

PLAN YEAR 2020 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) offers the following information to assist Individual and Small Group product filings outside of the California Health Benefit Exchange (Exchange) for the Plan Year 2020, 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 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 DMHC within the course of review of a health plan filing.

Filing Timeframes

Health plans amending benefit plan designs for the 2020 Plan Year must have DMHC approval of necessary filings, including, but not limited to: licensure, networks, product, benefit plan design, and rate filings. Complete filings are due as follows:

Type of Filing	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 as	No later than July 1	No later than August 1
Provider Network	No later than March 1	Within 30 days any change requiring a network Change Amendment filing. ¹
Rates Individual and CCSB	Individual Market: July 8 Small Group Market: July 16	Individual Market: July 8 Small Group Market: July 16

¹ 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-File system, use the subject title "Plan Year 2020 off-Exchange [Individual] or [Small Group] Products-[HMO], [PPO], [EPO], [POS]" The 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 2020 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 [2020 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 DMHC, including e-File 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 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 to Annual Network Review.

² 45 C.F.R. § 147.106(e).

³ Id.

- To ensure the Plan has adequately considered State Law as well as confirmed the 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: California Health and Safety Code sections 1399.849 and 1357.503.
- 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 DMHC review. Note, the health plan is not required to file the documents described above unless requested by the DMHC.
- Identify the page numbers of the EOC that demonstrate compliance with newly enacted statutes effective on or after January 1, 2019, including but not limited to⁴:
 - AB 315 (Wood, Ch. 905, stats. 2018) – Pharmacy Benefit Mangers
 - AB 1860 (Limón, Ch. 427, Stats. 2018) – Oral Anticancer Medications
 - AB 2193 (Maienschein, Ch.755, Stats. 2018) – Maternal Mental Health
 - AB 2863 (Nazarian, Ch. 770, Stats. 2018) – Prescription Drug Cost-Sharing
 - SB 1021 (Wiener, Ch. 787, Stats. 2018) – Prescription Drug Tiers and Cost-Sharing
 - SB 1375 (Hernandez, CH. 700, Stats. 2018) – Small Employer Groups
 - 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 DMHC in connection with the health plan's on-Exchange product(s) and provide the filing no. for the approved health benefits.
- 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 2020 Patient-Centered Benefit Plan Designs. If revision is not required, the health plan must provide a confirmatory

⁴ For additional guidance see the DMHC's All Plan Letter regarding newly enacted statutes in 2018 impacting health plan license filings on or after January 1, 2019.

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 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 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 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). Additionally, identify the page nos. 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 filing no. 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 2020 Dental Standard Benefit Plan Design (SOB) and Copay Schedule are based on the Dental Benchmark Plan and reflect the most recent CDT codes. Plans should follow Covered California's 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, 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 Benefits⁶ (EHB), such as acupuncture, pediatric dental or vision benefits, should include in Exhibit E-1 a brief explanation of each contractual relationship.

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

⁶ Section 1367.005; Rule 1300.67.005.

- ❑ 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.

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 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

⁷ Section 1366.6 subdivisions (c)-(e).

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 (Exhibit S,T, or U)**
 - For each proposed benefit plan design, submit a Schedule of Benefits (SOB).⁹
 - If the health plan prefers to submit a sample SOB, please use the DMHC's INDIVIDUAL AND SMALL GROUP MARKET REPRESENTATIVE BENEFIT PLAN DESIGN WORKSHEET (Representative Worksheet). Plans using this worksheet are not required to submit individualized Schedules of Benefits (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 2020 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 (Exhibit S-3).** A federal Summary of Benefits and Coverage (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 on and after April 1, 2017.¹⁰ If the health plan has already received approval of its representative SBC(s) pursuant to a separate filing, provide the e-File number in lieu of submitting the exhibit.
- **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 worksheet, as described above, it is not required to submit a new worksheet unless the

⁸ See the 2020 QDP Checklist for specific instructions for filing EHB dental benefits.

⁹ Id.

¹⁰ Template instructions, materials and supporting documents authorized for use on and after April 1, 2017, may be located at [The Center for Consumer Information & Insurance Oversight](#)

previously-approved worksheet requires amendment.

- **Prescription Drug EHB Benchmark Plan Benefits Chart (Exhibit T-4).** A Prescription Drug EHB Chart, as promulgated in 1300.67.005 (effective as of June, 27, 2017). Note, if the health plan has previously submitted a complete worksheet, as described above, it is not required to submit a new worksheet 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
- For each variation, a justification and basis for the health plan's determination of compliance with Rule 1300.67.005

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 19, 2018) 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

Report information related to each provider network connected to a non-grandfathered Individual or Small Group Market 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. For this purpose, it is not sufficient to reference the filing made pursuant to Annual Network Review.

A health plan need only submit a complete provider network filing if the health plan is required to submit network information pursuant to the Act.

If necessary, this filing should be made in a separate Amendment or Notice of Material Modification. When submitting a network for review, identify the name of the network and products utilizing 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 2020 benefit year must file a network with the DMHC as soon as practicable, but no later than March 1, 2019. Refer to the Checklist for New Networks and Service Area Expansions, available in the “Downloads” section of the e-File webportal, and be sure to include the following Exhibits with your filing:
 - Provider Network Rosters (Exhibits I-1, I-2, and I-3, utilizing the 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, utilizing the DMHC template available for download on e-File)
 - Standards of Accessibility (Exhibit I-5)
 - Enrollment Projections (Exhibit I-4, utilizing the DMHC template available for download on e-File)

- 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 Notice of 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 2020 benefit year must be filed as soon as practicable, but no later than March 1, 2019. Refer to the Checklist for New Networks and Service Area Expansions, available in the “Downloads” section of the e-File webportal, and 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, utilizing DMHC template available for download on e-File)
 - Standards of Accessibility (Exhibit I-5)
 - Enrollment Projections (Exhibit I-4, utilizing DMHC template available for download on e-File)

- 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 its network meets those circumstances, within 30 days of

identifying such a change, submit an amendment to the health plan's license in the e-File system.¹¹ See the "Downloads" section of the e-File webportal to locate and utilize the Checklist for Network Amendment Filings and the DMHC templates for filing provider roster information.

- If the health plan experienced greater enrollment in 2019 than was projected in the prior year's filing, or if the health plan projects a significant increase in enrollment in 2020 beyond what was previously projected for 2020, submit the following:
 - Enrollment Projections (projected over two years) (Exhibit I-4, utilizing DMHC template available for download on e-File)
 - Provider-to-enrollee Ratios (Exhibit I-4)
- If the health plan intends to enter into a new plan-to-plan contract with a Knox-Keene licensed health plan, or change the plan with which it currently has a plan-to-plan contract to another Knox-Keene licensed health plan, to provide some or all of its network providers, the DMHC will require information from both the health plan and the Knox-Keene 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 healthplan 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. 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 significant change to the health plan's network, as described in Rule 1300.52, subd. (f) and Section 1367.27, subd. (r). (The DMHC Checklist for Network Amendment Filings and templates for these exhibits are available for download in the e-File webportal).
 - The subcontracting health plan must file:
 - Provider-to-enrollee Ratios (Exhibit I-4) demonstrating that the plan has the capacity to take on the enrollment from the health 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

¹¹ Sections 1352 subdivision (a), 1367.27 subdivision (r); Rule 1300.52 subdivision (f).

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.

- An Exhibit H-1 demonstrating the subcontracting plan is approved for the service area in which the health plan intends to utilize the subcontracting plan's network. (The DMHC template for this exhibit is available for download in the e-File webportal).
- If the health plan intends to enter into a new plan-to-plan arrangement with a plan not licensed by the DMHC, or change the plan with which it currently has a plan-to-plan arrangement to a plan not licensed by the DMHC, 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 plan will result in a significant change to the health plan's network, as described in Rule 1300.52, subdivision. (f) and Section 1367.27, subdivision. (r). (DMHC templates for these exhibits are available for download in the e-File webportal).

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.¹²
- 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 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.”

¹² 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.

- 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' s 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 certification must describe the methodology with sufficient clarity and -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.