

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013



# Plan Management Webinar Frequently Asked Questions

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## Frequently Asked Questions (FAQs) # 1

Released Date: April 8<sup>th</sup>, 2013

### Guidance/Timeline

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#### Accreditation

**Q1: How should the National Committee of Quality Assurance (NCQA) / Utilization Review Accreditation Committee (URAC) accreditation templates be filled out if we are in the first year of the accreditation process?**

A1: We will be collecting accreditation information only from issuers that are currently accredited by NCQA and/or URAC on their commercial, Medicaid and/or Exchange market, if applicable. See 45 CFR 155.1045, which can be found at 78 FR 12865. Issuers that are in the process of receiving accreditation but are not yet accredited should mark "No" (that they are not accredited) in the accreditation section of the QHP application and should not fill out the NCQA/URAC templates.

**Q2: Once QHP Issuer Applications have been submitted, what is the process health plans should follow to report that Exchange products have received NCQA/URAC accreditation and when will this information be posted to the website? For example, if a health plan is scheduled to undergo an NCQA/URAC review in June and/or July and receives accreditation by September, how soon will that update be posted to the website?**

A2: At this time, HHS is only accepting accreditation information from currently accredited issuers. Issuers that are not accredited at the time of submitting their QHP application should mark "No," that they are not accredited, on the Accreditation section of the application. If you receive an accreditation status after the application closes, you should notify HHS and during the resubmission window you may submit your new accreditation information. For more information on this process, see pages 10-12 of the final Letter to Issuers on Federally-facilitated and State Partnership Exchanges (Issuer letter), published on the CCIIO website on April 5, 2013, at [http://cciio.cms.gov/resources/regulations/Files/2014\\_Letter\\_to\\_Issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf).



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013

### QHP Certification/Review Process

**Q3: What are the QHP certification submission window dates? Is this different for the Federally-facilitated Exchanges (FFE) and State Partnership Exchanges (SPEs)?**

A3: We expect that the QHP Application window in the FFE will be April 1-30, 2013. All parts of the applications are due at that time. In the SPE, the State will define the timeline for application submission. For more information on this, please reference chapter two of the draft issuer letter.

**Q4: What data elements will be part of the certification process? In an earlier call, HHS indicated that there are elements that will not be part of the certification and can be adjusted. For example, the network URL could be changed within the templates and not have an impact, because it was not an element that was under final approval.**

A4: All QHP Application final data elements and definitions can be viewed in the QHP Certification PRA package, OMB Control Number 0938-1187, available at [http://www.reginfo.gov/public/do/PRAViewICR?ref\\_nbr=201303-0938-004](http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201303-0938-004). The specific part of the certification process that this question speaks to is Plan Preview, scheduled for late August. Issuers will only be allowed to submit corrections to inaccurate data once they a) contact the FFE with the data inaccuracy concern and b) receive confirmation that they are allowed to resubmit the data. Only data that does not cause a "re-review" of the application, such as the network URL, will be eligible for correction.

### Dental

**Q5: Will there be benefit and rate templates specific for stand-alone pediatric dental plans?**

A5: For the FFE, we are planning to use a modified benefits template for stand-alone dental plans.

**Q6: If there is a stand-alone dental plan offered on the exchange, does a QHP still need to offer pediatric dental benefits as part of its Essential Health Benefits (EHBs)?**

A6: No. Please see 45 CFR §155.1065(b). In prior rulemaking, we sought information from issuers regarding whether they planned to offer stand-alone dental plans, and we collected this information through a PRA package, OMB Control Number 0938-1174. Further information on this voluntary dental reporting is available at <http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf> on CCIIO's website.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013

**Q7: Do plans offered outside of the Exchange have to have pediatric dental embedded in the medical benefit? Does this also apply in the small group market outside of the Exchange?**

A7: Plans offered outside of the Exchange must offer the full set of essential health benefits. 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. See the comment/response discussion for §156.150 of the EHB final rule at 78 FR 12852, available at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>.

**Q8: Can stand-alone dental plans submit actuarial certification to demonstrate that they meet the high or low Actuarial Value (AV)?**

A8: Yes, according to §156.150(b)(3) of the final EHB rule, found at 78 FR 12869, in order to demonstrate that stand-alone dental plan AV standards are met, an actuarial certification is required.

**Q9: Does the out-of-pocket maximum include both medical and dental benefits if pediatric dental benefits are embedded in the medical plan? Having a separate out-of-pocket maximum for medical and dental has been suggested.**

A9: Please refer to §156.150 of the EHB final rule for further information on stand-alone dental plans. If pediatric dental benefits are embedded in the QHP, then the one out-of-pocket maximum for the QHP applies.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013

**Q10: When the Advanced Payment of Premium Tax Credit (APTC) is calculated, will it balance for the missing cost of pediatric dental if the second lowest silver plan is a medical only plan?**

A10: If the second lowest cost silver plan for a particular taxpayer is a QHP that does not include the pediatric dental EHB, and the taxpayer chooses to enroll in the second lowest cost silver plan, the APTC will not cover the cost of the pediatric dental EHB, even if the taxpayer also enrolls in a stand-alone dental plan. However, if the taxpayer enrolled in a QHP and stand-alone dental plan that, together, were lower in cost than the second lowest cost silver plan, the APTC could cover some or all of the cost of the pediatric dental EHB covered by the stand-alone dental plan, provided that the total APTC does not exceed the limit established by the second lowest cost silver plan. Please see the IRS final rule at 77 FR 30377 for a description of this. The rule is available at <http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf>.

### Transactions

**Q11: Have specifications on the Edge Servers required by issuers been released yet?**

A11: HHS has provided a list of required data for the HHS-operated distributed data approach in the PRA package approved under OMB Control Number 0938-1155. After release of the final payment notice, we HHS is conducting a short series of educational webinars focused on details of the distributed data approach. You can register for these sessions at [www.REGTAP.info](http://www.REGTAP.info). The next session will be held on April 10, 2013. During these sessions, HHS will make available the data formats, definitions, and technical standards applicable to the HHS-operated distributed data approach in future guidance. This summer we plan to conduct followed by user group sessions and additional operational policy guidance.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013

**Q12: If the consumer enrolls through the FFE, will the FFE collect the binder payment (the payment that binds the individual to the coverage)? If not, how will issuers be notified?**

A12: The FFE will not aggregate premiums for issuers in 2014. However, the FFE will generate an 834 enrollment transaction upon plan selection and send that initial enrollment transaction to the issuer to effectuate the enrollment and to collect the appropriate portion of the premium for which the individual is responsible. The 834 enrollment transaction will detail the enrollment information, including total premium amount, with a breakdown of the APTC amount and the remaining individual responsibility portion of the premium for the enrollment group. This will include a breakdown of the APTC amount and the remaining individual responsibility portion of the premium for the enrollment group. The issuer will be responsible for collecting the individual responsibility portion of the premium. This is depicted as the Total Responsibility Amount of the 2750 loop in the FFE 834 companion guide. (The companion guide can be found at <http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf>.)

### Small Business Health Options Program (SHOP)

**Q13: Will there be a training session dedicated to FF-SHOP, including the interactions between the issuers, SHOP, and the aggregator(s)? Will there be a complete data dictionary for the files that will be exchanged between the FF-SHOP and the issuer and the aggregator and the issuer?**

A13: We are planning to conduct dedicated sessions on SHOP enrollment and payment matters involving premium aggregation services and will share a complete data dictionary for payment file transfers.

**Q14: How many eligible employees may a SHOP group have?**

A14: 100 full-time equivalent employees, although States may keep the upper limit of their small group market at 50 for 2014 and 2015; we anticipate that virtually all States will keep their upper limit at 50 for the first two years. See 45 CFR 155.20 for a definition of "small employer," and 45 CFR 155.710(b) for its applicability to the SHOP.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013

### States

**Q15: How do you envision the coordination process occurring between the FFE QHP filing and the State rate and policy form filing? What happens if the FFE approves the QHP application, but the State does not approve, or requires minor changes to the policy form?**

A15: No product can be sold on any Exchange unless it is first approved for sale by the State Department of Insurance (DOI). For more information on our approach and state/FFE roles, please see the General Guidance on the FFE, published May 16, 2012, at <http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf>. In the FFE, the issuer will submit the QHP application to the FFE in the Health Insurance Oversight System (HIOS) and will also submit form filing as required by the State. Before an issuer signs a QHP Agreement for a certified QHP, the issuer will have to confirm that the QHP has been approved for sale by the State. If a plan is approved as a QHP but does not attain approval by the DOI, it will not be available on the Exchange.

### Essential Health Benefits (EHB)

**Q16: Where a plan offers an EHB service in excess of the state benchmark (such as 30 visits as opposed to 15), how will visits 16 through 30 be treated with respect to both metal-tier actuarial value and the cost-sharing maximum?**

A16: Any EHB/Benchmark services offered, even in excess of minimums of the benchmark, are considered EHB services and apply to the index rate and must be spread evenly across the risk pool. See §156.115(a)(1) and the preamble discussion at 78 FR 12843 regarding §156.115.

### Rating

**Q17: When will the rate review template be published?**

A17: The Unified Rate Review template was published in the Federal Register on February 27, 2013 at 78 FR 13406. The publication of this template contains all the data elements that issuers are required to submit.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013

### Essential Community Providers (ECP)

**Q18: Can you please clarify what is an "Essential Community Provider"? Please provide a full definition and parameters for states that may not have all ECP's due to population size, geographic barriers, or provider types that do not exist specific to the state.**

A18: As defined in section 1311(c)(1)(C) of the Affordable Care Act and in 45 C.F.R. 156.235(c), ECPs are providers that serve predominantly low-income, medically underserved individuals, including providers described in section 340B(a)(4) of the PHS Act, and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. Please note that ECP inclusion will be evaluated based upon the extent to which ECPs are available in the service area of the issuer.

**Q19: Is the evaluation of ECPs at a county or service area level?**

A19: The percentage thresholds will be calculated based upon the issuer's service area. See 45 CFR §156.235 and the Letter to Issuers on Federally-facilitated and State Partnership Exchanges. To qualify for the safe harbor articulated in the issuer letter starting on page 7, the issuer will be expected to have contracts with at least 20 percent of the available ECPs in the proposed service area (published on the CCIIO website on April 5, 2013, at: [http://cciio.cms.gov/resources/regulations/Files/2014\\_Letter\\_to\\_Issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf)). To meet the safe harbor, please note that the issuer would also need to offer contracts to all Indian providers in the service area, and offer contracts to at least one ECP in each ECP category in each county of the service area, as noted in the letter.

**Q20: If a service area is statewide, does the safe harbor standard mean that the issuer can contract with 20 percent of the ECPs in the state overall and meet the requirements?**

A20: If the issuer's service area is statewide, then the issuer would need to contract with at least 20 percent of the ECPs in the State to qualify for the safe harbor. The issuer would also need to meet the standard set forth in the issuer letter and noted above, in question 20, regarding Indian providers and offering contracts to at least one ECP in each ECP category.

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/8/2013

**Q21: How will the requirement to offer contracts to at least one ECP per category apply if there are no ECPs in the category in the service area?**

A21: As a condition of the safe harbor, issuers will need to offer contracts to at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available. Please be sure to check the non-exhaustive listing of ECPs to determine the availability of ECPs in the service area. This list was published 3/26/13. Information on the list and a link to the list can be found at <http://cciio.cms.gov/programs/exchanges/qhp.html>.

**Q22: If there are not any available Indian Health Service (IHS) providers in the state per the IHS website, do the ECP requirements still apply?**

A22: Indian providers also include tribal and urban Indian organizations. Please check the non-exhaustive list of ECPs referenced previously to verify whether any Indian providers are available in the proposed service area.

**Q23: If the network adequacy standard for ECP cannot be met, issuers can submit a satisfactory narrative justification. What elements would make the response satisfactory as opposed to unsatisfactory?**

A23: HHS expects that an issuer that does not achieve the safe harbor standard submit a narrative justification using the ECP Supplemental Response Form. The QHP Application identifies the specific elements that must be addressed in the narrative justification in the ECP Supplemental Response Form. This would include providing information on why the issuer was not able to achieve the safe harbor standard, how the issuer plans to increase ECP participation, and how the existing network would provide access for low-income and medically underserved populations. Issuers will need to respond to each specific element requested in the ECP Supplemental Response Form, as applicable.

## Templates

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**Q24: Please provide the XML standards for the templates – are they different for each template?**

A24: Yes, they are different for each template. The template itself will generate the .xml file.

**Q25: Are the Individual (FFE) and SHOP (FF-SHOP) templates similar or exactly the same?**

A25: There is a single template for FFE and FF-SHOP submissions. You will be required to submit your Individual Plans and Benefits separately from your SHOP plans and benefits, but both use the



## QHP Frequently Asked Questions

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same template. The template validation will apply the market (FFE or FF-SHOP) dependent business rules.

**Q26: When is the rate review template due and will this be concurrently with the rest of the templates at the end of April?**

A26: If an issuer has at least 1 QHP Application, April 30 is the deadline. If the issuer is not submitting any QHPs, then they must follow State rules or submit before January 1, 2014.

### **System for Electronic Rate and Form Filing (SERFF)**

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**Q27: How does the plan information get into HIOS for HHS to review once the issuer submits through the SERFF system? Will the SPE QHPs submitted by the issuer to SERFF be automatically transferred to HIOS, or will we need to submit them to HIOS as well?**

A27: In States in which an SPE is operating, transfer of the issuer's QHP application data from SERFF to HIOS will take place after the State has reviewed the applications. The State will select recommended plans and then initiate the transfer of recommended QHPs' data to HIOS.