DEPARTMENT OF Managed Health Care

2027 CHECKLIST AND WORKSHEET FOR QUALIFIED HEALTH PLANS ON THE CALIFORNIA HEALTH BENEFIT EXCHANGE

The Department of Managed Health Care (DMHC or Department) offers the following information to assist Individual Qualified Health Plans (QHP) and Covered California for Small Business (CCSB) Issuers for the Plan Year 2027, 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 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 Department within the course of review of a health plan filing. For health plans licensed pursuant to the Act, the Department 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 and regulatory requirements of the Act and Rules apply to product(s) offered through the Exchange.

I. Filing Timeframes

Prior to certification, health plans 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:

Plan Year 2027	New Applicant; QHP Proposing New: Rating Region, Network, Service Area Expansion and/or Line of Business	QHP proposing no changes to Rating Region or Line of Business
All Exhibits other than Benefit Plan Designs/Networks	No later than March 2	No later than April 1
Provider Network	No later than March 2	No later than April 1
Benefit Plan Designs	No later than April 1	No later than April 1
Rates Individual	No later than July 13	No later than July 13
Rates CCSB (effective January 1, 2027)	No later than July 14	No later than July 14

II. Filing Checklist

A. 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 "**HBEX QHP Application 2027**."

B. 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.[1]

C. Health plans are not required to submit each on-Exchange network for full review for the sole purpose of QHP recertification unless certain network changes have or will occur (see below under "Provider Network").

D. Complete and file the attached QHP DMHC Filing Worksheet(s) as Exhibit E-1. Provide a narrative ensuring the description corresponds to the summary provided in the *QHP DMHC Filing Worksheet*.

E. Complete and file the attached *QHP Subcontractor Worksheet* as Exhibit E-1.

F. For each formulary utilized in connection with product(s) required to comply with the 2027 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 *Prescription Drug Compliance Attestation*.

G. Refer to Covered California's naming convention for on-exchange plans and off-exchange mirror products pursuant to Government Code Section 100503(f).

H. Changes and updates to previously approved exhibits should be highlighted in the filed documents by strikeout, underline, or other method in accordance with Rule 1300.52.

III. Narrative: Exhibit E-1

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

1. Whether the health plan's application with the Exchange is for Individual and/or Small Group contracts and identify the region(s) included in the application.

[1] 45 C.F.R. § 147.106(e).

2. Whether the proposed benefit plan designs were previously approved by the Department including e-Filing numbers of previously approved benefit plan designs.

3. An affirmation the health plan complied with the *Plan Year 2027 Networks Checklist and Worksheet for QHP and QDP Plans* filing requirements.

4. A list of each benefit plan design (specifying each metal level, market, region and network) offered by the health plan required to comply with 2027 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).

5. To ensure the health plan has adequately considered both Federal and 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 and Federal law, as applicable, including, but not limited to: Sections 1357.503 and 1399.849; California Code of Regulations, title 10, sections 6504 and 6520; and Code of Federal Regulations, title 45, sections 155.420 and 155.725. If the health plan is unable to provide the affirmation requested, it must provide the specific triggering event(s) at issue with appropriate justification.

6. 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. The health plan is not required to file the documents described above unless requested by the Department.

7. Identify the e-Filing number in which the health plan submitted the compliance filing associated with the Department's All Plan Letter (APL) 25-020.

8. Identify the page numbers of the Evidence of Coverage (EOC) that demonstrate compliance with newly enacted statutes or regulation(s), including but not limited to:[2]

    a. AB 116 (Committee on Budget, Ch. 21, Stats. 2025)—Health Omnibus Trailer Bill

    b. AB 144 (Committee on Budget, Ch. 105, Stats. 2025)—Health[3]

[2] For additional guidance see APL 25-020 regarding newly enacted statutes in 2025 impacting health plan license filings.
[3] For additional guidance see APL 25-015.

c. AB 260 (Aguiar-Curry, Ch. 136, Stats. 2025)—Sexual and Reproductive Health Care

d. AB 951 (Ta, Ch. 84, Stats. 2025)—Health Care Coverage: Behavioral Diagnosis

e. SB 40 (Wiener, Ch. 737, Stats. 2025)—Health Care Coverage: Insulin

f. SB 41 (Wiener, Ch. 605, Stats. 2025)—Pharmacy Benefits

g. SB 402 (Valladares, Ch. 413, Stats. 2025)—Health Care Coverage: Autism

h. SB 497 (Wiener, Ch. 764, Stats. 2025)—Legally Protected Health Care Activity

i. Any other newly enacted statute(s) or regulation(s) for which the health plan deems revision is appropriate.

Please note: Guidance regarding the requirements of SB 62 (Menjivar, Ch. 739, Stats. 2025)—Health Care Coverage: Essential Health Benefits, will be forthcoming and issued under a separate communication if the United States Department of Health and Human Services approves a new essential benefits benchmark plan for California.

9. Identify the page numbers of the Evidence of Coverage (Exhibit T-1), Disclosure Form (Exhibit S-1), or combined Evidence of Coverage/Disclosure Form (Exhibit U-1) that demonstrates compliance with the following template components of the standardized EOC/DF for use in health care service plan contracts in the individual and small group markets issued, amended, or renewed on or after January 1, 2027:[4]

   a. Exclusions and Limitations

   b. Members' Rights and Responsibilities

   c. Definitions

10. Identify the page numbers of the EOC revised for compliance with newly enacted or revised Endnotes in the 2027 Patient-Centered Benefit Plan Designs. If revision is not required, the health plan must

[4] The DMHC anticipates issuing an APL regarding compliance with the individual and small group standardized Evidence of Coverage/Disclosure Form in early 2026.

provide a confirmatory declaration, which states no revisions are required.

11. 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.

12. Affirm the health plan discloses coverage of pediatric vision benefits without annual or lifetime limits on the dollar value of 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.

13. For pediatric embedded dental benefits, where the dental EOC, Schedule of Benefits (SOB), and limitations and exclusions are fully embedded within the QHP materials, please identify by page and section number the dental information within the health plan's Exhibit E-1.

14. Affirm any anticipated change in the plan's enrollment for its Covered California products is less than 5 percent of the plan's total enrollment and would not have a material impact on the plan's financial position. If the change in enrollment is greater than 5 percent, please describe the impact of the change to the plan's financial position.

B. For Small Group benefit plan designs only, affirm that for every contract it offers coverage for:

1. The treatment of infertility, as defined in Section 1374.55, as amended by SB 729 (Menjivar, Ch. 930, Stats. 2024);[5] and

2. Orthotic and prosthetic and special footwear benefits, as set forth in Sections 1367.18 and 1367.19.

C. Contracts with Specialized Health Plans:

1. Full service health plans that contract with specialized health plans for the provision of Essential Health Benefits (EHB),[6] such as

[5] For additional guidance see APL 25-021.
[6] *See* Section 1367.005; Rule 1300.67.005.

acupuncture, pediatric dental or vision benefits, should include in the Exhibit E-1 a brief explanation of each contractual relationship.

2. 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 (e.g. rental of network) should be filed as an Exhibit N-1.

3. 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.

4. 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 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. See *2027 CHECKLIST FOR QUALIFIED DENTAL PLANS IN THE CALIFORNIA HEALTH BENEFIT EXCHANGE*, which encompasses dental plans contracting directly with a) the Exchange and b) QHPs.

5. Specialized health plans that contract to provide EHB may also need to submit EOCs, disclosure forms, and provider network information on behalf of the full service health plan. QHPs should share this checklist with contracted specialized health plans to ensure the specialized health plan's mirror filings include all Department requirements.

6. Specialized health plans are not required to provide eligibility information in connection with catastrophic or AI/AN benefit plan designs within their EOC. 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.

IV. <u>All Other Exhibits as Necessary</u>

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 the Exhibit E-1. The health plan is not required to submit these exhibits unless requested.

A. 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.

B. Provider and Administrative Services Contract(s) (Exhibits K and N). New or revised provider or administrative service contract(s) related to Exchange product(s).

C. Plan Organization (Exhibit L). New or revised organizational chart(s).

D. Plan-to-Plan Contracts (Exhibit P-5). New or revised Plan-to-Plan contract(s) related to the delivery of services to Exchange enrollees.

E. Grievance & Appeals (Exhibit W). New or revised Grievance and Appeal procedures.

F. Marketing (Exhibits V, Y, Z, AA, and BB). Advertising and marketing materials related to Exchange product(s).

V. Benefit Plan Designs: Exhibits S, T, and U

A. 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.[7]

B. Schedule/Summary of Benefits (SOB) (Exhibit S, T, or U).

1. For each proposed benefit plan design, submit a SOB.[8]

2. 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 worksheet are not required to submit 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 Exchange's 2027 Individual Silver 70 plan under the exhibit type(s) described above, together with the Representative Worksheet. For further instruction, see the Representative Worksheet instructions.

C. Federal Summary of Benefits and Coverage (SBC) (Exhibit S-3). A federal SBC disclosure form in connection with the Exchange's Individual

[7] *See* the 2027 QDP Checklist which has specific instructions for SBD dental benefits.
[8] *Id.*

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.[9] If the health plan has 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 within a separate filing the representative SBC(s) and provide the e-Filing number.

D. 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.

E. 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). 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 Exhibit E-1:

1. If EHB Count Chart includes generics;

2. A summary of any category/class variations from what is shown in the health plan's EHB Count Chart; and

3. For each variation, a justification and basis for the health plan's determination of compliance with Rule 1300.67.005.

VI. Representative Renewal Notices: Exhibit I-9

Renewal notices must comply with federal requirements including the Updated Federal Standard Renewal and Product Discontinuation Notices Bulletin (June 20, 2023[10]) 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

[9] 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.

[10] 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.

(June 26, 2014) issued by CMS.

VII. Provider Network

Health plans are not required to file network exhibits for the sole purpose of QHP recertification, and nothing related to networks will be reviewed in this filing. Please refer to the *Plan Year 2027 Networks Checklist and Worksheet for QHP and QDP Plans* for filing guidance.

VIII. Actuarial Value Calculation: Exhibit FF-4

A. Submit an actuarial certification that the benefit plan designs submitted do not vary by more than plus or minus two (2) percent.[11]

B. 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:

1. If the benefit plan design is compatible with the federal AV calculator submit the following:
    a. A screenshot of the AV calculator (Final Version) with inputs used for each benefit plan design.
    b. The Excel tab from the AV calculator entitled "User Inputs for Plan Parameters."
2. If the benefit plan design is not compatible with the AV calculator:
    a. Submit an actuarial certification on the methodology chosen from the options specified in 45 CFR §156.135(b).
    b. The certification must be prepared by a member of the American Academy of Actuaries.
    c. Calculate the benefit plan designs' AV by estimating a fit of the benefit plan design into the parameters of the AV calculator; or

[11] 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. Pursuant to 45 CFR 156.200(b)(3), the allowable AV variation range for Individual Silver is between 0 and +2 percentage points. Pursuant to 45 CFR 156.400, the allowable AV variation for Silver Variant is between 0 and +1 percentage points. Additional guidance may be forthcoming.

d. Partial use of AV calculator for health plan provisions that fit within the calculator parameters, in accordance with generally accepted actuarial principles and methodologies, 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.

3. For either methodology, provide the following:

   a. A screenshot of the AV calculator with inputs used for each benefit plan design.

   b. A complete description of the data, assumptions, factors, models, and methods used to determine the adjustments.

   c. The actuarial certification must describe the methodology with sufficient clarity and detail to enable another qualified health actuary to make an objective appraisal of the reasonableness of the data, assumptions, factors, models, and methods.

IX. Compliance Statement: Exhibit FF-5

Submit an Exhibit FF-5 for review. The Exhibit FF-5 statement must be in compliance with 45 CFR § 156.280 (a)-(e) regarding the segregation of funds utilized for abortion services for nongrandfathered individual market.

X. 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.

XI. Financial Projections: Exhibit HH

Financial projections may be requested by the Office of Financial Review, depending upon the financial position of the health plan. The projections should include a balance sheet, income statement, statement of cash flows, calculation of tangible net equity and calculation of administrative costs. If projections are requested, they should mirror the format of the enrollment projections noted above.

XII. Rate Review

2027 SERFF rate filings deadlines are listed on Page 1 of this checklist.