange, please explain whether it has submitted the proposal for Exchange approval.
- Changes and updates to previously approved exhibits should be indicated with clearly visible redlined changes.
- An affirmation that the Plan discloses coverage of pediatric vision benefits that are the same benefits as contained in the BCBS Association, 2014 FEP Blue Vision – High Option, including, but not limited to, low vision benefits, and that the Plan discloses coverage of the aphakia benefit without age limitations as required by Section 1367.005(a)(2). Please also identify the page nos. of the EOC which disclose the pediatric vision and aphakia benefits.

[1] 45 C.F.R. § 147.106(e).

For Small Group products only, affirm that for every contract it is offering coverage for:

- The treatment of infertility, except in vitro fertilization. The term "infertility" is as defined in Section 1374.55; and
- Orthotic and prosthetic and special footwear benefits, as set forth in Sections 1367.18 and 1367.19.

Contracts with Specialized Health Plans:

- Full service health plans that contract with specialized health plans for the provision of Essential Health Benefits (EHB), such as acupuncture, pediatric dental or vision benefits, should include in Exhibit E-1 a brief explanation of the contractual relationship.
- Specialized health plans are required to submit a mirror filing for new or amended plan-to-plan contracts. Plan-to-Plan contracts, where the specialized health plan is at risk, should be filed as an Exhibit P-5. Plan-to-Plan contracts, where the specialized health plan is not at risk (i.e. rental of network), should be filed as an Exhibit N-1.
- Full service health plans should include the filing number for the specialized health plan's mirrored filing. In addition, the full service health plan should ensure that the plan-to plan contract specifies which health plan will be performing Utilization Management, and Grievance and Appeals functions. Please ensure that this information is set forth in the plan-to-plan contract. See 2018 CHECKLIST FOR QUALIFIED DENTAL PLANS IN THE CALIFORNIA HEALTH BENEFIT EXCHANGE which encompasses dental plans contracting directly with a) Covered California and b) QHPs.
- Specialized health plans that contract to provide EHB may also need to submit Evidence of Coverages, disclosure forms, and provider network information on behalf of the full service health plan. QHP's should share this checklist with contracted specialized health plans to ensure that the specialized health plan's mirror filings include all DMHC requirements.

All Other Exhibits as Necessary

If the health plan will be relying on existing contracts, policies, or procedures previously approved by the DMHC, and there are no changes, the health plan should indicate this in Exhibit E-1, and is not required to submit these exhibits unless requested.

- Quality of Care (Exhibit J): Internal quality of care system(s) the health plan intends on implementing to serve Exchange enrollees, and address how it meets state and applicable ACA requirements.
- Provider and Administrative Services Contract(s) (Exhibits K and N): New or revised provider or administrative service contract(s) related to Exchange products.
- Plan Organization (Exhibit L): New or revised organizational chart(s).
- Plan-to-Plan Contracts (Exhibit P-5): New or revised plan-to-plan contract(s) related to the delivery of services to Exchange enrollees.
- Grievance & Appeals (Exhibit W): New or revised grievance and appeal procedures.
- Marketing (Exhibits V, Y, Z, AA, and BB): Advertising and marketing materials related to Exchange products.

Product Designs: Exhibits P, Q, S, T, and U

- Evidence of Coverage (EOC) or combined EOC and Disclosure Form (Exhibit T or U): EOC(s) for each line of business proposed (e.g. HMO, PPO, EPO). Ensure that all EHB are included in these exhibits, including those provided by a contracted specialized health plan.[2]

[2] Please see the 2018 QDP Checklist which has specific instructions for SBD dental benefits.

- Schedule/Summary of Benefit (Exhibit S,T, or U): For each product proposed.[3]
- Federal Summary of Benefits and Coverage (Exhibit S-3): A federal Summary of Benefits and Coverage (SBC) disclosure form in connection with **the Exchange's Individual Silver Product only. This SBC will be reviewed as a representative sample of all SBC's related to QHP products being offered in the Individual and Small Group markets.** Health plans are reminded to utilize the SBC instructions, materials and supporting documents authorized for use on and after April 1, 2017.[4] If the health plan has already received approval of its template SBC(s) pursuant to a separate filing, please provide the e-File number in lieu of submitting the exhibit.[5]
- EHB Filing Worksheet (Exhibit T-2): A new EHB worksheet, as promulgated in Rule 1300.67.005 (latest promulgation).
- Prescription Drug EHB Benchmark Plan Benefits Chart (Exhibit T-4): A new Prescription Drug EHB Chart, as promulgated in 1300.67.005 (latest promulgation).
- Individual/Group Contracts (Exhibit P or Q): New or revised individual and group health plan contracts.

Provider Network: Exhibits H and I

- Please report information related to each provider network that is connected to a QHP product, as described below. All health plans must provide the e-File number identifying the last time the network was reviewed by the DMHC, even if the network was reviewed under a different name or connected to a different product. A health plan need only submit a complete provider network filing for any of its QHP provider networks if the health plan is required to submit network information pursuant to the Act. When submitting a network for review, please be sure to identify the name of the network and which products utilize that network in an Exhibit E-1.

  As a reminder, the Act requires health plans to submit a complete network filing for review under the following circumstances:

  - An applicant is applying for a new license to operate as a health care service plan under the Act. (*See* Section 1351, Rule 1300.51.) Applicants are strongly encouraged to contact the DMHC and schedule a pre-filing conference before filing a new license application. Any new license applicants for the 2018 benefit year must file a network with the DMHC as soon as practicable, but no later than March 1, 2017. Please be sure to include the following Exhibits with the network portion of your filing:
    - Provider Network Rosters (Exhibits I-1, I-2, and I-3, utilizing the DMHC'S templates available for download on e-File)
    - Provider-to-enrollee Ratios (Exhibit I-4)
    - Description of Service Area, by zip code (Exhibit H-1)
    - Standards of Accessibility (Exhibit I-5)
    - Enrollment Projections (Exhibit EE)

[3] Id.

[4] Template instructions, materials and supporting documents authorized for use on and after April 1, 2017, may be located at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/

[5] Please see the 2018 QDP Checklist which has specific instructions for Standard Benefit Design dental benefits.

- The health plan is expanding its existing, approved network into a new service area or withdrawing from a service area. (*See* Section 1351; Rule 1300.52.4(d).) A network filing proposing a service area expansion or withdrawal must be submitted as a material modification to the health plan's license in the e-File system. Health plans are strongly encouraged to contact the DMHC and schedule a pre-filing conference before filing a service area expansion or withdrawal. Any service area expansions or withdrawals for the 2018 benefit year must be filed as soon as practicable, but no later than March 1, 2017. Please be sure to include the following exhibits with your filing:
  - Provider Network Rosters (Exhibits I-1, I-2, and I-3, utilizing DMHC templates available for download on e-File)
  - Provider-to-enrollee Ratios (Exhibit I-4)
  - Description of Service Area, by zip code (Exhibit H-1)
  - Standards of Accessibility (Exhibit I-5)
  - Enrollment Projections (Exhibit EE)
- Under certain circumstances, a health plan may be required to file an amendment to its license identifying a major network change. (See Rule 1300.52, subd. (f), Section 1367.27, subd. (r).) If the health plan has determined that its QHP network meets those circumstances, please submit an amendment to the health plan's license in the e-File system no later than June 1, 2017. On or about April 2017, the DMHC will make available a new template for the purpose of filing provider network information pursuant to Rule 1300.52, subd. (f) and Section 1367.27, subd. (r). Please visit the "Downloads" section of the e-File webportal to locate and utilize the new template.

- If the health plan experienced greater enrollment in 2017 than was projected in the prior year's QHP filing, or if the health plan projects a significant increase in enrollment in 2018 beyond what was previously projected for 2018, please submit the following:
  - Enrollment Projections (projected over two years) (Exhibit EE)
  - Provider-to-enrollee Ratios (Exhibit I-4)

- If the health plan intends to enter into a new plan-to-plan arrangement with a Knox-Keene licensed health plan, or change the plan with which it currently has a plan-to-plan arrangement to another Knox-Keene licensed health plan, to provide some or all of its network providers, the DMHC will require information from both the QHP and the Knox-Keene licensed subcontracting health plan as follows:
  - The QHP must file:
    - A statement within the Exhibit E-1 identifying the portion of the service area in which the QHP plan intends to utilize the subcontracting plan's network and affirmation that the subcontracting health plan has been approved to operate a network in that portion of the service area.
    - In some cases, Exhibits I-1, I-2, and/or I-3, as applicable, and Exhibit H-1. These need only be filed if the change in subcontracting arrangement will result in a significant change to the QHP's network, as described in Rule 1300.52, subd. (f) and Section 1367.27, subd. (r).

- The subcontracting health plan must file[6]:
  - Provider-to-enrollee Ratios (Exhibit I-4) demonstrating that the plan has the capacity to take on the enrollment from the QHP plan.
  - A statement within the Exhibit E-1 indicating the filing number of the most recent network review conducted by the DMHC and the filing in which the Plan was approved to operate in the service area covered by the QHP.
  - An Exhibit H-1 demonstrating that the subcontracting plan is approved for the service area in which the QHP plan intends to utilize the subcontracting plan's network.

- If the health plan intends to enter into a new plan-to-plan arrangement with a plan that is not licensed by the DMHC, or change the plan with which it currently has a plan-to-plan arrangement to a plan that is not licensed by the DMHC, to provide some or all of its network providers, the QHP will be responsible for providing all network information as follows:
  - A statement within the Exhibit E-1 identifying the plan with which the QHP intends to contract.
  - In some cases, Exhibits I-1, I-2, and/or I-3, as applicable, and Exhibit H-1. These need only be filed if the change in subcontracting plan will result in a significant change to the QHP's network, as described in Rule 1300.52, subd. (f) and Section 1367.27, subd. (r).

Actuarial Value Calculation: Exhibit FF-4

- Actuarial Value - Full-service health plans proposing to offer 9.5 and/or 10.0 EHB should submit through the e-File portal the following supporting documentation under Exhibit FF-4:
  - If the product is compatible with the AV calculator
    - A screenshot of the AV calculator with inputs used for each product design.
    - Submit the Excel tab from the AV calculator entitled "User Inputs for Plan Parameters."
  - If the product is not compatible with the AV calculator
    - Submit an actuarial certification on the methodology chosen from the options specified in 45 CFR §156.135(b).
    - The certification must be prepared by a member of the American Academy of Actuaries.
    - Provide a description of the chosen methodology used pursuant to 45 CFR §156.135(b).
    - Estimating a fit of the plan design into the parameters of the calculator; or
    - Partial use of AV calculator with appropriate adjustments to the AV identified by the calculator for substantial deviation in plan design features.

For either methodology, provide the following:

- A screenshot of the AV calculator with inputs used for each product design.
- A complete description of the data, assumptions, factors, rating models, and methods used to determine the adjustments.
- The certification must describe the methodology with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, models, and methods.

[6] If Dental Plans are contracting directly with a) Covered California or b) QHPs, please see 2018 QDP Checklist.

- The certification must include an Excel spreadsheet illustrating the adjustments used in the AV calculation.

- Adjustments to the AV must be based on a standard population. ACA §1302(d)(2).
- Employer contributions to health savings accounts and amounts made available under certain health reimbursement arrangements must be accounted for as specified in 45 CFR §156.135(c).
- Segregation of Funds for Abortion: Federal law (45 CFR § 156.280(e)(5)(ii)) provides that a QHP that offers coverage for abortions for which public funding is prohibited should submit a plan detailing its process and methodology for meeting the requirements of 42 USC § 18023(b)(2)(C), (D) and (E). The premium segregation plan should describe the QHP issuer's financial accounting systems, including documentation and internal controls, that will ensure the segregation of funds required by 42 USC § 18023 (b)(2)(C), (D) and (E). This methodology plan should be filed under Exhibit FF-5, even if previously filed with the DMHC.

Enrollment Projections: Exhibits CC, DD, and EE

- Enrollment projections and summary for all individual and small group contracts.

Rate Review

- Instructions regarding SERFF filing(s) different than non-QHP rate filings will be forthcoming.