

Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 9

Release Date: April 30, 2013

Guidance/Timeline

QHP Certification/Review Process

Q1: Can an issuer remove a plan from the Exchange, but still offer it off-Exchange?

A1: As long as a plan originally submitted as "Both", the issuer can withdraw it from on the Exchange and still offer it off the Exchange, subject to meeting any applicable state approval requirements. However, HHS encourages issuers to only submit applications for plans that it currently intends to offer on the Exchange.

Q2: What are the specific actions that an issuer attester must perform?

A2: The attester will be required to agree to the final plan offerings list, which will contain the QHPs the FFE is recommending for certification, as well as sign the QHP Agreement. The submitter and validator will provide the response to the Program Attestations during the initial QHP submission. The Attester's input is not required during the initial submission window.

Q3: Where can issuers view the QHP Agreement?

A3: HHS plans to release a copy of the agreement by mid-summer.

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Q4: Do products and/or networks need to be approved by the applicable state regulatory agency prior to April submission?

A4: QHP issuers can submit plans that are not yet approved by the State regulatory entity. During application submission, an issuer attests that it will have a license by the end of the certification period, be in good standing, and be authorized to offer each specific type of insurance coverage offered in each State in which the issuer offers a QHP. The issuer must submit evidence of licensure by the end of the resubmission window. At the time of certification, QHP issuers must agree that it is in compliance with all State laws and statutes related to its QHP plans in the State in which QHP plans are being offered, including that the forms for the QHPs it will offer have been approved or deemed by the State (as applicable in that State), and agree to notify HHS if in the future it is not compliance.

Dental

Q5: Outside of the Exchange, does the medical plan need to provide dental benefits if an individual provides reasonable assurance to an issuer that he/she has already purchased an exchange-certified stand-alone dental plan that covers the pediatric EHB?

A5: No. Outside of the Exchange, the issuer must have reasonable assurance that the individual has purchased exchange-certified stand-alone dental coverage that covers the pediatric EHB requirement, as noted in the preamble to the final rule on EHB at 78 FR 12853. This assurance could be obtained by requiring proof of coverage from the individual or establishing a method of confirming coverage directly with the stand-alone dental plan. The method of obtaining assurance is at the discretion of the issuer.

Q6: Can the Exchange-certified stand-alone dental plan and medical plan have separate deductibles and out-of-pocket maximums (provided the Exchange-certified stand-alone dental plan amounts are determined to be "reasonable")?

A6: According to the Letter to Issuers, under 45 CFR 156.150, rather than meeting the specific dollar limits that apply to comprehensive medical QHPs, stand-alone dental plans offered inside an Exchange will be required to demonstrate to the Exchange (FFE or otherwise) that they have a reasonable annual limitation on cost-sharing in place. The final rule also clarified that the Exchange is responsible for determining the level for "reasonable." For 2014 in the FFE, the annual out-of-pocket maximum for a stand-alone dental plan is \$700 for one child and \$1,400 for two or more children. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

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Q7: For off-Exchange business, if an individual does not purchase an Exchange-certified stand-alone dental plan, does the issuer have to embed the pediatric dental benefit into the medical plan?

A7: Outside the Exchange, the issuer should embed dental services including pediatric dental coverage if the issuer is not reasonably assured that the individual is enrolled in an Exchange-certified stand-alone dental plan.

Q8: If the pediatric benefits have to be embedded, do they have to track to a single combined deductible and out-of-pocket max?

A8: According to the EHB Final Rule, when the pediatric dental benefit is embedded in a health insurance plan subject to standards set forth in 45 CFR 156.130 and 156.140, HHS does not distinguish it from other benefits with respect to AV and cost-sharing requirements. The dental benefit can have a separate deductible and/or maximum out-of-pocket as long as the total combined with medical does not exceed what is allowed by the statute.

Q9: Is there an AV Calculator for stand-alone dental?

A9: As described in 45 CFR 156.150(b), a stand-alone dental plan may not use the AV Calculator, and instead must demonstrate that the stand-alone dental plan offers the pediatric dental EHB at either a low level of coverage with an AV of 70 percent or a high level of coverage with an AV of 85 percent, and within a de minimis variation of +/-2 percentage points. In order to meet this standard, the AV level of coverage for stand-alone dental plans must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.

Q10: Will dental plans complete the Unified Rate Review Template?

A10: As stated in the Letter to Issuers, stand-alone dental plans will not need to complete the unified rate review template. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

Q11: If an issuer offers a plan with pediatric dental carved out and an identical plan that includes pediatric dental coverage, should these plans have the same actuarial value for metal-level determination? Should issuers adjust the AV results for pediatric benefits?

A11: Although they are not separate calculator inputs, the AV Calculator does include both pediatric dental and vision claims as part of the standard population. However, a plan's inclusion of the pediatric dental benefit generally will not result in a material difference in AV because both cost and utilization are low in the standard population. Therefore, in most cases there will be no need to adjust the AV results.

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Q12: For an integrated pediatric dental and medical plan, is it permitted to establish two separate buckets for the out-of-pocket limit for medical and dental coverage as long as the total out-of-pocket limit does not exceed the QHP limit?

A12: Yes, that would be permitted.

Q13: What certification, if any, is required for a stand-alone dental plan?

A13: Please refer to Chapter 4 of the Letter to Issuers for details on the certification requirements. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at

http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

Q14: Where can issuers find information about stand-alone dental plans submitting intent to participate in FFEs?

A14: Information about the intent to participate in the FFE by stand-alone dental plan issuers can be found here: <http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf>.

Q15: When will the stand-alone dental plan templates be finalized?

A15: As stated in the Letter to Issuers: "Stand-alone dental plans will generally use the same QHP Application, but will complete and submit the application on an adjusted timeline. Some portions of the QHP certification application require modifications to accommodate the limited scope of stand-alone dental plans. For the 2013 QHP certification cycle, HHS anticipates that the draft plan benefits template will be ready for stand-alone dental plans by May 1." The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

Q16: What is the submission window for stand-alone dental plans?

A16: As stated in the Letter to Issuers: "Issuers of stand-alone dental plans can begin to work on completing the other QHP templates in advance of May; however, final submission of stand-alone dental plan applications will need to occur between May 15 and May 31." The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

Q17: Can the required pediatric dental EHB be a stand-alone dental plan?

A17: The pediatric dental EHB can be offered through a stand-alone dental plan in the Exchange.

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Essential Community Providers

Q18: In contracting with an Essential Community Provider (ECP), can an issuer contract with a doctor in the practice or does the issuer need to contract with the listed practice?

A18: The issuer would need to contract with the ECP as listed in the HHS non-exhaustive list of ECPs. The list is available at <http://cciio.cms.gov/programs/exchanges/qhp.html>.

Q19: Where can issuers find the Model Indian Addendum referenced in the ECP Template instructions?

A19: The Model Indian Addendum can be found on the CCIIO website at http://cciio.cms.gov/programs/Files/Model_QHP_Addendum_04_04_13.pdf.

Q20: Is the Model Indian Addendum document required to be submitted with the QHP Application?

A20: This addendum does not need to be submitted to HHS with the QHP application.

Q21: If a company is made up of multiple Physician Hospital Organizations, does it qualify for the alternate standard for ECPs?

A21: As referenced in the Letter to Issuers, in order to be considered as meeting the alternate standard, the issuer must meet the requirements laid out in 45 CFR 156.235(a)(2) and (b):

45 CFR 156.235(a)(2) states that a QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

45 CFR 156.235(b) states that Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

Essential Health Benefits

Q22: For testing Mental Health parity, does the Mental Health and Substance Abuse category also include services in the office?

A22: Yes, parity does include office visits for services included under the definition of mental health or substance use disorder benefits.

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Q23: Can issuers offer products off the Exchange that include EHB but do not meet the metal level?

A23: No. The Affordable Care Act requires issuers offering non-grandfathered health insurance coverage in the individual and small group markets both inside and outside the Exchange ensure that plans meet a level of coverage specified in Section 1302(a)(3) of the Affordable Care Act and defined in 45 CFR 156.140(b). Each level of coverage corresponds to an AV calculated based on the cost-sharing features of the plan.

Q24: When will issuers get more clarification about what "substantially similar" means with respect to benefits?

A24: An enforcing State (or HHS in non-enforcing states) will determine whether or not an EHB plan is substantially equal to the benchmark plan. As noted in the preamble to the final rule on EHB at 78 FR 12844, we seek to allow for flexibility of plan design. At this time, HHS does not expect to release additional guidance on this standard.

Q25: For FFEs, who is making the assessment that the benefits are substantially equal?

A25: Enforcement of the requirement to cover EHB is governed by section 2723 of the PHS Act, which looks first to States for enforcement, then to the Secretary where a State has failed to substantially enforce the standard.

If the State is enforcing the Affordable Care Act requirement, the State will make the assessment. If, however, the State does not enforce Affordable Care Act requirements, then HHS will make the assessment. Whichever entity makes the assessment will do so for the entire market (both inside and outside). The standards for the review are outlined in the Guidance on the State Partnership Exchange, posted to the CCIIO website on January 3, 2013 and available at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>

Q26: Is there a definition of "meaningful difference"?

A26: The Letter to Issuers provides further information and guidance on the meaningful difference standard. Please see pages 15 and 16 of the Letter to Issuers for more information. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

Q27: Will a metal plan qualify if prescription coverage is not included?

A27: Per 45 CFR 156.100, prescription benefits are one of the 10 benefit categories of EHB and therefore must be covered.

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Q28: Are issuers required to provide the services outlined in 45 CFR 156.115 (d), even if they are on the Plans & Benefits Template marked as EHB?

A28: Issuers are not required to provide the four services listed at 45 CFR 156.115(d) – routine non-pediatric dental; routine, non-pediatric eye exam services; long-term/custodial nursing home care; and non-medically necessary orthodontia -- (even if the benchmark covers those services) because those particular services are not EHB.

Q29: The FEDVIP brochure lists a lot of specifics in terms of specific dollar amounts that are allowed. If a pediatric vision plan has an allowance, can it be a dollar allowance amount and would that be considered some sort of limit?

A29: The Affordable Care Act prohibits annual and lifetime dollar limits on EHB, so even if the FEDVIP brochure includes such limits, EHB plans cannot impose such limits. See 45 CFR 147.126.

Q30: Could a child who receives coverage for lenses and frames under pediatric vision benefit receive an additional benefit under our Lenses and Frames rider for the amount that isn't covered?

A30: Yes, issuers can offer riders to cover additional benefits beyond EHB.

Q31: Does the Mental Health parity requirement apply to both SHOP and individual markets?

A31: Yes, all EHB plans must include mental health and substance use disorder services and those must comply with parity. Per 45 CFR 156.115(a)(3), since EHB plans are sold in the small group and individual markets, that means parity is required in both markets.

Q32: If a State's benchmark plan includes coverage for bariatric surgery, does the QHP have to cover bariatric surgery?

A32: Any state-required benefits enacted prior to 12/31/11 are considered EHB (45 CFR 155.170). QHP benefits and limits must be substantially equal to benchmark benefits and limits. See the final rule on EHB for additional explanation, available at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>.

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Q33: The AV Calculator only has a field for “Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services” and doesn’t split out the office visit services from the outpatient services. As a result, we don’t know if we need to fill out that field with parity to outpatient or parity to office visits. Our plan was to put in similar cost sharing for that benefit as medical outpatient and to explain in our Explanation of Coverage that behavioral health office visits would receive PCP cost sharing.

A33: We developed the AV Calculator for the purpose of calculating AV with a limited number of service inputs, and it was not specifically designed to demonstrate parity. Therefore, for the purposes of calculating AV, we recommend that you use your best actuarial determination to align these benefits to the AV Calculator, as described in the AV calculator methodology incorporated by reference into the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule. We further recommend taking the higher cost-sharing rate where possible. Per your example, we agree that you should provide any additional information in your EOC.

We also note that, under the mental health parity requirements applicable to coverage of the essential health benefit category of mental health and substance use disorder services, including behavioral health treatment, outpatient services and office visit services are considered to be within the same classification (*see* 45 C.F.R. § 146.136(c)(2)(ii)).

Q34: How can a State identify the issuers that have reported that they intend to offer stand-alone dental plans in the Exchange?

A34: At <http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf>, we explained how dental issuers voluntarily reported their intent to offer stand-alone dental coverage and we provided a list of states and how many issuers in each state intend to offer stand-alone coverage.

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Network Adequacy

Q35: If an issuer is accredited, can it skip the Network Adequacy section?

A35: Issuers must respond to all sections of the QHP Application, including Network Adequacy. The Network Adequacy section does not use a template, but has attestations that all issuers must complete in the QHP Application System.

As noted in the Letter to Issuers, in States without sufficient network adequacy review HHS will accept an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. Unaccredited issuers will be required to submit an access plan as part of the QHP Application. The access plan must demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with 45 CFR156.235(a).

Accredited issuers are still required to submit their Essential Community Provider (ECP) networks via the ECP template.

Q36: Are the network adequacy standards for FFEs the same as for Medicare Advantage?

A36: The network adequacy standards in the application apply to the FFE. They are different from the standards used in the Medicare Advantage program. Exchange network adequacy standards can be found at 45 CFR 156.230. More information is also in Chapter 1 of the Issuer Letter.

Q37: What is the definition of a network?

A37: A network is the system of health care providers offered by a specific plan.

Pharmacy

Q38: Can HHS provide a crosswalk table that maps the RxCUI to the class and counts?

A38: We do not intend to release the crosswalk table. We note, however, that the RxCUIs are drawn from the December 3, 2012, RxNorm release, which you can download at http://download.nlm.nih.gov/umls/kss/rxnorm/RxNorm_full_12032012.zip. To download the file, you need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. You can obtain a license and account at no charge by following the instructions at http://www.nlm.nih.gov/databases/umls.html#license_request.

The EHB Rx Crosswalk contains only 5,306 RxCUIs and 916 chemically distinct drugs. There are many more valid RxCUIs in the RxNorm database. Therefore, almost any drug list submitted to the USP Category Class Service will contain some unrecognizable RxCUIs. As long as you meet the EHB drug count standard for your State, you can ignore the list of unrecognized RxCUIs.

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Q39: What is considered “Off Label Prescription Drugs”?

A39: Off-label prescription drugs are FDA-approved prescription drugs that are prescribed for indications other than those stated in the labeling approved by the FDA.

Q40: What tier should issuers assign for items that are mandated to be provided at a \$0 cost share, when Tiers 1 – 7 are already utilized to list therapies which include a member cost share?

A40: The number of tiers in the prescription drug formulary template is limited to seven. For drugs with \$0 cost sharing, you may add those to the lowest cost sharing tier and indicate in the Plans and Benefits template that certain drugs in that tier have no cost sharing.

Q41: Since drugs covered under medical are not captured in the pharmacy drug list, how will these medical drugs be included to determine compliance with EHB? Will they need to be reported separately?

A41: Issuers will need to submit a list of the medical drugs covered as they would any other supporting documentation to justify any exception to any field in the Plans and Benefits template, i.e., upload a MS Word or PDF document into HIOS.

Please note that HHS still advises issuers to make use of the drug count tool in HIOS to verify that the RxCUIs in their list of "medical drugs" satisfy the category and class counts for the issuer's State's benchmark plan (as well as having at least 1 drug in each category and class).

Q42: Will issuers be able to update their drug list throughout the year and is this allowed for plans offered on the Exchange? Are issuers required to submit notice of adjustments made after the submission of the QHP application?

A42: In States with a Federally-Facilitated Exchange, issuers submit their drug list once during the annual QHP certification period. HHS understands that drug lists are dynamic and updated often. Issuers are permitted to change their drug lists throughout the year as long as they remain compliant with the EHB policy (45 CFR 156.122) requiring that every drug list includes at the least the greater of (1) one drug in every USP category and class or (2) the same number of prescription drugs in each category and class as the EHB state benchmark plan. Issuers are not required to submit updated drug lists to HHS throughout the year; however, policies in States with a State-based or Partnership Exchange may differ.

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Q43: If a benchmark plan does not cover any drugs in a specific Rx category, do issuers have to cover at least one drug in that category?

A43: The policy at 45 CFR 156.122 states that a formulary must include the greater of one drug in each USP category and class or the same number in each category and class as the State benchmark. Therefore if the State's benchmark drug list does not cover a drug in a particular USP category and class, then the issuer is responsible for covering one drug in that USP category and class.

Q44: If a plan has drugs offered through the medical benefit that it wants to count -- for reasons of compliance with EHB policy -- the minimum number of drugs per category/class, how should that be submitted to HHS?

A44: If the plan uses the USP Category Class Count Service and uploads a list of all RxCUIs covered under the plan's prescription drug benefit and meets (or goes above) the benchmark drug counts, the plan will be in compliance with this requirement. However, if the plan cannot meet the count unless it includes medical drugs in the drug list, HHS recommends the following steps to submit the QHP application -

- For each of the issuer's drug lists, enter all RxCUIs covered under the plan's prescription drug benefit in the Prescription Drug Template,
- Use the Formulary-Inadequate Category/Class Count Supporting Documentation and Justification, identified in Chapter 13C of the instructions, to identify how the drug list meets the requirement and submit the RxCUIs associated with the medical drugs for each drug list.

Premium Stabilization Programs

Q45: If the issuer has a capitated plan, does the issuer need to submit the claims from the PCP? These claims will have a \$0 Allowed Cost amount because the provider receives a set payment; will these claims pass the Edge Server Edit?

A45: The Edge Server will accept claims that have a \$0 allowed amount. For capitated services, Issuers will need to derive (or estimate) a paid amount for these services in order for them to be considered for reinsurance. In addition, the inbound claim file layout contains a field to indicate a derived amount has been computed for capitated arrangements. Further information and specific file layouts pertaining to capitated arrangements will be covered in the May 8th Distributed Data Collection (Edge Server) webinar. You can register for this webinar at <https://www.REGTAP.info/>.

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Service Area

Q46: Are issuers required to have their service area cover the entire geographic area of their network?

A46: Service areas in FFE States must satisfy 45 CFR 155.1055 of the Establishment of Exchanges and Qualified Health Plans final rule, which requires:

“(1) the service area of a QHP to cover a minimum geographical area that is at least the entire geographic area of a county, and (2) the service area to be established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost, or medically-underserved populations.”

As noted in the QHP Application Instructions, in most situations, the FFE will only approve service areas covering full counties. In the rare case in which the issuer is requesting to cover a service area containing a partial county, the issuer must provide the included ZIP codes, a justification for why the entire county will not be served, and a detailed description that illustrates why the request is not discriminatory.

Each QHP offered on the FFE must be approved or deemed for sale in the State (as applicable under state law) before final certification. Upon application, the issuer will need to attest to adhering to all applicable State and Federal law. This would include compliance with service areas defined by the State. There is no requirement that the service area cover the entire geographic area of the issuer's network.

Q47: If a health plan will be offering QHPs in certain cities and counties in a State, instead of the entire State, do issuers have to designate and name a unique service area ID for each city and county in the drop down box of the service area template? Or, would an issuer designate and name one service area and list all of the cities from the drop down box that are included in the service area?

A47: As noted in the QHP Application Instructions, within States where an issuer is licensed, they may offer plans in defined service areas which can include an entire State, certain counties within States, and under limited circumstances partial counties within a State. The template requires that an issuer's service area ID be generated (not user-assigned). Each plan must be associated with a single Service Area ID, so issuers should create enough service area ID's to cover each unique combination of counties for which it intends to offer a QHP. A single Service Area ID can be used for multiple plans. Application Instructions are also posted on the REGTAP website at <https://www.REGTAP.info/>.

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SHOP

Q48: Are individual market issuers (currently not a small group issuer) allowed to participate in SHOP to sell individual policies to small group employees?

A48: Only small group market products can be sold on SHOP.

Q49: If a group is larger than the small group threshold and subsequently the size falls below the small group threshold, will the group be allowed to keep its existing products, or will it be required to purchase new products?

A49: An employer has the right to renew or continue in force coverage originally purchased in the large or small group market, even though the employer may no longer meet the definition of a large or small employer. If the employer voluntarily drops the coverage, however, that employer would only be able to purchase coverage in the relevant market (and the coverage would have to comply with the relevant market requirements). Please reference Insurance Standards Bulletin Series, Group Size Issues under Title XXVII of the Public Health Service Act, Transmittal 99-03, available at http://cciio.cms.gov/resources/files/Files2/10112011/hipaa_99_03_508.pdf.pdf.

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Q50: How does "Reasonable Assurance" work in the Small Group market? Is the requirement on the issuer to establish reasonable assurance that the Employer has a dental policy or on the employer to get assurance for employees?

A50: The EHB final rule (78 FR 12834) stated the following with respect to coverage of pediatric dental EHB in the outside market: "The Affordable Care Act does not provide for the exclusion of a pediatric dental EHB outside of the Exchange as it does in section 1302(b)(4)(F) of the Affordable Care Act for QHPs. Therefore, individuals enrolling in health insurance coverage not offered on an Exchange must be offered the full ten EHB categories, including the pediatric dental benefit. However, in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan off the Exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan offered outside an Exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB. HHS notes that the stand-alone dental plan would have to be an Exchange-certified stand-alone dental plan to ensure that it covered the pediatric dental EHB, as required for Exchange certification under section 1311(d)(2)(B)(ii) of the Affordable Care Act. However, the Exchange-certified stand-alone dental plan would not need to be purchased through an Exchange. This alternate method of compliance is at the option of the medical plan issuer, and would only apply with respect to individuals for whom the medical plan issuer is reasonably assured have obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan." As long as a health insurance issuer is reasonably assured that an employer offers a Marketplace-certified stand-alone dental plan to its employees, the issuer can allow the small employer to select a plan without the pediatric dental EHB.

Technical Guidance

Q51: How can issuers determine if and how a template has changed from what is currently available on the SERFF website compared to what is available on the Plan Management tool?

A51: All templates contain a version number. Use that number to determine whether the SERFF template is the same as the one on the one from the Plan Management Tool.

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Q52: When will the final user guide for QHP submission through HIOS will be available and where users will be able to obtain the user guide?

A52: The most current HIOS portal user guide is available at <http://cciio.cms.gov/resources/other/> under the section titled "Content Requirements for Healthcare.gov." The complete instructions for submitting the QHP Application can be found at <https://www.REGTAP.info/>.

Q53: Can issuers submit more than one attachment?

A53: In the Issuer Module, each supporting document is a single upload. If you upload a document again, it will replace the previous upload. In the Benefits and Service area module, you can upload multiple 'other' supporting documents. The Rating module does not require supporting documents.

Q54: Can a partially completed template be stored in the system?

A54: You cannot download or upload partially completed templates. We recommend that you download the template and save to your local drive, then enter data. Once you complete the template, save it on your local drive then upload the XML generated by the completed template.

Q55: When are the zip codes provided in the Service Area Template validated?

A55: The zip codes are validated after the template is uploaded and processed.

Q56: Are there special character limitations in text fields?

A56: This depends on the field and if the field is in a template or on the User Interface. The HIOS User Guide provides the valid characters for the fields in the templates. If it is a field on the User Interface, there are no special character limitations in text fields.

Q57: If an issuer has multiple Issuer IDs, will the issuer need to complete multiple plan and benefits templates?

A57: Yes, the issuer would require multiple Plan and Benefit Templates. However, the issuer would be able to use the same add-in file for all of the templates as long as the add-in file was stored to the same hard-drive as all the benefits templates.

Note: It is recommended that the issuer not have more than one Plan and Benefit template open at once.

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Q58: Do separate Plan and Benefits templates need to be completed for the SHOP and Individual markets if the issuer is submitting for both markets?

A58: Yes, each application would require a SHOP and Individual template. However, the issuer would be able to use the same add-in file for all of the templates as long as the add-in file was stored to the same hard-drive as all the benefits templates.

Again, we recommend that the issuer not have more than one Plan and Benefit template open at once.

Rating

Q59: Will a subscriber be locked into his/her smoker status/rate region for a full contract year, or can these items change mid-year and change the premium rate mid-year as a result?

A59: If a subscriber's smoking status changes from smoker to non-smoker mid-year (or in the small group market, the subscriber agrees to participate in a tobacco cessation program pursuant to PHS Act section 2705(f)), any tobacco surcharge should be immediately be prospectively removed from the premium.

Q60: Can a family plan cover family members who reside in different rating areas of the same State?

A60: Yes, issuers can cover family members who live in different rating areas under the same plan. For the individual market family plan, all family members can be rated at the location of the subscriber, even if a family member is residing in a different rating area than the subscriber.

Q61: In the individual market, if an enrollee permanently moves to a new geographic rating area mid-year, is he/she required to switch to a plan in the new rating area, or can he/she keep their other plan until the next renewal?

A61: Whether or not an individual can remain on a plan depends on whether the individual still lives or resides within the service area of the plan upon moving to the new location.

Q62: If the enrollee does re-enroll, per the previous question, are the rates based on age and tobacco use at the new enrollment date?

A62: If the individual enrolls in a new plan, age and tobacco use would be determined at time of enrollment.

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Q63: Does validation compare the age 65 rate to the age 0-20 rate, or compare the age 65 rate to the age 21 rate? Is this because the age 65 rate cannot be more than 3x the age 21 rate?

A63: The 3 to 1 age ratio factor requires that the 64+ age band be no more than 3 times the rate of a 21 year old who would be rated at 1.0. Validation is being done against the age 21 category. This validation is being done across non-smoking rates, and is also being applied between rates for smokers. Early versions of the template may have been built with incorrect references, but these have been corrected. The current rate table template version is 1.6.

Templates

General

Q64: What network ID should an issuer use for a network consisting of other networks?

A64: Each QHP submitted must be associated with a single Network ID as identified in the Network ID Template. If an issuer has, for example, three networks associated with a given QHP, the issuer will need to create a fourth Network ID consisting of those three networks, and use that single ID for completing the Benefits Template.

Q65: What should issuers enter for the field “User Access Contact” on the administrative template?

A65: The optional User Access contact should be supplied if the issuer would like to have a single point of contact for addressing issues related to HIOS system access.

Q66: Is there a policy limit to the number of children on a SHOP plan? How should the Business rules template field “number of children allowed under a contract-only SHOP” be completed?

A66: There is no limit on number of children covered in a SHOP. The selection specifically states 1, 2, or 3-or-more. Limiting it to a maximum of 3 (or more) children is strictly for purposes of pricing the family rate. It does not mean there is a limit on the number of children that could be on a given policy.

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Q67: On the business rules template, is the question “Is there a maximum age for a dependent” meant to address dependent eligibility not child rating?

A67: “Is there a maximum age for a dependent” actually refers to the maximum age for a child on the policy. Per the Health Insurance Market Rules final rule at 45 CFR 147.102(c)(1), an issuer can rate up to 3 children on a policy. The maximum age for these children is 20. The question on the template allows the issuer to increase this age (essentially extending the 20 year limit, allowing older individuals to be rated as child dependents). Issuers would not need to raise this to allow for the age 26 requirement-that is taken care of elsewhere.

Q68: How should an issuer indicate any exceptions to this limiting age? For example, if an issuer operates in a State that requires coverage of dependents older than age 26 if they are disabled.

A68: If certain other types of dependent are allowed, this can be noted in the final column on the business rules template, which asks what dependent relationships are allowed.

Q69: Can issuers use the column “Drug Tier Type” in the prescription drug template to indicate specialty drugs?

A69: Please use the “Only select brands” option in the Drug Tier Type field to indicate that the tier is a specialty drug tier.

Q70: Can an administrative template contain more than one Issuer ID?

A70: Issuers must submit a single application for each Issuer ID.

Benefits Template

Q71: If an issuer intends to offer some identical plans on and off the Exchange in the individual market in order to take advantage of protections available through the 3Rs, the issuer must have a unique Component ID. In the Plans & Benefits Template, should the issuer select “on-Exchange,” “off-Exchange,” or “both” for the component identifier?

A71: By selecting “both,” the issuer is indicating that the plan will be offered both on and off the Exchange.

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Q72: If an issuer does not cover routine foot care except in the case of a diabetes diagnosis, how should the issuer list Routine Foot Care on the QHP template?

A72: Issuers should place any additional limitations in the Explanation field for Routine Foot Care. Any benefit level exclusions should be placed in the Exclusions field for Routine Foot Care. Please refer to Chapter 10: Instructions for the Plans & Benefits Application Section for more information. The Instructions can be found on the zONE or at <https://www.REGTAP.info/>.

Q73: How should issuers use the fields "1st tier and 2nd tier utilization"?

A73: If the plan applies different levels of in-network cost sharing depending on the tier of the provider or facility, indicate that the plan has multiple in-network tiers in the Plans & Benefits template. For plans with multiple in-network tiers, you are required to enter the proportion of claims cost that is anticipated to be utilized in each tier. These utilization amounts are entered into the "1st Tier Utilization" and "2nd Tier Utilization" fields in the Plans & Benefits template. If the plan does not have multiple in-network tiers, "1st Tier Utilization" will be pre-populated to 100% and "2nd Tier Utilization" will be grayed out.

Q74: How should issuers fill in the field "Plan Effective Date"?

A74: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, the Plan Effective Date is a required field. It must be January 1 for individual market and SHOP. The instructions can be found on the zONE or at <https://www.REGTAP.info/>.

Q75: How does an issuer complete the Copay and Coinsurance columns in the cost share variance worksheet under the following scenarios: (a) the cost sharing for a particular benefit varies based on place of service (b) the cost sharing for a particular benefit varies based on provider type (i.e., specialist copay versus PCP copay)?

A75: The Cost Share Variance worksheet does not allow copays or coinsurances to vary for a particular benefit based on place of service or provider type. The Actuarial Value Calculator can only accommodate a single coinsurance rate or copay for each benefit. If you have multiple coinsurance rates or copays for a single benefit, then you should consider this plan to be a unique plan design (and indicate this on the Benefit Package worksheet) and fill out the necessary supporting document, and an actuarial certification for unique plan design, as set forth in 45 CFR 156.135.

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Q76: Should each benefits package be created on a separate tab?

A76: Each benefit package needs to have its own tab.

If you want to create additional benefits packages, click the “Create New Benefits Package” button on the menu bar under the Plans and Benefits ribbon. The HIOS Issuer ID, Issuer State, Market Coverage, Dental Only Plan, and TIN fields will be auto-populated.

If the benefit package for all of your products and plans is identical, only one benefit package tab is needed.

Q77: Rather than importing the Service Area IDs, Formulary IDs and Network IDs, is it possible to manually enter them in?

A77: Yes, issuers may manually enter the IDs. However, the IDs must match the IDs that are generated in the Service Area, Prescription Drug, and Network ID templates.

Q78: Is there a problem with the benefits template that requires leaving cells for outpatient surgery and prescription drugs blank?

A78: You should be able to run plans with outpatient surgery and prescription drug cost sharing inputs. However, please note that the Chapter 11 Plans and Benefits Template Instructions on Actuarial Value provide some specific guidance on inputting these items: 1) The AV Calculator does not support copay values for the Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services benefit categories. If either of these benefit categories has a copay in the Plans & Benefits template, the AV Calculator will return an error. For purposes of the AV Calculator, issuers may convert a plan’s Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services copay into an estimated coinsurance and enter this coinsurance into the Plans & Benefits template. 2) The AV Calculator does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance are entered for a drug benefit in the Plans & Benefits template, the AV Calculator will return an error. This document is available at: https://www.REGTAP.info/uploads/library/Chapter_11_Ver1_3_042213.pdf

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Q79: Are medical copay amounts considered when using the AV calculator macro?

A79: Yes, the medical copay amounts are considered in the AV Calculation of the Plans and Benefits Template. Specifically, if you refer to the Plans and Benefit Template Chapter 11 Instructions on Actuarial Value, there is a section that explains how the Plans and Benefits Template maps to the data inputs to the stand-alone AV Calculator inputs. This document is available at:

https://www.REGTAP.info/uploads/library/Chapter_11_Ver1_3_042213.pdf

Q80: Do all limits need to be identified, or can issuers list one limit and then state “other limits apply”?

A80: Per 45 CFR 156.115, plans must have benefits that are substantially equal to the benchmark. EHB plans may include quantitative limits that are substantially equal to quantitative limits in the benchmark. Both the medical plan template and the dental template provide an area for plans to describe both limits that are present in the benchmark or other limits. While we encourage detailed provision of any benefit limits, there is no requirement that every limit in the plan is input in the plan’s application. Issuers may include additional details in the explanations field and plan brochure to inform consumers about the plan’s limits.

Q81: Does every exclusion need to be noted in the template? If an issuer does not list a benefit as excluded, is it assumed to be covered?

A81: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section Exclusions is an optional field in the Plan & Benefits template. Issuers may enter any benefit level exclusions in this field if particular services or diagnoses are subject to exclusions (covered under some circumstances but not others) or if no services or diagnoses are excluded, leave this field blank. Information regarding exclusions will help inform consumers, and additional information may be included in the plan brochure. The instructions are available on the zONE or at <https://www.REGTAP.info/>.

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Q82: In regards to relating to differing PCP visits on a CSR variant plan in the Plans & Benefits template: The 'Begin Primary Care Cost-Sharing after a Set Number of Visits?' input is only set once in the Plans & Benefits template and therefore cannot differ among silver plan CSRs and limited cost sharing plan variations. How should an issuer complete the Plans and Benefits template for this issue? Should this be a unique plan design with an included screenshot or is there something else that an issuer should be entering in?

A82: As described in 45 CFR 156.420, silver plan variations must have equal or more generous cost sharing with respect to each essential health benefit than the standard silver plan or any other silver plan variation with a lower actuarial value (AV). This includes cost sharing parameters described in the Plans and Benefits Template as *"Begin Primary Care Cost-Sharing After a Set Number of Visits," "Begin Primary Care Deductible/Coinsurance After a Set Number of Copays" and "Set a Maximum Number of Days for Charging an IP Copay?"* However, since the QHP issuer cannot change these inputs in the Plans and Benefits Template for the silver plan variations without modifying the standard silver plan design, a QHP issuer wanting to provide more generous cost sharing through these parameters would need to designate that particular standard silver plan and its plan variations as a unique plan design using the "Unique Plan Design?" field of the Plans and Benefits Template.

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The QHP issuer should then calculate the actuarial value of the plan variation using the stand-alone AVC, and input the more generous cost sharing parameters. The QHP issuer must then complete the “Issuer Actuarial Value” data field with the value from the stand-alone AVC for the appropriate plan variations. The QHP issuer should also upload a screen shot of the stand-alone AVC for the plan variations with the more generous cost sharing parameters, as a supporting document for each plan variation for which this situation occurs. They should indicate the HIOS Plan ID (Standard Component) in the Description field when uploading the screen shot as a supporting document in HIOS as well as indicating the HIOS Plan ID (Standard Component) in the file name of the screen shot. Note that the QHP issuer will need to follow this same process for the standard silver plan on which these plan variations are based.

Please note that in this situation designating the plan as a unique plan design will not require submission of an actuarial certification and you will not be considered unique for review purposes. QHP issuers should also note that the *“Begin Primary Care Cost-Sharing After a Set Number of Visits,” “Begin Primary Care Deductible/Coinsurance After a Set Number of Copays” and “Set a Maximum Number of Days for Charging an IP Copay?”* fields should reflect the values for the standard plan – not the plan variations. We note that these data elements will not be displayed on the Plan Compare website. Lastly, QHP issuers should note that pursuant to 45 CFR 156.420(d) they may NOT change the values of these parameters for the zero cost sharing plan variation or the limited cost sharing plan variation of any of their QHPs.

Q83: Will the MOOP be changed from \$6400 to \$6350 for 2014?

A83: At the time of writing this response, the IRS has not issued this number yet. Per the Letter to Issuers released on April 5, “In the FFE, if IRS-published limits are below \$6,400/\$12,800, HHS will flag QHP applications with out-of-pocket maximums above the allowed amount. Affected issuers will be permitted to revise their out-of-pocket maximums during the resubmission window built into the QHP certification process. HHS will allow issuers to adjust other associated data elements for affected plans if necessary. For example, issuers will be permitted to modify other cost-sharing parameters in order to maintain an actuarial value (AV) consistent with the standards of 45 CFR 156.140.” The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at:

http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

HHS encourages States, particularly those participating in a State Partnership Exchange, to use this approach to allow updates during the revision window. States may instruct issuers to follow an alternate process to correct deficiencies of this type of issue.

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Q84: For a limited cost sharing plan variation of a QHP that does not cover services when furnished by an out-of-network provider, does the cost sharing need to be eliminated for EHB out-of-network services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services?

A84: As discussed in Q&A 27 of QHP FAQ #3 (published on REGTAP on April 11, 2013) in relation to the zero cost sharing plan variation, enrollee spending for non-covered services is not considered cost sharing. As a result, if a QHP does not cover certain services (or all services) furnished by a provider outside of the network, the spending for these non-covered services would not need to be eliminated for the zero cost sharing plan variation or the limited cost sharing plan variation, even if the service was furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services. QHP issuers, including HMOs, should note however, that reimbursement is required in compliance with section 206 of the Indian Health Care Improvement Act.

In general, QHP issuers should be aware that they can indicate that a service is not covered by marking the service as not covered on the Benefits Package Worksheet, or, if a service or no services are covered when furnished by an out-of-network provider, the QHP issuer can set the out-of-network coinsurance for the service(s) to 100%, set the out-of-network copay(s) to “no charge,” and indicate that enrollee spending for those service(s) does not count towards any deductible or towards any maximum out-of-pocket limit.

In addition, as discussed in Chapter 10 of the Plans and Benefits Application, QHP issuers should be aware that the cost-sharing reductions under the limited cost sharing plan variation do not need to be recorded in the Plans and Benefits Template.

Q85: How should QHP issuers indicate HSA eligibility if the standard plan is HSA eligible, but one of the cost-sharing reduction plan variations is not HSA eligible?

A85: If a QHP issuer chooses to offer an HDHP standard plan, with associated plan variations that are not eligible for pairing with an HSA, the QHP issuer should still select “yes” in the “HSA Eligible” field on the Plans & Benefits template.

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HIOS

Q86: How do issuers use HIOS if they are in a non-Partnership FFE?

A86: To offer QHPs in non-Partnership FFEs for the 2014 plan year, health insurance issuers will complete QHP Applications electronically through HIOS. Before submitting an application, issuers must gain access to HIOS and define user roles (such as data submitter, data validator, and attester), and obtain HIOS user IDs.

HHS expects that between April 1 and April 30, 2013, the issuers will access the QHP Application in HIOS to submit all information necessary for certification of health plans as QHPs. The QHP Application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 CFR parts 155 and 156 and other programmatic requirements necessary for the operational success of an Exchange, and provide requested supporting documentation. These attestations will also apply to vendors and contractors of the issuer or company.

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Q87: How do issuers use HIOS if they are in a Partnership state?

A87: There are several instances when a user submitting a QHP Application to a SERFF State will need to utilize HIOS. First, anyone using the HHS/SERFF templates will need to access HIOS to obtain product and plan IDs. If your organization has been selling in the Individual or Small Group Markets, then you should have been entering HIOS for the PlanFinder collection associated with HealthCare.gov, and the process is exactly the same. Issuers need to submit basic information on their form filings as “products” which generates product IDs. All QHP submissions must link up to a reported product in HIOS. Once you have submitted that basic information, you can request a block of Standard Component IDs (formerly called plan IDs). Instructional materials are available at the REGTAP site <https://www.REGTAP.info/>. If you have staff who have been reporting for HealthCare.gov, those individuals should be able to walk you through the process.

In addition to the above, in Partnership States, HIOS will receive data from SERFF for use in finalizing the QHP Certification process. Issuers who submitted QHP Applications in SERFF will need to interact with HIOS as part of the Plan Preview period (currently estimated August 22-26) as well as to finalize the certification of QHPs at the end of the process and sign agreements with HHS (currently estimated September 5-9).

Also, existing filing and submission requirements for other HHS programs still apply, such as the requirements related to providing rate increase submissions under CFR 45 154.215. If you plan to offer products outside of the Federally Facilitated Exchange, please follow the rate review filing requirements under CFR 45 154.220 and contact your State to determine state specific filing requirements.

As noted in the Health Insurance Market Rules; Rate Review final rule <http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf> when making a rate filing submission, all on- and off-Exchange products must file the Part I Unified Rate Review template and Part III Actuarial Memorandum into HIOS. If an issuer is not applying to offer any QHPs in the same risk pool, the Part I Unified Rate Review template and Part III Actuarial Memorandum are due on the timeline set by the state, but before January 1, 2014.