DEPARTMENT OF Managed Health Care

PLAN YEAR 2022 CHECKLIST FOR NON-GRANDFATHERED INDIVIDUAL AND SMALL GROUP MARKET PRODUCT(S) OFF OF THE CALIFORNIA HEALTH BENEFIT EXCHANGE

The Department of Managed Health Care (DMHC or Department) offers the following information to assist Individual and Small Group product filings outside of the California Health Benefit Exchange (Exchange) for the Plan Year 2022, for compliance with the Knox-Keene Act at California Health and Safety Code sections 1340 et seq. (the Act or KKA). References herein to "Section" are to sections of the Act. References to "Rule" are to the regulations promulgated by the Department at California Code of Regulations, title 28.

This checklist applies non-grandfathered Individual and Small Group Market benefit plan designs offered pursuant to Section 1366.6 subdivisions (c) and (e), and non-standard health benefit plans offered pursuant to Section 1366.6 subdivision (d). This checklist and attachments 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 Department within the course of review of a health plan filing.

Filing Timeframes

Health plans amending benefit plan designs for the 2022 Plan Year must have Department approval of necessary filings, including, but not limited to: licensure, networks, product, benefit plan design, and rate filings. Complete filings are due as follows:

	New Licensee; Existing Licensee Proposing New: Rating Region, Line of Business, and/or Benefit Plan(s)	**Existing Licensee proposing no changes to Rating Region or Line of Business**
Benefit Plan Designs and All Other Exhibits Other Than Networks	No later than July 1	No later than August 2
Provider Network	No later than March 1	Within 30 days of any change requiring a network Change Amendment filing.[1]
Rates Individual and CCSB	Guidance regarding rate filing deadlines forthcoming.	

[1] *See* Sections 1352, subdivision (a), 1367.27, subdivision (r); Rule 1300.52, subdivision (f).

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.
- When submitting your filing in the e-Filing system, use the subject title "Plan Year 2022 off-Exchange [Individual] or [Small Group] Products-[HMO], [PPO], [EPO], [POS]" The health plan should utilize only the applicable variable language most accurately describing the content of its filing.
- Benefit plan design or product revisions that do not meet the federal Uniform Modification standards should be submitted as a Notice of Material Modification filing.[2] Health plans amending non-standard benefit plan designs or products must affirmatively demonstrate the proposed amendments qualify as a uniform modification by providing legal analysis.[3]
- Health plans participating on the Exchange are not required to file a network pursuant to the Act for the sole purpose of QHP recertification (see below under "Provider Network").
- Complete and file the attached Subcontractor Worksheet as Exhibit E-1.
- For each formulary utilized in connection with product(s) required to comply with the 2022 Patient-Centered Benefit Plan Designs pursuant to Section 1366.6 subdivision (c), submit: (i) an Exhibit T-3 that contains a copy of the formulary, and (ii) an Exhibit T-5 that contains a signed Prescription Drug Compliance Attestation.
- Changes and updates to previously approved exhibits should be indicated with clearly visible redlined changes.

Narrative: Exhibit E-1

At a minimum, the health plan must provide the following information in its Exhibit E-1:

- Whether the proposed benefit plan designs have been previously approved by the Department, including e-Filing numbers of previously approved benefit plan designs.
- A description of the provider network(s) to be used to provide health care services to enrollees in connection with the health plan's proposed product(s), including all necessary documentation and filing numbers of all previously approved provider networks, and Plan-to-Plan contracts. For this purpose, it is not sufficient to reference the filing made pursuant

[2] 45 C.F.R. § 147.106(e).
[3] *Id.*

to Annual Network Review. Also provide an indication of the product types (i.e., large group, small group, and/or individual) for which the preciously approved network was reviewed and approved.

Note: File any network revisions in a separate Amendment or Material Modification, as required under the Act based on the change (see "**Provider Network: Exhibits H and I**" below).

- ❑ To ensure the health plan has adequately considered State Law as well as confirmed the health plan's processes conform as such, provide an affirmation that the health plan's special enrollment period (SEP) triggering events are consistent with State law, as applicable, including, but not limited to: Sections 1357.503 and 1399.849.
- ❑ Identify the health plan's documents that disclose SEP triggering events to the public and/or enrollees and whether said document(s) were previously filed for Department review. Note, the health plan is not required to file the documents described above unless requested by the Department.
- ❑ Identify the e-Filing number in which the health plan submitted the compliance filings associated with the Department's All Plan Letter (APL) 21-002.
- ❑ Identify the page numbers of the Evidence of Coverage (EOC) or other policy and procedure that demonstrate compliance with newly enacted statutes or regulations(s) effective on or after January 1, 2021, including but not limited to[4]:

    - SB 406 (Pan, Ch. 302, Stats. 2020) – Omnibus Bill (restrictions on lifetime and annual limits, Section 1367.001.)
    - SB 406 (Pan, Ch. 302, Stats. 2020) – Omnibus Bill (preventative health care services Section 1367.002.)
    - SB 855 (Weiner, Ch. 151, Stats. 2020) – Mental Health and Substance Use Disorder Coverage.
    - Any other newly enacted statute(s) or regulation(s) for which the health plan deems revision is appropriate.

- ❑ For health plans that participate on the Exchange and product(s) offered off of the Exchange pursuant to Section 1366 subdivision (c), affirm the provision of Basic Health Care Service and Essential Health Benefits (health benefits) included in the applicable health plan documents' are identical to the health benefits approved by the Department in connection with the health plan's on-Exchange product(s) and provide the e-Filing number for the approved health benefits.

[4] For additional guidance see the Department's All Plan Letter regarding newly enacted statutes in 2020 impacting health plan license filings on or after January 1, 2021.

- For health plans that participate on the Exchange, benefit plan designs offered pursuant to Section 1366.6 subdivision (c) must identify the page numbers of the EOC revised for compliance with newly-enacted or revised Endnotes in the 2022 Patient-Centered Benefit Plan Designs. If revision is not required, the health plan must provide a confirmatory declaration, which states no revisions are required.
- For health plans that do not participate on the Exchange and/or for non-standard product(s)[5], affirm the health plan's health benefits are identical to the Kaiser Foundation Health Plan Small Group HMO 30 plan, in the first quarter of 2014. Please ensure the health plan submits an EHB Filing Worksheet, if applicable. For further guidance, see the section entitled *Benefit Plan Designs* item *EHB Filing Worksheet* below.
- An affirmation that the health plan discloses coverage of pediatric vision benefits without annual or lifetime limits on the dollar value of the covered 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 health plan discloses coverage of the aphakia benefit without age limitations as required by Section 1367.005, subdivision (a)(2). Additionally, identify the page numbers of the EOC which disclose the pediatric vision and aphakia benefits.
- For health plans that participate on the Exchange, affirm the pediatric dental benefits are identical to the pediatric dental benefits approved by the Department for its on-Exchange products and provide the e-Filing number for the approved dental benefits.
- For health plans that do not participate on the Exchange, affirm the pediatric dental benefits are identical to the 2014 Medi-Cal dental program (Dental Benchmark Plan). Please note, the Dental Benchmark Plan utilizes outdated CDT codes. Covered California's 2022 Dental Standard Benefit Plan Design (Dental SOB) and Copay Schedule are based on the Dental Benchmark Plan and reflect the most recent CDT codes. Health plans should follow Covered California's Dental SOB when developing the pediatric dental benefits. Contact your assigned reviewer if you need assistance obtaining any of these documents.

For Small Group benefit plan designs only, affirm that for every contract it is offering coverage for:

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

[5] Note, this provision is also applicable to health plans participating on the Exchange in connection with non-standard benefit plan designs.

Contracts with Specialized Health Plans:

- Full service health plans that contract with specialized health plans for the provision of Essential Health Benefits[6] (EHB), such as acupuncture, pediatric dental or vision benefits, should include in the Exhibit E-1 a brief explanation of each contractual relationship.
- Specialized health plans are required to submit a mirror filing in coordination with a contracted full service health plan 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.
- If the full service health plan is not providing its own specialized services list the entities providing specialized services on behalf of the full service health plan.
- Full service health plans should include the filing number for the specialized health plan's mirrored filing, if applicable. In addition, the full service health plan should ensure the Plan-to-Plan contract specifies the health plan that will be performing Utilization Management, and Grievance and Appeals functions. Ensure this information is set forth in the plan- to-plan contract.
- Specialized health plans are not required to provide eligibility information in connection with the Minimum Coverage benefit plan design within their Evidence of Coverage. Specialized health plans must file the Minimum Coverage Schedule of Benefits, if applicable.[7] Note, full service health plans must also include the information regarding those benefit plan designs in the full service health plan's disclosure documents.

Contracts with Specialized Dental Plans:

- Dental Plan should identify whether it will be filing a mirrored filing or whether the pediatric dental information will be contained within the full service filing. If the dental plan is filing a mirrored filing, provide the filing number of the full service off-exchange filing in the Exhibit E-1.
- Dental benefits off-exchange must comply with the 2014 Medi-Cal Dental Program (Benchmark Plan). If your health plan does not provide dental benefit on Covered California, please reach out to your assigned reviewer for a copy of the Benchmark Plan.
- Dental Benefits off-exchange must follow the Covered California Standard Benefits Design for the benefits CDT codes, and the limitations and exclusions. Plan's may go to the Covered California website for a

[6] *See* Section 1367.005; Rule 1300.67.005.
[7] *See* Section 1366.6 subdivisions (c)-(e).

copy of the Standard Benefit Design or contact the assigned reviewer.

- Dental Plans must provide to the full service health plans 1) an EOC addendum containing the dental information or 2) identify by page and section numbers the dental portions of the full service EOC. The page and section numbers can be provided in the full service health plan's Exhibit E-1.

All Other Exhibits as Necessary

If the health plan will be relying on existing contracts, policies, or procedures previously approved by the Department, 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 federal requirements.
- **Provider and Administrative Services Contract(s) (Exhibits K and N).** New or revised provider or administrative service contract(s) related to Exchange product(s).
- **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 product(s).

Benefit Plan Designs: Exhibits S, T, and U

- **Evidence of Coverage (EOC) or combined EOC and Disclosure Form (Exhibit T or U).** EOC(s) for each benefit plan design and/or product(s) proposed. Ensure all EHB are included in these exhibits, including those provided by a contracted specialized health plan.[8]
- **Schedule/Summary of Benefits (SOB) (Exhibit S,T, or U)**
    - For each proposed benefit plan design, submit a SOB.[9]
    - If the health plan prefers to submit a sample SOB, please use the Department's INDIVIDUAL AND SMALL GROUP MARKET REPRESENTATIVE BENEFIT PLAN DESIGN WORKSHEET (Representative Worksheet). Health plans using this Representative Worksheet are not required to submit

[8] See the 2022 QDP Checklist for specific instructions for filing EHB dental benefits.
[9] *Id.*

individualized SOBs for each benefit plan design offered in the Individual and/or Small Group markets. Health plans utilizing the Representative Worksheet or similar worksheet(s) must provide one representative SOB populated for use in connection with the California Health Benefit Exchange's 2022 Individual Silver 70 plan under the exhibit type(s) described above, together with the Representative Worksheet. For further instruction, see the Representative Worksheet Instruction.

- **Federal Summary of Benefits and Coverage (SBC) (Exhibit S-3).** A federal SBC disclosure form in connection with the Exchange's Individual Silver benefit plan design only. This SBC will be reviewed as a representative sample for all benefit plan designs offered in the Individual and Small Group markets. Health plans are reminded to utilize the SBC instructions, materials and supporting documents authorized for use for any plan years that begin on or after January 1, 2021.[10] If the health plan has already received approval of its representative SBC(s) pursuant to a separate filing, provide the e-Filing number in lieu of submitting the exhibit. If the health plan has not received approval of its representative SBC(s), submit in a separate filing the representative SBC(s) and provide the e-Filing number.
- **EHB Filing Worksheet (Exhibit T-2).** An EHB worksheet, as promulgated in Rule 1300.67.005 (effective as of June 27, 2017). Note, if the health plan has previously submitted a complete EHB worksheet, as described above, it is not required to submit a new EHB worksheet unless the previously approved EHB worksheet requires amendment.
- **Prescription Drug EHB Benchmark Plan Benefits Chart (Exhibit T-4).** A Prescription Drug EHB Chart, as promulgated in Rule 1300.67.005 (effective as of June, 27, 2017). If the health plan has previously submitted a complete Prescription Drug EHB Chart, as described above, it is not required to submit a new chart unless the previously-submitted worksheet requires amendment.

  As part of the submission of the chart disclose the following in the Exhibit E-1:

  - If EHB Count Chart includes generics;
  - A summary of any category/class variations from what is shown in the health plan's EHB Count Chart; and
  - For each variation, a justification and basis for the health plan's determination of compliance with Rule 1300.67.005.

[10] Template instructions, materials and supporting documents authorized for use on and after January 1, 2021, may be located at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index

Renewal Notices: Exhibit I-9

- **Representative Renewal Notices (Exhibit I-9).** Renewal notices must comply with federal requirements including the Updated Federal Standard Renewal and Product Discontinuation Notices Bulletin (September 2, 2016; amended on July 31, 2020[11]) issued by the Centers of Medicare & Medicaid Services (CMS), Form and Manner of Notices When Discontinuing a Product in the Group or Individual Market (September 2, 2014) issued by CMS, and Draft Standard Notices When Discontinuing or Renewing a Product in the Small Group or Individual Market (June 26, 2014) issued by CMS.

Provider Network: Exhibits H and I

- Health plans are not required to file network exhibits for the sole purpose of recertification. Health plans must submit a complete network when required under the Act, as follows:[12]
  - New License Application: The health plan is applying for a new license to operate as a health care service plan under the Act. (*See* Section 1351, Rule 1300.51.) Network exhibits must be filed with the Department as part of the application for licensure. (*See* Rule 1300.51.)
  - Service Area Change or New Network: The health plan is expanding its existing, approved network into a new service area, proposing a materially different provider network for use in an existing service area, or withdrawing from a service area. (*See* Section 1351; Rule 1300.52.4, subd. (d).) Network exhibits must be filed with the Department as a Notice of Material Modification. (*See* Rule 1300.52.4, subd. (d).)
  - 10 Percent Change to Already-Approved Network: The health plan has experienced a 10 percent or greater change in the names of providers included in Exhibits I-1, I-2, or I-3 previously reviewed by the Department. (*See* Section 1367.27, subd. (r); Rule 1300.52, subd. (f).) Network exhibits may be filed with the Department as an Amendment to the health plan license. (*See* Rule 1300.52, subd. (f).)
- Material Modification Filing or New License Application: Any service area expansions, withdrawals, new networks, or new license applications for the 2022 benefit year must be filed as soon as practicable, but **no later than March 1, 2021.** A network filing proposing a service area expansion, new network, or withdrawal must be submitted as a **separate**

[11] Updated guidance may be issued by CMS after the creation of this document. When completing the Plan's submission, the most current version of CMS guidance should be utilized. Contact the plan's assigned licensing reviewer if you have any questions regarding renewal notices.

[12] The Networks eFiling Instruction Manual-June 2020, available via the e-Filing webportal, should be reviewed prior to preparing the health plan's submission.

Notice of Material Modification to the health plan's license in the e-Filing system. Health plans are strongly encouraged to contact the Department and schedule a pre-filing conference before submission in the e-Filing system. Please refer to the checklist for New Networks and Service Area Expansions, and/or the checklist for Service Area Withdrawals contained within the Networks eFiling Instruction Manual-June 2020, as well as the Department's templates for filing provider roster information, all available in the "Downloads" section of the e-Filing web portal. Be sure to include the following Exhibits with your filing:

- Provider Network Rosters (Exhibits I-1, I-2, and I-3, utilizing the Department templates available for download on the e-Filing web portal)
- Provider-to-enrollee Ratios for the overall enrollment in the network to be used in the Plan's proposal. (Exhibit I-4)
- Description of Service Area, by ZIP Code (Exhibit H-1, utilizing the Department template available for download on the e-Filing web portal)
- Requests for Alternative Standards of Accessibility (Exhibit I-5, utilizing the Department's template available for download on the e-Filing web portal)
- Enrollment Projections (Exhibit I-4, utilizing the Department template available for download on the e-Filing web portal)
- Any new or amended network Policy and Procedure documents (Exhibits I-5, I-6 and/or J-13). Please submit all amended versions of previously approved documents in both "clean" and "redline" versions.

- ❑ Amendment Filing: If the health plan has determined that its network has experienced a 10 percent or greater change in the names included in the health plan's Exhibits I-1, I-2, or I-3, please submit an amendment to the health plan's license in the e-Filing system within 30 days of any change requiring a network Change Amendment filing. Please refer to the checklist for Network Amendment Filings contained within the Networks eFiling Instruction Manual-June 2020, as well as the Department's templates for filing provider roster information, all available in the "Downloads" section of the e-Filing web portal.
- ❑ Significant Enrollment Changes: If the health plan experienced greater enrollment in 2021 than was projected in the prior year's filing, or if the health plan projects a significant increase in enrollment in 2022 beyond what was previously projected for 2022, submit the following:
    - Enrollment Projections (projected over two years) (Exhibit I-4, utilizing Department template available for download on the e-Filing web portal)

- Provider-to-enrollee Ratios (Exhibit I-4)

- New or Revised Plan-to-Plan Arrangement: If the health plan intends to enter into a new Plan-to-Plan contract with a Knox-Keene licensed health plan, or change the health plan with which it currently has a Plan-to-Plan contract to another KKA licensed health plan, to provide some or all of its network providers, the Department will require information from both the health plan and the KKA licensed subcontracting health plan as follows:
  - The health plan must file:
    - A statement within the Exhibit E-1 identifying the portion of the service area in which the health plan intends to utilize the subcontracting health plan's network and affirmation that the subcontracting health plan has been approved to operate a network in that portion of the service area. For this purpose, it is not sufficient to reference filings made pursuant to Annual Network Review.
    - 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 10 percent or greater change to the health plan's network exhibits, as described in Rule 1300.52, subdivision (f) and Section 1367.27, subdivision (r). (The Department Checklist for Network Amendment Filings and templates for these exhibits are available for download in the e-Filing webportal).
  - The subcontracting health plan must file:
    - Provider-to-enrollee Ratios (Exhibit I-4) demonstrating that the health plan has the capacity to take on the enrollment from the health plan.
    - A statement within the Exhibit E-1 indicating the e-Filing number of the most recent network review conducted by the Department and the filing in which the health plan was approved to operate in the service area covered by the health plan. For this purpose, it is not sufficient to reference the filing made pursuant to Annual Network Review.
    - A statement within the Exhibit E-1 indicating whether any of the provider rosters (Exhibits I-1, I-2, or I-3) have experienced a 10 percent or greater change in provider names since the most recent time the network was filed and reviewed. The calculation of change in names should be based on the change since the e-Filing referenced above.

- An Exhibit H-1 demonstrating the subcontracting health plan is approved for the service area in which the health plan intends to utilize the subcontracting health plan's network. (The Department template for this exhibit is available for download in the e-Filing webportal).

- New or Revised Plan-to-Plan Arrangement with Non-KKA Licensed Plan: If the health plan intends to enter into a new Plan-to-Plan arrangement with a health plan not licensed by the Department, or change the health plan with which it currently has a Plan-to-Plan arrangement to a health plan not licensed by the Department, to provide some or all of its network providers, the health plan will be responsible for providing all network information as follows:
  - A statement within the Exhibit E-1 identifying the plan with which the health plan 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 health plan will result in a 10 percent or greater change to the health plan's network exhibits, as described in Rule 1300.52, subdivision (f) and Section 1367.27, subdivision (r). (Department templates for these exhibits are available for download in the e-Filing webportal).
- Required Network Information for All Re-Certification Filings: As described in the "Exhibit E-1" section above, for each recertification filing, regardless of whether a network filing is required under the Act, include the following network information in the Exhibit E-1:
  - The name of network for each network,
  - The e-Filing number associated with the most recent time each network was filed and reviewed (even if the network was reviewed under a different name or connected to a different product), and
  - A brief overview of any changes to the health plan's networks previously approved for use on the Exchange.

Actuarial Value Calculation: Exhibit FF-4

- Submit an actuarial certification that the benefit plan designs submitted do not vary by more than plus or minus two (2) percent.[13]
- Actuarial Value – Full service health plans proposing to offer 9.5 and/or 10.0 EHB should submit through the e-Filing portal the following supporting documentation under Exhibit FF-4:
    - If the benefit plan design is compatible with the federal AV calculator submit the following:
        - A screenshot of the AV calculator with inputs used for each benefit plan design.
        - The Excel tab from the AV calculator entitled "User Inputs for Plan Parameters."
    - If the benefit plan design 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.
        - Calculate the benefit plan designs' AV by estimating a fit of the benefit plan design into the parameters of the AV calculator; or
        - Partial use of AV calculator for plan provisions that fit within the calculator parameters and with appropriate adjustments to the AV identified by the calculator for benefit plan design features that deviate substantially from the parameters of the AV calculator.

For either methodology, provide the following:

- A screenshot of the AV calculator with inputs used for each benefit plan design.
- A complete description of the data, assumptions, factors, rating models, and methods used to determine the adjustments.
- The actuarial certification must describe the methodology with sufficient clarity and detail to enable another qualified health

[13] Actuarial value for nongrandfathered Individual and Small Group benefit plan designs shall not vary by more than plus or minus two (2) percent pursuant to Sections 1367.008, subdivision (b)(1) and 1367.009 subdivision (b)(1), respectively. The actuarial value for a nongrandfathered Bronze level health plan that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan, as defined in United States Code, title 26, section 223, subdivision (c)(2), may range from plus five (5) percent to minus two (2) percent pursuant to Section 1367.0085.

actuary to make an appraisal of the reasonableness of the data, assumptions, factors, models, and methods.

Enrollment Projections: Exhibits CC, DD, and EE

- Enrollment projections and summary for all Individual and Small Group contracts. The first year of projections should be prepared on a monthly basis and the second year on a quarterly basis. The projections should include a balance sheet, income statement and statement of cash flows.

Financial Projections: Exhibit HH

- Financial projections may be requested by the Office of Financial Review, depending upon the financial position of the health plan. If projections are requested, they should mirror the format of the enrollment projections noted above.

Rate Review

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