Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 12
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Guidance/Timeline

QHP Certification/Review Process

Q1: Is "Justification 13g: Cost Sharing for plans exceeding annual limitation on small group deductibles" required during the application, or during deficiency phase?

A1: To the extent that the submitted plan deductibles exceed the statutory deductible limitations, the applicant should have submitted justification 13g along with its application. However, this form can be submitted during the resubmission window in response to communicated deficiencies. Through submission of this form, the applicant attests that the identified health plans that are listed on the form exceed the annual limitation on small group deductibles and are doing so because they could not "reasonably reach a given level of coverage (i.e. metal level) without doing so." The applicant should also include discussion of why they could not reach the coverage levels. HHS would also recommend the issuer reach out to their state regulators as to their requirements in this area, as some states will be conducting the review of this information.

Q2: Does each benefits template submitted require both a gold and silver plan? If an issuer is offering product off exchange only, are they required to offer a silver and gold plan?

A2: Under § 156.200(c)(1), a QHP issuer must offer through the Exchange at least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act. However, there is no federal requirement to offer gold or silver plans off the Exchanges. For additional information on how to access the Plans and Benefits Template that can account this, please refer to the May 22 announcement entitled "Guidance for QHP Issuers Submitting Non-Exchange Plans and/or Dental Rates" that is posted in REGTAP portal.

Q3: Is there a limit on the number of plans an issuer can offer in the Exchange?

A3: Not specifically, but issuers must ensure that their plan designs are meaningfully different.

Please Note: Similar questions may be combined and answered only once in this document.

Q4: Where are the specific attestations asking about network adequacy?

A4: The attestations relating to network adequacy are listed in QHP Instructions: Chapter 06 Network Adequacy Instructions which can be found on the www.REGTAP.info Website.

Q5: How are the new data traceability matrices (DTMs) used in completing the templates?

A5: These files, available on CMS zONE describe the data elements in the templates and the high-level business rules and validation requirements for each element.

Q6: Does an issuer have to be an approved Federal contractor in order to sign an agreement to market and sell on the Federally-Facilitated Marketplace (FFM)?

A6: No, the issuer does not need to be an approved Federal contractor.

Q7: For the network URL, are there requirements for the number of clicks it will take to view the network providers?

A7: There is no requirement; however, we do advise issuers to ensure that network information is easily accessible to consumers.

Q8: What will be the time window and process for the plans to update the links to their plan brochures and SBC's prior to October 1, 2013 Exchange go-live?

A8: Issuers may update the links to their Plan Brochures and SBCs during either the resubmission process or the Plan Preview process.

Q9: For enrollees who are also Medicare beneficiaries, may a plan charge different premiums for enrollees based on whether their Medicare coverage is primary vs. secondary?

A9: No, as described at http://cciio.cms.gov/resources/factsheets/marketreforms-2-22-2013.html: Health insurance issuers may vary premiums only based on age (within a 3:1 ratio for adults), tobacco use (within a 1.5:1 ratio for adults and subject to wellness program requirements in the small group market), family size, and geography. Since factors related to Medicare and the coordination of Medicare benefits are not amongst the allowable rating factors, then plans may not charge the enrollees different premiums based on these factors.

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Essential Health Benefits

Q10: If a state enacts a new requirement that issuers who provide coverage of IV chemotherapy must cover oral chemotherapy at parity, does the state have to defray the cost?

A10: No. We do not consider such payment parity bills to create a requirement to cover a new benefit. In addition, in the preamble to the EHB Final Rule (45 CFR 156.122) we stated that plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB.

Q11: If a state enacts a new requirement for Applied Behavioral Therapy, is that a benefit above EHB or can Applied Behavioral Therapy be considered EHB because it is a service specific to an EHB category (falls w/in habilitative OR mental health including behavioral health treatment).

A11: *Defining* habilitative services would not result in a mandate, but *requiring* specific treatments/benefits, including ABA, creates a new mandate.

Example of Definition - Habilitative benefits for purposes of the state's EHB Benchmark plan are defined as follows: "Habilitative services are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the state's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration."

Example of mandate – Bill requires private insurance companies to provide coverage under group health insurance policies for psychiatric care, psychological care, habilitative or rehabilitative care (including applied behavior analysis (ABA) therapy), therapeutic and pharmacy care to children who have been diagnosed with autism spectrum disorder (ASD).

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Actuarial Value

Q12: Can states require issuers to exclude non-preferred drugs as being non-EHB and, as a result, exclude this tier of drugs from a plan's actuarial value calculation?

A12: No. States may not require plans to exclude non-preferred drugs from EHB and, thereby, exclude these drugs from calculating a plan's actuarial value. EHB policy does not prohibit tiering unless such tiers are designed in a discriminatory manner. As stated in the preamble of the Final Essential Health Benefits Rule (78 FR 12848), while plans must offer at least the greater of one drug in each USP category and class or the number of drugs (in each USP category and class) as in the EHB benchmark plan, plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB. In other words, all drugs offered by the plan are considered essential health benefits. Therefore plans must take all drugs into account when calculating actuarial value. Plans that cover non-preferred drugs should mark that category as "covered" on the plans and benefits template and use the EHB Variance reason "additional EHB."

Q13: Will a catastrophic plan have a lower AV than a bronze plan (i.e., below 58% AV)?

A13: No, a catastrophic plan does not have an AV. Information on how to input these plans into the Plans and Benefits Template is available the Chapter 10 instructions under "Catastrophic Plan Instructions."

Q14: If a Bronze or Silver or possibly Gold plan has a deductible in excess of $2,000 (i.e., in excess of the limits set forth in Section 1302(c)(2)) of the Affordable Care Act, what does that do to its status as a QHP?

A14: Section 1302(c)(2) of the Affordable Care Act only applies to the small group market. As a result, the AV Calculator can exceed a $2,000 deductible to allow the calculator to account for situations where the user is running plan designs that are not small group plans.

Dental

Q15: Within the Exchange, is it considered two plans if we offer a plan with and without embedded dental?

A15: Yes, for purposes of QHP certification these would be considered two plans.

Please Note: Similar questions may be combined and answered only once in this document.

Q16: How will plans with an embedded pediatric dental EHB apply for certification in the FFE?

A16: If pediatric dental benefits are embedded in the QHP, then the pediatric dental EHB would be treated like any other benefit for the purposes of premiums, AV, and out-of-pocket maximums for purposes of the FFE certification application. The pediatric dental EHB is considered embedded if the medical plan is also collecting the premium for the dental benefits, includes the dental benefits as part of its contract, and is legally liable for the claims experience of the dental coverage. This can be achieved through a subcontractual agreement; the key feature is the party that is legally responsible for the claims.

Q17: As URAC and NCQA accreditation does not apply to stand-alone dental plans, can a stand-alone dental issuer offering no QHPs answer "No" to accreditation questions and not be subject to certification denial?

A17: The QHP certification requirement to have URAC or NCQA accreditation does not apply to stand-alone dental plans, so an Issuer offering only dental plans should answer “No” to the accreditation questions. This will not be considered a deficiency in the application. Outside of the Exchange, any applicable state laws regarding accreditation would apply.

Q18: If an issuer offers a stand-alone dental plan, can it set up the business rule or eligibility rules to ensure that only consumers that have selected the issuer’s medical policy can purchase the dental plan?

A18: In the FFE, an issuer will not be able to tie enrollment between a QHP and a stand-alone dental plan.

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SHOP

Q19: Does the FF-SHOP participation provision at 45 C.F.R. § 156.200(g) apply to stand-alone dental issuers wanting to participate in the individual market FFEs?

A19: No. For the following reasons, we do not interpret the FF-SHOP participation provision as applying to stand-alone dental plans seeking certification to participate in the FF-SHOPs.

First, the FF-SHOP participation provision provides that issuers are subject to it based on small group market share, which is determined based on earned premium data submitted annually to HHS by medical plan issuers pursuant to 45 C.F.R. § 158.110. Stand-alone dental issuers are not subject to the reporting requirement at § 158.110, and therefore HHS would generally not have the data it would require to determine whether they are subject to the participation provision.

Second, the FF-SHOP participation provision requires issuers subject to it to offer both a silver QHP and a gold QHP in the FF-SHOP. The terms "silver" and "gold" refer to comprehensive medical plans subject to the metal tier actuarial value requirements. Generally speaking, issuers of stand-alone dental plans, which are subject to different actuarial value level requirements and are permitted to issue stand-alone dental plans at only one level, would not be able to meet this requirement.

We note that 45 C.F.R. § 155.1065(a)(3) requires stand-alone dental plans being offered through an Exchange to meet all qualified health plan (QHP) certification standards, except for any certification requirement that cannot be met by a stand-alone dental plan. We believe that the exception at § 155.1065(a)(3) applies to the FF-SHOP participation provision.

Pharmacy

Q20: In question 42 of the 5/9/13 FAQ document previously posted to REGTAP, you stated that if a pharmacy claim cannot be pended during months two and three of the grace period, an issuer may deny the claim. This FAQ further indicated that if the enrollee pays for prescriptions out-of-pocket and subsequently becomes up-to-date on premiums within the grace period, the issuer must reimburse its share of the cost of covered pharmacy benefits filled during the grace period, if the enrollee submits a receipt. In this case, can the issuer have reasonable procedures to count only the cost-sharing amount towards the out-of-pocket maximum (MOOP)?

A20: Yes, where the issuer reimburses for a service to make the enrollee whole, the issuer should count applicable cost sharing towards to the MOOP.

Rating

Q21: Where and when will information about tobacco use be collected from applicants?

A21: Consumers will answer a question regarding tobacco use as part of the plan selection process.

Q22: If a QHP is approved in a particular rating area to be sold on-Exchange, is that plan considered a QHP in all rating areas, even if it is not sold on the Exchange in those other rating areas?

A22: If a proposed plan is approved for sale in a rating area, it can be considered a QHP for the rating area for which it is approved.

Q23: Does one set of rates apply for the entire calendar year, or can an issuer provide rates that change by month or quarter due to trend assumption changes?

A23: In the individual market, one set of rates applies for the entire calendar year. A rate is good until the end of a calendar year, so someone enrolling in June would have that rate until December 31 of that year. In SHOP, once a group has effectuated coverage, the rate is locked in for 12 months. If an issuer submitted trend increases during the initial QHP application window, approved rates will be applied as scheduled.

Q24: Will issuers have an opportunity to adjust rates throughout the year?

A24: For individuals, the rates are set on a yearly basis. We intend to provide further guidance on rate updates for the SHOP at a future time. In the Program Implementation NPRM under §156.80, we propose that issuers in the small group market (including SHOP) may make rate changes no more frequently than quarterly, effective as early as July 1, 2014. These rates would apply to both new and renewing businesses during the course of the year.

Q25: How do issuers indicate the rate trends for Small Group in the templates?

A25: In order to indicate rate trends for Small Group, issuers can create four sheets on the template, with the appropriate (and non-overlapping) effective and end dates on the appropriate tab.

Q26: What does "No Preference" mean in the tobacco use drop-down list?

A26: No preference means that there is only one rate, regardless of smoking status. If an issuer selects the other option (Smoking/Non-smoking), another column will appear, allowing the issuer to enter both smoking and non-smoking rates.

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Q27: Will there be a field for a dependent child rate separate from ages 0-20?

A27: No, that is not available.

Q28: How can an issuer offer a plan and rates for only a portion of a rating area?

A28: Issuers should submit their service area using the Service Area template. The FFE does not require that an issuer's service area cover a complete rating area. However, issuers are also bound by State service area requirements, so issuers should carefully review their States' guidance on this topic to ensure that their proposed service areas comply with State requirements. In some states, issuers may be allowed to split service areas by submitting multiple applications.

Q29: Why are rates being requested by tier when the rates have to be built up by member?

A29: Rates, for the majority of States (except only New York at this point) are to be entered by age and tobacco status. These rates will then be used to build rates for individuals and families in the Exchange as their family demographics are determined.

Q30: What correlation is there, if any, between the Rating Areas and the Service Areas created in the Service Area template?

A30: The Service Area template defines the area (State-wide, a list of counties, or in rare cases partial counties) where a plan will be offered. In the FFE, a service area can cover one or more complete or partial rating areas. For each plan, issuers must submit rates for every rating area within its service area, and those rates will be displayed to the appropriate consumers within the plan's service area on Plan Compare. Issuers should also refer to any additional State requirements on Service Area and ensure that the proposed Service Area is in compliance.

Q31: The age column uses the term "subscriber" in the definition but the rate will be built by adding each individual member's rate together, correct?

A31: That is correct. In individually rated States, the rate will be determined by adding up the age-determined rates of all the individual members.

Q32: Does the rating template allow a tobacco rate for 18-20 year olds as well as 0 to 17 year olds?

A32: No. Individuals 20 years and under should be subject to the same rating rules.

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Q33: For a family of 5, with 19-year-old parents, how would the three child cap apply?

A33: The three-child cap refers to child dependents. In the case of two 19-year-old parents with three children, the parents would be rated as the primary and secondary subscriber, and all three children would be rated.

Q34: In the question "Is there a maximum age for a dependent?" on the Business Rules template, should this be interpreted as up to and including the age?

A34: This field is inclusive, so it should be considered up to and including that age.

Q35: How can issuers find the rating area IDs assigned for their State?

A35: This information is available at http://cciio.cms.gov/programs/marketreforms/state-gra.html.

Q36: In column L of the Business Rules template, why is it significant that the individuals on the policy live together?

A36: This field is provided because some issuers may allow certain dependent relationships when the dependent lives in the same household as the subscriber, but not if the dependent lives elsewhere.

Q37: Will there be only one area rating applied per application?

A37: Correct. This is necessary for both the federal rating engine and risk adjustment systems and processes.

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Q38: Are child-only policies being sold strictly on a one per child basis? Will issuers be allowed to sell child-only with the three child limit?

A38: The market rules do not specify that child only policies should be issued with a certain number of children covered. The Exchange tools are built to support the inclusion of any number of children, with a maximum of three children being quoted on a policy. There is no way to identify a specific number of children who may be included. If an issuer desires to limit child-only policies to a single child, it may do so by indicating that it does not cover any of the allowed relationships to the reference person on the policy (rating rules template, right most column). If a plan is reported as not allowing siblings or other relationships, a child-only request would assign the reference to the youngest person under that request, and if no allowed relationship is identified, the other individuals on the request would be communicated back to enrollment as needing separate policies, which would be rated independently of the first policy. The exception to this is if one of the additional children is a spouse or domestic partner of the reference person, in which case that person would be allowed on the original policy as consistent with laws and the business rules evaluations.

Rate Review

Q39: In order to enter plans on a combined basis, does each plan need to have the same exact rate increase?

A39: Plan rate increases can be entered as combined for the product or individually.

Q40: Is the uniform rate review template required only for rate increases on existing products, not new rates?

A40: All plans are required to be included when the template is submitted, including new plans.

Q41: Since issuers can vary distribution costs and administrative expenses by product, can an issuer offer all products with different distribution costs to a subset of the single risk pool groups?

A41: Division of risk pool groups is not permitted. All plans are guaranteed available and should be priced based on the anticipated populations the issue has, as a whole. For an issuer to do otherwise could mean that the issuer is segregating the risk pool and thus discriminating.

Essential Community Providers

Q42: Should the non-exhaustive database listing for a particular service area be used to calculate a plan's ECP compliance with the Safe Harbor standard and/or Minimum Expectation?

A42: The evaluation of an issuer's compliance with the safe harbor or minimum expectation standards as articulated in the Letter to Issuers on Federally-facilitated and State Partnership Exchanges in Chapter 1, Section 1 will consider the extent to which each network includes a sufficient number of ECPs that meet the regulatory standard for each service area the QHP will cover. HHS will use the non-exhaustive database of ECPs as the basis for determining the number of available ECPs in the QHP's service area. This would form the denominator of the percentage of available ECPs included in the issuer's provider networks(s). All providers included in a QHP issuer's application that meet the federal regulatory standard will count toward the numerator of the evaluation percentage. The Letter is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

States

Q43: Does the QHP Application impact state rate and form filing requirements? Will states use the QHP application in lieu of their form and rate filings?

A43: States will continue to establish standards for rate and form filings, including what information and data issuers should provide, how issuers should submit such data, and when issuers should submit such data. Issuers should contact the appropriate state regulator(s) for assistance in complying with state requirements. Issuers should not assume that completion of the QHP Application will satisfy state rate and form filing requirements.

Please Note: Similar questions may be combined and answered only once in this document.

Q44: How do issuers know which components the state will review vs. which components will be reviewed by the FFM?

A44: Where a FFM is operating, CMS will conduct QHP certification. However, as CMS indicated in the "Guidance on State Partnership Exchanges" (available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf), CMS recognizes that determination of whether issuers and health plans meet QHP certification standards outlined in 45 CFR 156.200 involves activities that are already or will be performed by state regulators under state law, including state laws that address 2014 market reforms. For example, we know that many states will conduct reviews for the following: coverage of EHB, including formulary reviews for EHB purposes; compliance with actuarial value (AV) and market rating reforms; and rate increases, consistent with state authority and federal law. Accordingly, CMS will not duplicate state reviews where a state is enforcing these and other Affordable Care Act standards. CMS will evaluate QHPs against all other certification standards. The list of certification standards is included in the State Partnership guidance linked above.

Q45: If our product form filings are "deemed" approved by the appropriate state regulatory authority because our state failed to timely review them in accordance with state law, will the Exchange consider the product approved by the state?

A45: Yes. If a product can be considered "approved for sale" in a state pursuant to the terms of a deemer clause under state law, the FFM will accept the issuer's attestation that the product has been approved for sale by the State Department of Insurance.

Q46: Should issuers complete HIOS or SERFF uploads first?

A46: The order does not matter, but if the state is the primary reviewer, HHS would generally expect the issuer to submit to the state first.

Plan Compare/Website

Q47: Are issuer's member-facing websites required to be 508 compliant if they participate on the Exchange?

A47: No. 45 CFR 156.250 establishes standards for issuer applications and notices, but not websites.

Please Note: Similar questions may be combined and answered only once in this document.

Q48: Will the FFE support mobile devices?

A48: As stated in chapter 6 of the final Letter to Issuers on Federally-facilitated and State Partnership Exchanges, released on April 5, 2013 and available on the CCIIO website at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf the FFE "website will be provided in a mobile-friendly format using responsive design techniques."

Q49: What elements will the Exchange combine to form plan display names?

A49: The plan name will be displayed as [Issuer Marketing Name + Plan Marketing Name + Plan type]. The combination of these plan attributes make up the plan name in that order. The final name that will be displayed on the marketplace will be displayed in this format.

Cost Sharing

Q50: For plan 03 (AI/AN above 300% FPL), are issuers required to only apply the $0 cost share to Tribal providers to the on exchange states?

A50: 45 CFR 156.420(b)(2), as described in the final Payment Notice (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), requires QHP issuers to offer a limited cost sharing plan variation with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services – regardless of the state in which the coverage is provided, or the state in which the provider is located. Please see Q84 of QHP FAQ #9 for additional information.

Q51: Can individual plans gain relief using the MOOP "safe harbor" referred to in the February 20 FAQ similar to group plans?

A51: No. The one-year transitional exemption from the ACA's MOOP limitations does not apply to individual market plans. It only applies to small and large group market plans and self-insured plans that use multiple benefit administrators.

Systems

HIOS

Q52: Do issuers have to close all Product IDs and request new IDs for the QHP application submission?

A52: No. Products should only be closed if they are being removed from the market. If QHPs are being created based on existing filings and HIOS products, they can use those product IDs and related standard component IDs. If new filings are being done to support the creation of QHPs, those filings should have an equivalent new product filed in HIOS, and standard component IDs generated to submit the QHPs.

Q53: At what point is the HIOS Plan ID generated?

A53: After an issuer has reported the product filings as Products in HIOS, Standard Component IDs (plan IDs) can be generated. This should precede filling out the QHP templates for submission to the FFM or an SBE.

HPID

Q54: Are QHPs required to get a Health Plan Identifier (HPID)?

A54: HPIDs are not required for certification of QHPs.

Q55: Will the "Associated HPID" field within the Administrative Data Elements section be a required field?

A55: It is not currently a required field. Issuers may need to provide this identifier at a later date.

Q56: How can issuers receive information about our HPID?

A56: Now that the HPOES Module is open in HIOS, an issuer can enter the module to request an HPID. An issuer will receive an HPID when the process is completed.

Templates

Benefits Template

Q57: Where do issuers supply what an estimated payment would be for the three CSR variations of each Silver plan?

A57: As discussed on page 15487 of the final Payment Notice (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), for the 2014 benefit year, the advance payment estimates for the silver plan variations and the zero cost sharing plan variations will be developed using a methodology that utilizes data that QHP issuers submit for other purposes – specifically, the expected allowed claims cost (from the Unified Rate Review Template) and the actuarial value (from the Plans and Benefits Template). As a result, issuers would not be required to submit any additional data or supporting documentation to receive advance payments in benefit year 2014 for the value of the cost-sharing reductions that would be provided under the silver plan variations or the zero cost sharing plan variation. However, if a QHP issuer wants to receive advance payments for the value of cost-sharing reductions provided under the limited cost sharing plan variation, the QHP issuer must submit an estimate of this advance payment amount through the Plans and Benefits Template, along with a justification for the estimate (see Chapter 13i of the QHP application instructions).

Q58: How do issuers enter the combined In/Out of Network MOOP and Deductible? What about the Combined In/Out of Network Medical/Drug EHB deductible?

A58: If the plan has separate MOOPs or deductibles, it would enter these separately on the benefits template. If the plan only has a combined (no in network) MOOP (or deductible), either all of the plans in a benefits package need to set their in network MOOP (or deductible) to a dollar value, or they all need to set their in network MOOP (or deductible) equal to Not Applicable and set their combined in/out network MOOP (or deductible) to a dollar value.

Q59: In order to qualify for the 2014 safe harbor for small group plans, must the MOOP for medical and pharmacy total less than $6350, or must each independently be less than $6350?

A59: A QHP can be structured with combined or separate OOP amounts for medical and pharmacy. The OOP limitations apply to non-grandfathered individual and small group market plans, requiring that the combined OOP or the total sum of the separate medical and pharmacy OOPs do not exceed the statutory limitation of $6350 for 2014. Some small group market plans which have separate medical and pharmacy MOOPs may qualify for a one-year exemption from the statutory MOOP limits if the major medical and pharmacy (or other EHB benefit) are separately administered. In such cases, and solely for group market plans 2014, each of these MOOPs is separately subject to the statutory limits, such that they medical MOOP must not exceed the $6350 limit and the separate pharmacy MOOP cannot exceed the $6350 limit. Please see the Letter to Issuers on Federally-facilitated and State Partnership Exchanges released on April 5, 2013.

Q60: Can we submit multiple plans in a single benefits tier (for example, 3 silver plans), using the templates?

A60: Yes, you can submit and offer multiple benefit plans at the same level of coverage (e.g., silver, bronze). All plans defined within a Benefits Package will share the same set of benefits and limits but may differ in cost sharing. To offer a different set of benefits and limits, you will need to create a new Benefits Package. Please refer to Chapters 10 in our instructions guide for more details which is available on the CMS zONE online repository at https://zone.cms.gov/ or on www.REGTAP.info.

Q61: Should the coinsurance reflect what the member will pay or what the insurer will pay?

A61: On the Plan and Benefits template, the coinsurance amounts should reflect what the member will pay.

Q62: My template validated successfully, but when I uploaded it, I got a validation error requesting a valid EHB variance reason. How can this be fixed?

A62: For state mandates that are market-specific, the template populates the benefits based on the market and validates the mandates as EHB. However, the upload validation only considers these benefits to be EHB when they are mandated in both markets.

Therefore, if your state has market-specific mandates, you will be asked to submit an EHB variance reason when you submit one of the market-specific state mandated benefits. In this case, the EHB variance reason should be “Additional EHB Benefit.”

Q63: In the "Plan Type" column of the Plan & Benefits Template, what does "EPO" mean?

A63: EPO refers to an Exclusive Provider Organization.

Q64: If an issuer has a major medical plan where the member pays 100% out-of-pocket until the deductible is met, but then 0% is paid by the member once meeting the deductible, how does an issuer enter this in the Cost Sharing fields?

A64: If a copayment is charged for a benefit, enter the dollar amount in the copay field. If no copayment is charged, choose from *No Charge*, *No Charge after deductible, $X Copay*, *$X Copay after deductible*, or *$X Copay before deductible* in the Plan & Benefit Template.

If coinsurance is charged for a benefit, enter the percentage in the coinsurance field. If no coinsurance is charged, enter *No Charge*, unless your plan has a tier 1 copayment that the enrollee pays only until the deductible is met. In this case, enter *0%*. Choose from *No Charge, No Charge after deductible, X% Coinsurance after deductible,* or *X%* Plan & Benefit Template.

Issuers may refer to Chapter 10: Instructions for the Plans & Benefits Application Section for additional information.

Q65: If the plan does not pay for a benefit but the members are entitled to a discount on the services since they are a member, would this be considered a covered benefit?

A65: Benefits may only be included in the Plan and Benefits template if the issuer covers all or part of the service. Discounts on services or products that come with the coverage would not be considered covered benefits.

Rating Template

Q66: Do issuers need to submit two sets of HIOS rate sheet templates (one with on exchange plan codes and one with off exchange) even though the benefits and rates are the same?

A66: HHS cannot comment on how SBEs are prepared to combine data. In general, rate tables are stored and calculated based on QHP IDs (standard component IDs generated in HIOS). QHPs are submitted exclusively to the FFM, and the integration of on and off-exchange plans is not an issue. HHS would anticipate that rate tables need to be submitted based on Standard Component IDs. HHS might expect an SBE to ask for two templates (one for QHPs, one for off exchange), but that is simply an expectation.

Q67: The regulations allow for a 1.5:1 rate factor for tobacco use. However, the Rate Template does not allow for this and errors out because the spread in some instances is more than 3:1 by age. For example, take a 21 year old smoker and a 64 year old smoker, you might have a 1.10 smoking factor for the 21 year old and a 1.30 factor for the 64 year old smoker. When you apply the age factors, the 64 year old smoker would have a rate that is more than 3 times higher than the 21 year old smoker. Will there be an opportunity to updates the rates issuers submitted during the application window?

A67: The preamble to the Health Insurance Market Rules Rate Review final rule (Market Rule), published on February 27, 2013, states that younger enrollees could be charged a lower tobacco use factor than older enrollees provided the tobacco use factor does not exceed 1.5:1 for any age group. For example, a 21-year-old smoker could be rated at 1.2 to 1 and a 65-year-old smoker can be rated in the same plan at 1.5 to 1. Because of a system limitation in the Rating Tables Template, however, the system currently cannot process a premium for a 65-year-old smoker that is rated more than 3 times the premium of a 21-year-old smoker.

Accordingly, HHS asks that, until further notice, all issuers that are required to use the Rating Tables Template and that will be offering non-grandfathered plans in the individual and small group markets implement the tobacco rating factor for their non-grandfathered policies so that older adult smokers are not rated in total more than 3 times of the total rate for a younger adult smoker. One way to accomplish this is if an issuer imposes a 1.2 to 1 tobacco rating factor on a 21-year -old smoker, the issuer should use the same 1.2 tobacco rating factor for the 65-year-old smoker. If an issuer implements the tobacco rating factor with the result that an older smoker is rated up more than 3 times of that of a younger smoker, the submission of the issuer will be rejected by the system. HHS intends to implement a system change that will allow for processing of tobacco rating factors that vary based on age, and HHS expects this to be completed after calendar year 2014.

HHS also reminds issuers that the Market Rule provides that a tobacco rating factor may be applied only with respect to individuals who may legally use tobacco under federal and state law. Different states may have different age limits regarding the sale of cigarettes. If a state, for example, prohibits the sale of cigarettes to individuals under the age of 19, then individuals under the age of 19 in that state cannot be rated for tobacco use. Therefore, health insurance issuers seeking to impose tobacco rating should be aware of the age limit in every state where they will offer health insurance coverage subject to tobacco premium rating.

URRT

Q68: If an issuer is entering a market for the first time and has no experience, how should they input information on Worksheet 1 of the Unified Rate Review Template under the Section 1: Experience Period and how will the results be published?

A68: Issuers have to input a number greater than $0, which was an unintended error in the template. HHS does not know how information will be published at this time, but as required by rule, issuers will be notified before we publish and given the opportunity to make comments and/or seek a confidentiality exemption for information determined to be published.

Q69: How do issuers enter Product IDs on past experience for terminated plans in the URRT?

A69: Most products in the individual market have been required to be submitted to the HIOS Plan Finder for over 2 years and over 1 year for the small group market, so HHS anticipates that most issuers will have at least 1 Product ID to input for terminating products. If not, the issuer will be required to seek a Product ID from HIOS and that request will be handled as quickly as possible.