2019 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 2019, 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, product, benefit plan design, 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
Benefit Plan Designs	No later than April 1	
Rates Individual and CCSB	Individual: July 6, 2018 (tentative)[1] Small Group: July 25, 2018	

[1] Deadline is tentatively based on the federal *DRAFT Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2019*. The filing deadline is subject to change based on future federal guidance.

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 in the e-File system, please use the subject title "HBEX QHP Application 2019."
- 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 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 as Exhibit E-1.
- For each formulary utilized in connection with product(s) required to comply with the 2019 Patient-Centered Benefit Plan Designs, submit: (i) an Exhibit T-3 that contains a copy of the formulary, and (ii) an Exhibit T-5 that contains a signed 2019 Prescription Drug Compliance Affidavit, which is attached.
- Changes and updates to previously approved exhibits should be indicated with clearly visible redlined changes.

Narrative: Exhibit E-1

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

- Whether the health plan's QHP Application with the Exchange is for individual and/or small group, and identify the region(s) included in the application.
- Whether the benefit plan designs being proposed have been previously approved by the DMHC including e-File numbers of previously approved benefit plan designs.
- 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 contracts. For this purpose, it is not sufficient to reference the filing made pursuant to Annual Network Review.
- A list of each benefit plan design (specifying each metal level, market, region and network) offered by the health plan that is required to comply with 2019 Patient-Centered Benefit Plan Designs and an explanation of whether the health plan utilizes the same or different formularies for different benefit plan designs or product(s).

[2] 45 C.F.R. § 147.106(e).

- ❑ Identify the page numbers of the EOC that demonstrate compliance and/or have been revised to demonstrate compliance with statutes enacted in 2017, including but not limited to:
  - AB 1048 (Arambula, Ch. 616, Stats. 2017)—Pain Management and Schedule II Drug Prescriptions
  - AB 1074 (Maienschein, ch. 385, Stats. 2017)—Pervasive Developmental Disorder or Autism
  - SB 133 (Hernandez, ch. 481, Stats. 2017)—Continuity of Care
  - SB 223 (Atkins, ch. 771, Stats. 2017)—Health Care Language Assistance Services
  - Any other newly enacted statute(s) or regulation(s) for which the health plan deems revision is appropriate.
- ❑ Identify the page numbers of the EOC revised for compliance with newly-enacted or revised Endnotes in the 2019 Patient-Centered Benefit Plan Designs. If revision is not required, the health plan must provide a confirmatory statement which states no revisions are required.
- ❑ If the health plan is proposing to offer non-standard plan(s) on the Exchange, explain whether it has submitted the proposal to the Exchange for approval.
- ❑ 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). Please also identify the page nos. of the EOC which disclose the pediatric vision and aphakia benefits.

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 Benefits[3] (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 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 plans is not providing its own specialized services list the plans or other 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. 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

[3] Section 1367.005; Rule 1300.67.005.

plan- to-plan contract. See 2019 CHECKLIST FOR QUALIFIED DENTAL PLANS IN THE CALIFORNIA HEALTH BENEFIT EXCHANGE which encompasses dental plans contracting directly with a) the Exchange 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.
- Specialized health plans are not required to provide eligibility information in connection with catastrophic or AI/AN benefit plan designs within their Evidence of Coverage. Specialized health plans must file catastrophic and AI/AN Schedule of Benefits. 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 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 that all Essential Health Benefits are included in these exhibits, including those provided by a contracted specialized health plan.[4]
- Schedule/Summary of Benefit (Exhibit S,T, or U): For each benefit plan design proposed.[5]
- 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

[4] Please see the 2019 QDP Checklist which has specific instructions for SBD dental benefits.
[5] Id.

reminded to utilize the SBC instructions, materials and supporting documents authorized for use on and after April 1, 2017.[6] If the health plan has already received approval of its representative SBC(s) pursuant to a separate filing, please provide the e-File number in lieu of submitting the exhibit.

- EHB Filing Worksheet (Exhibit T-2): A new 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 consistent with the Emergency Rule, effective on November 28, 2016, and received approval, it is not required to submit a new worksheet unless the previously-approved worksheet is being amended.
- Prescription Drug EHB Benchmark Plan Benefits Chart (Exhibit T-4): A new 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 consistent with the Emergency Rule, effective on November 28, 2016, it is not required to submit a new worksheet unless the previously-submitted worksheet is being amended. 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

- Renewal notices must comply with federal requirements including the Updated Federal Standard Renewal and Product Discontinuation Notices Bulletin (September 2, 2016) 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. Submit representative renewal notices which comply with the requirements above. If the health plan has previously received approval of its representative renewal notices pursuant to a separate filing and revisions are required, provide the e-File number in lieu of submitting the exhibit.

Provider Network: Exhibits H and I

- Please report information related to each provider network that is connected to a QHP, 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 for any of its QHP provider networks 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

[6] 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/

Modification. 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 2019 benefit year must file a network with the DMHC as soon as practicable, but no later than March 1, 2018. Please 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 EE-1, 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 2019 benefit year must be filed as soon as practicable, but no later than March 1, 2018. Please 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 EE-1, 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 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, 2018. Please visit 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 2018 than was projected in the prior year's QHP filing, or if the health plan projects a significant increase in enrollment in 2019 beyond what was previously projected for 2019, please submit the following:
  - Enrollment Projections (projected over two years) (Exhibit EE-1, 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 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. 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 QHP'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 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. For this purpose, it is not sufficient to reference the filing made pursuant to Annual Network Review.
    - 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. (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 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).

(DMHC templates for these exhibits are available for download in the e-File webportal).

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 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, then
    - 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 detail that another qualified health actuary can make an objective 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.