



QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Plan Management Webinar Frequently Asked Questions

Frequently Asked Questions (FAQs) # 3

Released Date: April 11th, 2013

Guidance/Timeline

QHP Certification/Review Process

Q1: Will there be an opportunity to update the URL for provider networks after the initial application period?

A1: As included in the Letter to Issuers (Table 2.1 Key Dates), issuers will have the opportunity to review data during the plan preview period and submit data corrections (this is tentatively scheduled from August 22 –August 26). URL updates/corrections can be made at that time. The Letter to Issuers can be found at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf

Q2: At what level does the organizational chart need to be submitted?

A2: This data needs to be submitted at the issuer applicant level.

Q3: What should issuers fill in for a Network ID, Service Area ID, and Formulary ID?

A3: Network IDs, Service area IDs, and Formulary IDs are internal system generated IDs. In each template you have the ability to generate these IDs. You must assign networks the same numbers as those assigned in the Network ID and Benefit templates.

Q4: Do the sections of the application have to be completed in order?

A4: No, the sections may be completed in any order.



QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Accreditation

Q5: For an issuer offering products during Federally-facilitated Exchange (FFE)/Partnership Exchange open enrollment in 2013 and not holding existing National Committee of Quality Assurance (NCQA) or Utilization Review Accreditation Committee (URAC) accreditation, on or before what date must it be awarded accreditation by URAC or NCQA to allow its Quality Health Plans (QHPs) to continue participation on the Exchange?

A5: Issuers without existing accreditation that offer a product as part of an FFE or Partnership Exchange in 2014 (open enrollment in 2013) must be accredited on QHP policies and procedures 90 days prior to 2014 open enrollment in order to be certified for the 2015 coverage year.

Q6: Must accreditation be completed before the QHP issuer's second year of certification, but not before the third year of certification?

A6: The issuer must be accredited on the QHP policies and procedures before the issuer's second year of certification, and must continue to be accredited on the policies and procedures in the third year of certification. The issuer must obtain full accreditation (in accordance with 45 CFR 156.275) by the fourth year of certification.

Technical Guidance

Q7: If an uploaded document is incorrect, can issuers upload a new document to replace it?

A7: Yes.

Q8: What format do uploaded supporting documents need to be in?

A8: Supporting documents can be uploaded as PDF or Word formats.



QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q9: How do issuers correct errors found upon final submission (cross template validation) if it is not possible to change the information once the data validation has been performed?

A9: For states using the FFE, the validator can reverse the validation decision to allow revision of the submitted data during the initial submission period.

For states using the System for Electronic Rate and Form Filing (SERFF), issuers will need to manually validate that each plan has a valid network, service area, and prescription drug ID; that there are rates submitted for each plan; and that they have submitted the rating rules template.

Q10: What documents can be deleted or overwritten after they are uploaded in the QHP application?

A10: For templates, a newly uploaded template will overwrite the previous template in the Issuer, Rating and Benefits, and Service Area Modules. Supporting documents may be deleted in the Issuer Module. Supporting documents may not be deleted in the other modules. In the Benefits and Service Area module, issuers may use the comment field to indicate that an updated version has been submitted.

Q11: Will HHS provide validation reports when issuers submit the templates? Will issuers be able to correct errors during the application window?

A11: Every template has a validate button. After you upload the template, the system will complete a validation. There is an update status button to check the status. There is an error report delivered on screen.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Dental

Q12: Is dental subject to the same minimum thresholds as medical in regards to Essential Community Providers (ECPs)?

A12: Yes, dental plan issuers are subject to the Essential Community Provider thresholds. See 45 CFR §156.235 for more information on Essential Community Providers. More information on the thresholds can be found in the Letter to Issuers in Federally-facilitated and State Partnership Exchanges on the Center for Customer Information and Insurance Oversight (CCIIO) website at:

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

The list of ECPs that provide dental services is available here:

<https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu>

Q13: Will there be a dental ECP list?

A13: Yes, ECP providers that cover dental services will be identifiable. The list of ECPs that provide dental services is available at: <https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu>

Q14: If someone enrolls in the pediatric oral Essential Health Benefit (EHB) offered through a stand-alone dental plan (SADP) during the normal open enrollment process and then drops the coverage mid-year, will he or she be allowed to re-enroll during the next open enrollment period with the same company, or can plans include and enforce a lock-out period (for example 2 years) to discourage this anti-selection behavior?

A14: Yes, when provided under a separate policy or contract, limited scope dental benefits are excepted benefits, as defined by PHS Act section 2791, and thus not subject to the requirements of the PHS Act, including section 2702 guaranteed availability standards [Please refer to the Letter to Issuers in Federally-facilitated and State Partnership Exchanges for more information:

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



QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Small Business Health Options Program (SHOP)

Q15: Are child-only plans required on the SHOP Exchange?

A15: Yes, offering a child-only option is a requirement under section 2707(c) of the Affordable Care Act for enrollees under the age of 21, or in the case of the SHOP, employees under the age of 21.

Q16: If an employer with less than 20 employees signs up through the SHOP, would an employee who is also on Medicare pay the same rate on the SHOP?

A16: The SHOP follows the same Medicare Secondary Payer rules as the outside market. All else equal, a small group rate does not differ based on Medicare eligibility. Please see 45 CFR 147.102.

Q17: Can families pick different plans in the SHOP exchange?

A17: For FFEs, pursuant to the proposed March 11 Notice of Proposed Rule Making (NPRM), (77 CFR 15553) an employer may only offer one plan to its employees in the first year of FF-SHOP operation. This proposal does not permit the scenario described in this question.

Q18: In States with an FFE, will the State definition be followed in States that define small group as 2-50 employees?

A18: Section 2791 of the PHSA defines the small group market for employers with 1 – 100 employees. Flexibility is provided to State-based Exchanges in 2014 and 2015 regarding the upper limit of the small group market (the state may reduce the upper limit to 50) and the method of determining employer size for the state's small group market - not regarding whether or not a group health plan exists. As described in the preamble to the Exchange Final Rule (77 FR 18398) A State-based SHOP may use both the numerical upper limit and the state method of determining employer size. The FF-SHOP will use the state's numerical upper limit (50 or 100) but must use the FTE method of determining employer size. States, State-based SHOPS, and FF-SHOPS must use ERISA/PHS Act provisions that prevent a business without at least one common law employee from forming a group benefit plan (sole proprietors, certain S-corp shareholders, and family members of either are not common law employees).

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

USP/Pharmacy

Q19: What is the format for the USP Category and Class Count input file?

A19: The USP Category and Class Count service input file must contain a header line that reads "RXCU," (not case sensitive), must not contain any blank lines, must contain RxCU's that contain only numbers, and are no longer than 8 digits in length (any leading 0's will be truncated). For more information about this file, please see section 4.2 of the User Guide.

Essential Health Benefits/Actuarial Value

Q20: As is mentioned in the Actuarial Value (AV) Calculator user guide, 100% general coinsurance rates should only be used for copay based plans, but in cases where the issuer is inputting a coinsurance based plan that has 100% coinsurance, what should the issuer input for the coinsurance rate?

A20: When inputting 100% coinsurance rate, the AV Calculator will attempt to calculate an effective coinsurance rate to apply, expecting a copay plan. However, if the plan is a 100% coinsurance plan and is not a copay-based plan, the plan should use 99.99% coinsurance rate as the effective coinsurance rate.

Q21: There is a provision that allows the annual deductible to exceed \$2,000 if needed in order to get to the appropriate AV. Does this mean stand-alone dental EHB can have a separate deductible amount (dental standard example \$50) that would not be subject to coordination of benefits with the medical EHB plan in order to achieve the required AV levels?

A21: A stand-alone dental plan may have a separate deductible amount and will not need to coordinate with the medical plan. Because AV levels are different for stand-alone dental plans, high of 85% and low of 70%, as established in 45 CFR 156.150, CCIIO does not currently expect that stand-alone dental plans will exceed allowable deductible amounts in the small group market in order to reach AV targets.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q22: Should issuers provide information about optional riders that do not impact Essential Health Benefits (EHBs)?

A22: The FFE and State Partnership Exchange templates do not collect and will not display optional riders. In situations where an issuer would traditionally offer a rider and is interested in offering that optional benefit on the FFM an issuer should submit two plans, one with and one without the rider. Depending upon the benefit that would have been traditionally offered in a rider, it may not be displayed on the FFM website to consumers, but it may be displayed by issuers and provided to consumers in plan documents.

Q23: What can be used as a source document for understanding the required benefits of the benchmark?

A23: The regulatory standard for plans wishing to offer EHB is that plans must offer benefits and limits that are substantially equal to the benefits and limits in the benchmark, as outlined in 45 CFR 156.115. The benefits available through the CCIO website are a summary of the EHBs for each respective state. The CCIO website also includes an explanation of what is listed and how to review, and a document called "Guide to Reviewing Essential Health Benefits Benchmark Plans." In order to provide states, issuers, and others more information on the benchmark, the National Association of Insurance Commissioners (NAIC) has recently made more detailed benefit documents available. As published in the EHB final rule, EHB compliance is the responsibility of states regardless of Exchange type. We would encourage issuers to work with their enforcing state to further understand what enforcement or review for EHB will entail.

Transactions

Q24: Do issuers need to be QHP certified if they only offer off-Exchange products, but still want to be able to receive the 3Rs (reinsurance, risk adjustment and risk corridor)?

A24: The reinsurance program applies to all applicable individual market issuers inside and outside of the Exchange, and the risk adjustment program applies to applicable individual and small group market issuers inside and outside of the Exchange. Products outside of the Exchanges do not need to be QHPs in order to take part in these programs. The risk corridor program is only applicable to QHPs.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q25: Is the data submission process for Medicare applicable to the Edge Server?

A25: The data and submission process on the Edge Server is specific to the reinsurance and risk adjustment programs specified in the ACA (e.g., private insurance and not Medicare). Medicare data should not be submitted to the Edge Server.

Q26: Per the final Payment Notice, the initial Risk Adjustment model will exclude prescription drug data. However, the final Payment Notice states that claims and encounter data for prescription drugs are required to be submitted on the Edge Server. Why is this?

A26: The transitional reinsurance program considers pharmacy claims as reinsurance-eligible claims. All reinsurance-eligible claims will be included during the payment calculation process on the Edge Server for the HHS-operated reinsurance program.

Q27: For the zero cost sharing plan variation of a closed-panel HMO QHP, does the cost sharing for out-of-network services need to be eliminated?

A27: A zero cost sharing plan variation, as defined at 45 CFR 156.420(b)(1), is a variation of a QHP with all cost sharing eliminated. However, cost sharing is defined at 45 CFR 155.20 to be any expenditure required by or on behalf of an enrollee with respect to Essential Health Benefits, including deductibles, coinsurance, copayments, or similar charges, but excluding premiums, balance billing amounts for non-network providers, and spending for non-covered services. Therefore, if the QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network (i.e. cost sharing for services provided by an out-of-network provider is 100%), the spending, or cost sharing, for these non-covered services would not need to be eliminated for the zero cost sharing plan variation associated with this QHP, and should be entered as it would be for non-covered out-of-network services under the corresponding standard plan. For covered benefits that are not Essential Health Benefits, the coinsurance and copays must be the same as the associated standard plan (despite the template auto-populating them with 0's). For additional information, please consult the final HHS Notice of Benefit and Payment Parameters, published March 11th 2013.



QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Essential Community Providers (ECP)

Q28: The Essential Community Provider (ECP) Template includes a column for Provider Name. Is an issuer required to enter each ECP by name or can the issuer enter the ECP entity name when applicable, knowing that an ECP entity may include multiple providers?

A28: Please enter the name of the ECP entity for each location of the ECP entity, even if the ECP entity has multiple providers at a specific location.

Q29: If we subcontract our psychiatric work, how do we represent that on the ECP template?

A29: If the issuer subcontracts with another entity for psychiatric services and the entity in turn contracts with an ECP, the ECP should be included in the issuer's ECP template if listed in the provider directory for the issuer's QHP.

Q30: If an Indian health provider does not contract with an issuer, can the issuer treat it as a non-participating provider?

A30: Even if an issuer does not have a contract with an Indian health provider, and the Indian health provider provides services to an Indian who is a member of the issuer's QHP, the Indian health provider would have a right of recovery authorized under section 206 of the Indian Health Care Improvement Act (25 U.S.C. §1621e). Section 206(a) and (i) of the Indian Health Care Improvement Act provide that the Indian Health Service, an Indian tribe, tribal organization, and urban Indian organization have a right to recover reasonable charges billed, or, if higher, the highest amount an insurance carrier would pay to other providers. However, HHS notes that if an issuer and Indian health provider sign a QHP agreement that uses the model QHP Addendum for Indian health providers and the issuer and Indian health provider mutually agree to rates or amounts specified in the QHP agreement as payment in full, the QHP issuer is deemed to be compliant with Section 206 of Indian Health Care Improvement Act.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q31: How should an issuer handle out-of-state Indian providers; should they be treated as in network or out-of-network?

A31: To the extent that an out-of-state Indian health provider is not a part of an issuer's network, the issuer could consider the Indian health provider as an out-of-network provider. However, the Indian health provider's right of recovery afforded under section 206 of the Indian Health Care Improvement Act referenced in the response to the question "If an Indian health provider does not contract with an issuer, can the issuer treat it as a non-participating provider?" (above) would apply. HHS notes that issuers may want to consider contracting with Indian health providers in neighboring states, as tribal lands often cross state borders.

Templates

Q32: What is the purpose of the field "Unique Plan Design" in the benefits template?

A32: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, issuers must indicate if the health insurance plan has a unique design, for purposes of the AV Calculator. This is a 'Yes' or 'No' field, and issuers will be asked to indicate whether the plan design is unique, meaning it cannot use the standard AV Calculator. If the plan design is unique for purposes of calculating AV, upload the Unique Plan Design Supporting Documentation and Justification (See Chapter 13: Unique Plan Design Supporting Documentation and Justification for a suggested format.). The actuarial certification is a signed and dated certification indicating that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable Federal and State laws and actuarial standards of practice.

An example of plan designs that could be considered "unique" for purposes of determining AV would be a plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10 percent coinsurance for the first \$1,000 in consumer spending after the deductible, 20 percent coinsurance for the next \$1,000 in consumer spending, and 40 percent coinsurance up to a \$6,400 out-of-pocket maximum. This plan design would be considered "unique" because the current AV Calculator can only accommodate a single coinsurance rate for each benefit.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q33: How should the benefits template be completed if infertility is not covered?

A33: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, if a benefit is not covered, select “Not Covered” in the “Is this Benefit Covered” field of the Plan & Benefits template. If this field is changed to 'Not Covered' for an EHB then you must substitute another benefit or combination of benefits in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification (Instructions Chapter 13B) to support the actuarial equivalence of the substitution.

Q34: What should be entered in fields starting with “Primary Care Visit to Treat an Injury or Illness,” when a plan has a copay or coinsurance, but not both??

A34: Please refer to the “Covered Benefits” section of Chapter 10: Instructions for the Plans & Benefits Application Section for information to complete the copayment and coinsurance fields of the Plans & Benefits Template.

For example, under "Copay–In Network (Tier 1)," if an in-network copayment is charged, enter the dollar amount. If no copayment is charged, enter No Charge. Choose from the following:

- a. No Charge
- b. No Charge after deductible
- c. \$X Copay
- d. \$X Copay after deductible
- e. \$X Copay before deductible.

Under "Coinsurance–In Network (Tier 1)," if an in-network coinsurance is charged, enter the percentage. If no coinsurance is charged, enter “No Charge,” unless your plan has a tier 1 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter “0%.” Choose from the following:

- a. No Charge
- b. No Charge after deductible
- c. X% Coinsurance after deductible
- d. X%.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q35: What are the "Plan Data Elements" identified in appendix B1 needed for?

A35: Plan-level data elements are used to identify high-level data about each plan, including its ID and which network, service area, and formulary the plan will be using. Plan-level information applies to each standard plan you want to create for this benefits package. A standard plan is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage, and a benefits package is a group of plans that cover the same set of benefits; each plan in a benefits package can have different cost sharing, which is defined in the Cost Share Variances tab.

Q36: In the Benefits template what do utilization, cost share, and projected utilization rates mean?

A36: When the user is using Multiple In-Network Tiers, the Plans and Benefits Template requires that the user input the service utilization rates in each of those tiers that are equal to 100%. This information is used in the calculation of AV. If the user does not have multiple in-network tiers and selects "no" under column "I" (Multiple In-Network Tiers), the Plans and Benefits Template grays out the second tier of utilization and the user should input the "100%" under the first tier.

Q37: How should the Drug Tier IDs be defined?

A37: The Drug Tier ID is a required field in the Prescription Drug template (see Chapter 12: Instructions for the Prescription Drug Application Section). This template populates the number of tiers according to your selection in Number of Tiers.

Issuers may refer to the "Suggested Coordination of Drug Data Between Templates" in Chapter 10: Instructions for the Plans & Benefits Application Section for additional information related to tier and deductible data for drug and medical benefits.

Q38: What does the field "CSR variation type" mean?

A38: The "CSR Variation Type" refers to Cost Sharing Reduction information that must be submitted at the plan and benefit cost sharing levels. This field auto populates with the following based on cost sharing data entered into the template: Standard Silver Off Exchange Plan, Standard Silver On Exchange Plan, Zero Cost Sharing Plan Variation, Limited Cost Sharing Plan Variation, 73% AV Level Silver Plan, 87% AV Level Silver Plan and 94% AV Level Silver Plan.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q39: What fields will be pre-populated with the Benchmark Plan data?

A39: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, the following fields may auto-populate in the Plan & Benefits Template: EHB, State Mandate, Is this Benefit Covered?, Quantitative Limit on Service, Limit Quantity, Limit Unit, Minimum Stay and Explanation.

Q40: For State-based Exchanges, will issuers receive pre-populated templates?

A40: HHS has made the add-in file with benchmark information available to all States. In a State-based Exchange, please defer to the State for guidance on the specific data collection instrument that will be used.

Q41: Are coverage level and metal level the same?

A41: As noted Chapter 10: Instructions for the Plans & Benefits Application Section, the terms coverage level and metal level are used interchangeably throughout the templates and QHP Application.

Q42: How do issuers incorporate riders?

A42: The FFE and State Partnership Exchange templates will not collect or display optional riders. In situations where an issuer would traditionally offer a rider and is interested in offering that optional benefit on the FFM, an issuer should submit two plans, one with and one without the rider. Depending upon the benefit that would have been traditionally offered in a rider, it may not be displayed on the FFM website to consumers, but it may be displayed by issuers and provided to consumers in plan documents.

Q43: How do issuers enter coinsurance values in the Plans & Benefits template and the AV Calculator?

A43: While the coinsurance values in the Plans & Benefits template represent the percentage of costs that the enrollee pays for a given service, the coinsurance values in the AV Calculator represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AV Calculator must be set equal to 1-X%, where X% is the coinsurance value entered in the Plans & Benefits template. For example, if enrollees pay 10 percent of Specialist Visit costs, the coinsurance in the Plans & Benefits template would be equal to 10 percent. The coinsurance in the AV Calculator would be equal to 90 percent to represent the 90 percent of costs incurred by the issuer.

QHP Frequently Asked Questions

Selected Responses

Release Date: 4/11/2013

Q44: There have been a variety of technical problems with the benefits template. How can issuers move forward with using this template?

A44: Issuers may have technical issues when the Plans and Benefits Template Add-in file is not installed. To fix this:

1. Delete all versions of the add-in file.
2. Download the current version of the add-in file. Make sure you select “Save” from the dialog box, not “Open.”
3. Open the Plans and Benefits Template. You should see a “Plans and Benefits v.X.XX” on the features bar.
4. Enable Macros.
5. See the user guide and instructions for troubleshooting help.
6. Call the helpdesk if the previous suggestions do not solve the technical problem.

System for Electronic Rate and Form Filing (SERFF)

Q45: After issuers in State partnership States complete their application in SERFF, what further steps are required?

A45: States will communicate with issuers about the status of their applications once completed in SERFF.