

QHP Webinar Series Frequently Asked Questions

Selected Responses

April 18, 2013



Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 7

Release Date: April 24, 2013

Guidance/Timeline

QHP Certification

Q1: Does a certification year equal exactly 12 months?

A1: In the Federally-facilitated Exchange, a certification year is 12 months. At 45 CFR 155.1075, we state that “an Exchange must establish a process for recertification of QHPs.” For the FFE, we have established that QHP certification is for 12 months, as generally discussed in various guidance documents, including the Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf. We note that this does not apply to CO-OP and Multi-State Plans.

Q2: What if an issuer is unable to correct a deficiency within the resubmission window? For example, what if the problem is with the certification of good standing?

A2: If the deficiency identified requires follow-up with the State or other parties that cannot be completed in the time allowed for resubmission, the issuer should submit an explanation describing the activities being conducted to address the deficiency.

Q3: What supplementary documentation is needed for the "Good Standing" section?

A3: If the issuer is in compliance with State solvency requirements and is not under any corrective action related to financial review, then no supporting documentation is required. Please see Chapter 4 of the Instructions for a description of supporting documentation and justifications required if an issuer is out of compliance or under corrective action.



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Q4: Is a final provider directory required at the time of application or may updated provider directories be submitted after the QHP application is submitted?

A4: Issuers are required to provide a URL link to their provider directory at the time of submission. However, the sites themselves do not need to be live until open enrollment. Also, Issuers will have the opportunity to correct any errors to URLs that are provided at the time of submission during the plan preview period.

Q5: When can issuers update their provider directories?

A5: If an issuer has an error in the network URL, the issuer can submit a correction during the resubmission window or during plan preview in late August. No changes will be accepted after Plan Preview.

Q6: Where do issuers submit plan materials such as evidence of coverage?

A6: Supplemental documentation such as evidence of coverage can be submitted using the upload “supplemental document” feature in the Benefits & Service Area module of the QHP Application. Users may refer to Plan and Benefits user guide for additional information on submitting supplemental documents.

Accreditation

Q7: If an issuer is submitting a QHP application for a State-based Exchange through SERFF, and the State is not requiring the NCQA and URAC templates, does it need to submit the NCQA and URAC templates to SERFF in order to pass validation of the SERFF application?

A7: Issuers in State-based Exchanges should comply with the requirements for accreditation data collection that have been specified by the State-based Exchange. Issuers who are submitting QHP applications through SERFF for a State-Partnership exchange do not need to submit the Accreditation templates. Issuers that are submitting QHP applications through SERFF may also contact the NAIC for information about SERFF-specific requirements.

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Service Area

Q8: If an issuer's service area is the entire State, and the issuer wants to offer a plan that is only available in a certain part of the State, would that be another service area?

A8: Yes. Each QHP must be associated with a single service area ID.

If an issuer is applying to offer three QHPs, one available in service area A, a second available in service area B, and a third available across A and B, then the issuer should define a service area C by listing all of the counties included in both A and B, and use service area C for the third QHP. Having an entire State service area for one QHP does not preclude also having one or more smaller service areas defined as a county or group of counties within the State for other QHPs.

Q9: Do the rating areas and service areas have to match? Will the service area be defined by the given State similar to the Rating Areas?

A9: There is no FFE requirement that Service Area and Rating Areas have to match. See 45 CFR 147.102(b) and the preamble discussion in the final market rules at 78 FR 13410. States may have specific requirements related to Service Area, and issuers in the FFE are responsible for complying with these State requirements. Issuers will identify their service areas using the Service Area template. See the Chapter 9 of the Instructions for more information on filling out the Service Area template.

Q10: If an issuer plans to offer individual coverage on the Exchange in 10 counties in a single State, will the 10 counties be considered 1 service area or 10 service areas?

A10: Each QHP must be associated with a single service area ID. In this example, the ten counties would make up the QHP's single service area.



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Transactions

Q11: Is there any information available regarding how to register as a trading partner? Are hardware, software, or network requirements available for processing transactions timeframe for testing send and/or receive transactions?

A11: Information about how to register as a trading partner and details about the network requirements for establishing connectivity, meeting security requirements, and processing transactions is forthcoming. We will also be providing information about the testing schedule in the near future. This applies to issuers that will be approved to participate in the FFE as well as in SBEs.

Q12: Which issuer should submit reinsurance contributions for enrollees in point-of-service plans when the plan provides health insurance coverage through two affiliated issuers?

A12: When a point-of-service enrollee is covered by two affiliated issuers, the enrollee need only be counted once for reinsurance contribution purposes. The issuers should coordinate to ensure the total reported is an unduplicated aggregate enrollment count for all enrollees. Reinsurance contributions should be made for the point-of-service enrollees by the issuer of the plan through which the enrollees would receive the majority of benefits, as reasonably determined by the issuers. The issuers must submit to HHS documentation substantiating the enrollment count pursuant to 45 CFR 153.400(b), including references to the issuer that counted the point-of-service enrollee in their annual enrollment count, and the issuer that did not.

As an example, assume that Comprehensive Health Insurance Company, Inc. offers a point-of-service product in the individual market in State X. The point-of-service product includes a PPO option written by Comprehensive Health Insurance Company, Inc. (Comprehensive Health) and an HMO product written by Comprehensive Health Insurance HMO, Inc. (Comprehensive HMO), which offers HMO products in the individual market in State X. Assume that there are 1,000 enrollees in State X in the point-of-service product, and therefore, both Comprehensive Health and Comprehensive HMO, which are under common control, have the same 1,000 individuals as enrollees. The 1,000 enrollees receive the majority of their benefits from Comprehensive HMO. In this scenario, Comprehensive HMO would make reinsurance contributions with respect to the 1,000 enrollees, whereas Comprehensive Health would omit these 1,000 enrollees from their enrollment count.



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Q13: For purposes of reinsurance payments, how will claims covered by a point-of-service plan be allocated when the plan provides health insurance coverage through two affiliated issuers?

A13: HHS is in the process of working through the payment processes that would apply to point-of-service plans provided through two affiliated issuers. We will provide further guidance specifying how claims for point-of-service products will be aggregated for reinsurance payment purposes in those cases.

Network Adequacy

Q14: If an issuer has different networks for dental, vision, and medical, should all three be submitted?

A14: Each QHP must be associated with a single Network ID. If an issuer has dental, vision, and medical networks for a QHP offering all three types of benefits, the network URL provided in the Network ID template should provide the consumer access to view all three networks.

If an issuer is Tier 3 and is submitting a network access plan, that plan should describe standards applicable to all three parts of the network. See the Chapter 6 of the Instructions for more information on Network Adequacy reviews. An issuer offering dental benefits should also include its dental providers in the ECP network provided through the ECP template. A list of dental ECPs is available here: <https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu>.

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Pharmacy

Q15: If there is more than one RXCUI for a particular drug, which RXCUI should be included for the drug list to be compatible with the USP Category Class Count Service in HIOS?

A15: The USP Category Class Count Service is provided to assist issuers in complying with the essential health benefits (EHB) prescription drug benefit policy. Per 45 CFR 156.122, this policy requires that every EHB plan covers at least the greater of: (i) one prescription drug in every United States Pharmacopeia (USP) category and class; or (ii) the same number of prescription drugs in each category and class as the EHB-benchmark plan. However, meeting these EHB-required prescription drug coverage levels is a minimum requirement and issuers are permitted to exceed this requirement. Please refer to the EHB final rule (<http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>) for further information on the EHB benchmark standard and prescription drug policy.

A drug list should include all drugs (RXCUIs) the issuer intends to cover under its prescription drug plan, which means issuers should not leave out the unrecognized RxCUIs from the drug list. Please note that only the ones that are recognized by the EHB Rx Crosswalk will be considered for EHB compliance. 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 Drug Count Service will contain some unrecognizable RxCUIs. As long as you meet the EHB drug count standard for your State, you can ignore the unrecognized RxCUIs and include them in your drug list.

Q16: What types of RxCUIs are included in the EHB Rx Crosswalk?

A16: Use the December 3, 2012, full monthly release of RxNorm to find a list of valid RxCUIs, which should have one of the following term types (TTYs): semantic branded drug (SBD), semantic clinical drug (SCD), branded pack (BPCK), or generic pack (GPCK).

Q17: What does the error “unrecognized RXCUIs” mean and why are they “unrecognized”?

A17: Unrecognized RXCUIs are RxCUIs with valid formats (8 digits or less) that are not included in the EHB Rx Crosswalk. As noted above, the Count Service only recognizes 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 Count Service will contain some unrecognizable RxCUIs. Plans must meet the prescription drug EHB standards, described in 45 CFR 156.122, but plans may also continue to cover unrecognized drugs that are not counted towards EHB compliance.

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Q18: Are there any over-the-counter (OTC) drugs included in the EHB drug counts?

A18: A manual review was performed on RxCUIs that were identified as OTC drugs in the RxNorm database. RxCUIs that were confirmed as OTC drugs were removed from the EHB Rx Crosswalk, so those OTC drugs were not included as part of the benchmark drug counts and will not be counted in the USP Category Class Count Service. However, plans may continue to cover OTC drugs.

Q19: Does the USP Category Class Count Service report categories and classes with no drugs?

A19: The “Category Class Count Report” returned by the USP Category Class Count Service only includes category and class combinations in which the uploaded drug list has at least one drug. If the uploaded drug list does not include any drugs in a particular category and class combination, the category and class will not be included in the “Category Class Count Report.”

Q20: How can an issuer determine if its drug list meets the benchmark count?

A20: 1. Use the December 3, 2012, full monthly release of RxNorm to find a list of valid RxCUIs. Download the RxNorm release 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.

2. Upload the drug list’s RxCUIs into the USP Category Class Count Service.

3. Download the “Category Class Count Report” returned by the Count Service.

4. Download your state’s “Summary of EHB benefits, limits, and prescription drug coverage” file at <http://cciio.cms.gov/resources/data/ehb.html>. This document includes each state’s benchmark plan drug count by category and class. Compare these benchmark drug counts to your drug list’s counts in the “Category Class Count Report.” The drug list must include at least the greater of: 1) One drug in every United States Pharmacopeia (USP) category and class; or 2) The same number of prescription drugs in each category and class as the EHB-benchmark plan, per 45 CFR 156.122.



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Q21: Should Loperamide be included in the EHB Rx Crosswalk?

A21: Based on issuer input, CMS has noted an error in the USP Category Count Service.

The brand name RxCUI for Loperamide 2mg was mistakenly included in the EHB Rx Crosswalk. Loperamide, as the distinct chemical ingredient, should not have been included on the EHB Rx Crosswalk in brand form because it has an Over the Counter (OTC) equivalent. If issuers have problems with meeting the Gastrointestinal Agents Category, Other class due to this error, please follow the steps that are listed below:

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 QHP Application instructions manual, to identify reasons for an inadequate drug count in a specific category or class.

Actuarial Value

Q22: Do issuers have to submit a completed AV Calculator as part of QHP certification?

A22: The Plans and Benefits Template that is used to certify QHPs is integrated with the AV Calculator. Therefore, if the issuer is using the Plans and Benefits Template, the issuer will need to download the AV Calculator because the Plans and Benefits Template will require the user to open the AV Calculator into the Plans and Benefit Template. Then, the Plans and Benefits Template will automatically map the fields to the AV Calculator to produce the plan's AV. Additional information on this process is available in Chapter 11 the Plans and Benefits Instructions at:

http://www.serff.com/documents/plan_management_data_instructions_ch11.pdf. Issuers should defer to their state regulator regarding the submission of a completed AV Calculator.



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Essential Health Benefits

Q23: If the benchmark lists a benefit, does it need to be listed on the template as well? If an issuer don't list each and every benefit covered by the benchmark, will the issuer be deemed non-compliant?

A23: Please see the plan documents (Evidence of Coverage, Plan Benefits Summary, etc.) for more information regarding the particular items or services covered by the benchmark plan. As stated in the EHB final rule, published at 78 FR 12834, the benchmark plan defines the benefits. See, generally, 45 CFR 156.110 and 156.115. Moreover, an EHB plan is expected to be substantially equal to the benchmark pursuant to 45 CFR 156.115(a)(1), so you may not list every benefit but you would have to substitute or offer other benefits to be deemed substantially equal.

Q24: Can issuers have a small group plan at the silver level that exceeds the \$2000/4000 deductible in some plan variations even if the issuer can reach the silver level with a \$2000/4000 deductible (as long as the AV meets the silver level)?

A24: Per 45 CFR 156.130(b)(3), "a health plan's annual deductible limit may exceed the annual deductible limit if the plan may not reasonably reach the actuarial value of a given level of coverage as defined in § 156.140 of this subpart without exceeding the annual deductible limit." However, for example, if you input a plan with a \$2,000 deductible with a 75% coinsurance and \$5,000 out-of-pocket maximum, subjecting all of the benefits to the deductible and the coinsurance, the AV will be within the silver range.

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Q25: How do maximum out-of-pocket limitations apply to large group plans providing coverage for both in and out-of-network services?

A25: Out-of-pocket amounts for covered services received from providers outside of the plan's network are not required to count towards the out-of-pocket limitations. As stated in 45 CFR 156.130(c), "[i]n the case of a plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not count towards the annual limitation on cost-sharing (as defined in paragraph (a) of this section)."

This would apply regardless of whether the plan expresses its out-of-pocket maximum separately for in- and out-of-network services, or as a unified amount for any services received. Only out-of-pocket amounts for covered services received from in-network providers would count towards the amount which is subject to the statutory/regulatory limitation. However, the plan would need to be able to track in-network cost sharing amounts in order to ensure that it is complying with the limitation.

Q26: If the benchmark plan includes waiting periods, can these be included in QHP offerings?

A26: If the benchmark plan has waiting periods (not to exceed 90 days) then the EHB plan can also have waiting periods, but keep in mind the EHB plan limits must be substantially equal to the benchmark plan limits.

Q27: The Missouri individual market "PlansBenefits.xlsm" template does not include "Applied Behavior Analysis Based Therapies," which is an EHB-benchmark plan benefit that the HIOS application collection system requires in order to validate a submission. What should issuers in Missouri do to ensure that they can submit their PlansBenefit.xlsm template in HIOS?

A27: To ensure that Missouri issuers can submit their applications in HIOS, prior to clicking "Create Cost Sharing Variances" on the Plans & Benefits ribbon, issuers should add the benefit "Applied Behavior Analysis Based Therapies" to the Benefits Package 1 tab of the PlansBenefits.xlsm template. This should be done by clicking "Add Benefit" on the Plans & Benefits ribbon, and completing all associated fields with the same information that populates for the Missouri SHOP (Small Group). As a reference, those data elements should be as follows: "Benefits = Applied Behavior Analysis Based Therapies," "Is this Benefit Covered = Covered," "Subject to Deductible (Tier 1) = Yes," "Subject to Deductible (Tier 2) = Yes," "Excluded from In Network MOOP = No," "Excluded from Out of Network MOOP = No." If an issuer has already clicked "Create Cost Sharing Variances," they should delete the Cost Sharing Variances 1 tab and then "Create Cost Sharing Variances" on the Plans & Benefits ribbon.



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Rating

Q28: When will the rate review template be published?

A28: The Unified Rate Review (URR) template was published in the Federal Register on February 27, 2013 at 78 FR 13406. The HIOS enabled version is available within the Unified Rate Review Module of the Plan Management and Market Wide Functions section of HIOS, along with downloadable URR Template Instructions and the Actuarial Memorandum Instructions.

Q29: Do non-Exchange plans have to be submitted for rate review at the same time as QHPs?

A29: Yes, any time that the URR template is completed, all plans in the risk pool, even those not being submitted for QHP have to be included. Since the Index Rate can be set only once per year for the whole risk pool, that also means that all plans in the risk pool have to have their rates approved at the same time, both on and off the Exchange.

Q30: Does the URR template have to be submitted in HIOS for a partnership State?

A30: Yes, any time that the URR template is submitted to a State, it must also be submitted to CMS via HIOS. Alternatively, any time the URR template is submitted to CMS in HIOS, it must be submitted to the State. This includes modifications or changes required by either government entity.

Q31: Will a “user guide” be provided for the URR Template?

A31: Yes, one is currently available in the URR Module of HIOS.

Q32: Because network design and structure is an allowable modifier to the Index Rate, can an issuer sell two plans with identical benefit and cost-sharing designs where the only difference is the network type?

A32: Yes, if there is a meaningful difference in the networks of the two plans, they can be identical in other ways and still be considered two different QHPs. Please see the 2014 Letter to Issuers for further information on meaningful difference in Chapter 1, Section 4.

Q33: If a State with a State Partnership Exchange has a different submission deadline, when is the URR template required to be submitted to HIOS?

A33: The submission to CMS in HIOS should be at the same time as the submission to the state.



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Q34: Does the Part III Actuarial Memorandum have to be submitted every time the Part I, Unified Rate Review Template is submitted?

A34: Yes, the Part III Actuarial Memorandum is now required with every initial Part I URR template submission. The Part II Consumer Justification Narrative is only required when at least 1 product in the risk pool is experiencing a rate increase of 10% or more.

Q35: What the difference between the Unified Rate Review system and the Rate Review Justification system?

A35: The Unified Rate Review (URR) Module, within the Plan Management & Market-Wide Functions section of HIOS is the module used to submit all rate filings required after 4/1/2013. The Rate Review Justification (RRJ) Module is the legacy system which was used to submit rate filing justifications prior to 4/1/2013. The RRJ Module continues to be used to provide rate reasonableness determinations and justifications until all submission made prior to 4/1/2013 have received determinations.

Q36: For rate review, how is a “new” product defined?

A36: A “new” product is one which had no previous enrollment, does not represent a previous plan with enrollment which is being modified to comply with State or Federal mandates or as defined by the appropriate state regulator.

Q37: Are all non-grandfathered business renewing in 2014 new, and therefore would it not need to be submitted in HIOS?

A37: The FFE application requirements include submitting the entire risk pool using the URR module and templates, if even one plan in the risk pool is included in the QHP application.

Q38: If an issuer is modifying existing non-ACA compliant plans to be ACA compliant for 2014, how is the rate increase determined?

A38: Rate increases take into account all reasons for the rate change, including State mandated benefits or compliance with EHB standards.

Q39: Will there be instructions released for the URR template and Actuarial Memorandum?

A39: Yes, they are published in the URR Module within HIOS.



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Q40: Are there different rate review templates for new rates versus rate increases?

A40: No, the same template is used for all new and existing plan rates. The instructions provide an explanation of how to handle discontinuing plans rate experience, continuing plans experience and projections, and new plan projections.

Q41: If an issuer wants to include grandfathered experience in its projections, how is this done?

A41: The URR template instructions provide further guidance on this, but grandfathered experience, if included, should be included in the Credibility Manual Adjustment within worksheet 1.

Q42: If we plan to modify all grandfathered health plans such that it will lose grandfathered status, should we include the experience of those grandfathered health plans in the experience period?

A42: Yes, if you are modifying the entire grandfathered health plan such that it will no longer be considered a grandfathered health plan, the experience should be included in the experience period data on the URR template.

Q43: If an issuer changes rates by less than 10% in 2013, does it have to submit them in the new URR template after April 1, 2013?

A43: Yes, all rate changes submitted after April 1st, 2013 must be submitted on the URR template, and when submitted, the entire risk pool must be included.

Q44: Will the entire QHP application be rejected if rates are found to be unreasonable?

A44: If unreasonable rate determinations are made, the Exchanges are required to take that information into account within their determination, but an automatic rejection is not required by rule or law. See Chapter 1, Section 3 of the Issuer Letter for more information on review of rates. If an issuer's rates are declared "unreasonable" the State or HHS will generally provide the issuer a window to make corrections.

Q45: If a State has an Effective Rate Review program and an issuer has no QHPs, does the issuer still have to submit the URR template to CMS?

A45: If an issuer has a rate increase on any plan after April 1, 2013, it is required to submit the increase and the entire risk pool to both their state and CMS pursuant to 45 CFR 154.200.

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Q46: Is the index rate meant to be representative of specific plan richness, e.g., 60% actuarial value (AV)? Similar to AV, is the index rate meant to be the 21 year old rate in an area that has a factor of 1.0 so that all other rating factors can be applied to it?

A46: No. The index rate is an average rate based on the total combined claims experience derived from providing EHB to enrollees in all non-grandfathered health plans in a market. The index rate is utilized to set the base rate for all of an issuer's products in a market. The index rate may be adjusted at the plan level to reflect a plan's actuarial value and cost-sharing design; provider network; benefits in addition to EHB; administrative costs; and with respect to catastrophic plans, the specific eligibility categories of the plan. The premium rate for a given individual may further vary based on the premium rating factors in section 2701 of the PHS Act.

Q47: When deriving an index rate, what normalization factors are permitted?

A47: The market reform final rule, published on February 27, 2013 at 78 FR 13406, does not allow for normalization, since the index rate must use the issuers' EHB claims experience in the market. The only plan-specific adjustments to the market-wide index rate are those described above.

Q48: The final market reform rule says that the index rate cannot be adjusted for induced demand. Is this intended at the plan level, market level, or both? If not allowed at the plan level, would that mean that induced demand could be socialized across all plans based on an assumed distribution?

A48: As stated in the market reform final rule, 78 FR 13406, we exclude an induced demand factor from the plan-specific rate adjustments because of the actuarial difficulty of measuring whether differences in total plan expenditures are due to risk selection or induced demand. However, for the purpose of developing an adjustment to the market-wide index rate for individual plans based on the plan's actuarial value, issuers would use pooled allowable claims data as a basis for calculating the plan-specific actuarial value.

Essential Community Providers (ECP)

Q49: Where can the "ECP Supplemental Response form" be found?

A49: You may download the form at <http://cciio.cms.gov/programs/exchanges/qhp.html> under QHP Application Materials, specifically at http://cciio.cms.gov/programs/Files/ecp_supplemental_response_Form_03_08_13.pdf.



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Q50: For ECPs that are facilities, can issuers list both the facility and the provider in the ECP template?

A50: Please list the location of each facility.

Q51: If an Indian Health Provider refuses to contract with an issuer, can the issuer treat them as a non-participating provider?

A51: 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. The issuer could not balance bill. However, we note 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.

Q52: How should an issuer treat out-of-state Indian Health Providers?

A52: Even if the Indian provider is out-of-state, the Indian health provider's right of recovery afforded under section 206 of the Indian Health Care Improvement Act references in the response to the previous question would apply. We note that issuers may want to consider contracting with Indian health providers in neighboring states, as tribal lands often cross state borders.

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Q53: If an Indian Health Provider is contracted, does an issuer treat that provider as an Indian Health Provider or does that mean they are treated as a network provider (i.e., can the issuer balance bill)? Are referrals from Indian Health Providers to a non-Indian Health Provider for AI/AN individuals who make over 300% FPL included in the 100% cost share or treated as normal contract rates?

A53: If the issuer has a contract with the Indian health provider and the provider furnishes services to an Indian with income in excess of 300% of FPL, the issuer should consider the provider as a network provider. Since the issuer holds a contract with the Indian health provider, the issuer would not be able to balance bill the provider for covered services. Furthermore, the Indian health provider also has the right of recovery afforded under section 206 of the Indian Health Care Improvement Act as described in the previous questions, which would also preclude balance billing for non-covered or out-of-network services, to the extent balance billing practices are permitted under state law.

Q54: On the ECP template, please clarify what "Ancillary" and "Other" refer to.

A54: Only issuers that qualify for the alternate ECP standard outlined in Chapter 1 of the Issuer Letter should list locations of ancillary providers in HPSA or low-income zip codes. Ancillary providers that are those not providing primary care, specialty care, inpatient or outpatient hospital services, or pharmacy. For issuers that do not qualify for the alternate ECP standard, please see the description of the "Other ECP Category" contained in the Issuer Letter.

Q55: In the HRSA 340B database, ECPs may have multiple NPI numbers based on their organizational structure. Will HHS be matching on all NPIs an entity has or a specific NPI that an entity has?

A55: As noted in Chapter 7 of the QHP application instructions, NPI is an optional field in the ECP template for this year. We are not matching on NPI this year, but are gathering data on available NPIs. If multiple NPIs exist for a given ECP, please use the NPI that mostly closely matches the specific location or department for the provider listed in the ECP database, if possible.



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Q56: When would an issuer enter NA in the ECP template?

A56: Please see Chapter 7 of the QHP application instructions. If the alternate ECP standard applies to the issuer, please complete the Provider Type column and mark "NA" in the ECP Category column. If the alternate ECP standard does not apply to the issuer, please complete the ECP Category column and mark "NA" in the Provider Type column.

Q57: Both the ECP and Network templates generate Network IDs. Do those both refer to the same network? Do the network names need to be consistent?

A57: When entering Network IDs, you must assign networks the same numbers as those assigned in the Network ID and Benefit templates. Please see Chapter 7 of the QHP application instructions.

Q58: What if an ECP provider type does not exist in our State in some regions?

A58: As specified in 45 CFR 156.235(a), a QHP issuer must have a sufficient number of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area. If there are no ECPs that belong to a particular ECP category in the service area of the issuer, the issuer should indicate this in the justification. However, if there are ECPs in a particular ECP category in some regions of service area, the issuer would still be expected to offer contracts to those ECPs as part of the safe harbor standard.

Q59: If an issuer contracts with some of the providers that work at an ECP listed on the non-exhaustive ECP database, but not with the ECP itself, can the issuer include the ECP on its ECP template?

A59: No. If the issuer contracts with providers that work for an ECP listed on the non-exhaustive ECP database, but not with the ECP entity itself, the issuer cannot include the ECP on the issuer's ECP template. However, if the issuer does not meet either the 10% or 20% thresholds, the issuer may list or describe its contracts with individual providers that work for the ECP as part of its justification.

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Templates

General / Other Questions

Q60: Can the templates be validated and finalized from a SharePoint site?

A60: Depending on your organization's settings, it may not be possible to use the Plans and Benefits template from a network drive or SharePoint site. The Import IDs and Check AV Calculation macros require you to browse for additional files. In general, you will get best results if you work with the templates on a local drive. You may store the saved versions anywhere.

Benefits Template

Q61: If an issuer has an ER copay of \$150, which covers the facility charge part, but at the same time the member will be billed the physician part subject to deductible and coinsurance, how should the template be filled out?

A61: The template cannot accommodate the described situation where the facility charge is not subject to deductible/coinsurance but the physician/professional charges are. The issuer should fill out this benefit identical to how it would complete the stand-alone AV Calculator. We recommend that the issuer use whichever charge typically is predominant for consumers. For example, if the facility charge typically makes up the majority of the total allowed costs, then input the facility portion of the benefit into the data fields and enter the physician portion into the free text explanations field.

Q62: Do the silver cost reduction variations need to be submitted with separate standard component IDs?

A62: No. The template on the Cost Share Variances tab will automatically add suffixes to the standard ID for the appropriate cost sharing reduction variations.

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Q63: In the Cost Share Variances tab, are issuers expected to run the SBC calculator and input numbers into the columns L-S?

A63: As noted in Chapter 10 of the instructions, this template section contains fields for basic information about two SBC scenarios. While these data fields are optional, issuers are advised that the FFE may be using certain data elements from the SBC in Plan Compare. If this issuer does not provide this information, then Plan Compare will show “not available.”

Q64: Is there documentation on the macros in the plan_management_data_templates_plans_benefits workbook or add-in? Where can issuers find the source code?

A64: There are several documents available on zONE to give you more detailed technical information about the templates, including:

- Data Traceability Matrix (DTM)
- Data Dictionary
- Populating FFE Spreadsheets By Developers

Q65: How should plans represent a sanction for out-of-network claims?

A65: In the case of a monetary penalty that cannot be defined using the copay and coinsurance fields, the issuer may use the Explanations fields (at the benefits level) or the Plan-Level Exclusions field to describe the extra cost sharing associated with out of network sanctions.

Q66: What should issuers enter in the out-of-pocket maximum fields if there are no separate drug and EHB benefits?

A66: If the plan does not have separate medical and drug deductibles or maximum out-of-pockets (MOOPs), you should use the “Medical & Drug Deductibles Integrated?” or “Medical & Drug Maximum Out of Pocket Integrated?” fields on the Cost Share Variances tab of the Plans & Benefits template to indicate that the deductibles or MOOPs are integrated and not separate. Answering “Yes” to these fields will grey out the separate deductible or MOOP fields, so that you only need to enter deductibles or MOOPs in the “Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)” or “Combined Medical and Drug EHB Deductible” fields, respectively. If you have integrated deductibles or MOOPs, only one individual deductible or MOOP and one family deductible or MOOP will be displayed to consumers on the Plan Compare website.

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Q67: For an HMO copay driven plan that does not have out-of-network benefits or coinsurance applied, what should be entered in the template?

A67: For a benefit category where there is a copay, but no coinsurance applies, enter “No Charge” in the coinsurance field.

For a benefit category that does not have out-of-network benefits, enter \$0 in the out of network copay field and 100 percent in the out-of-network coinsurance field.

Q68: How should we complete Column Q “Limited Cost Sharing Plan Variation - Est Advanced Payment?”

A68: Please refer to Chapter 10: Instructions for the Plans & Benefits Application Section regarding how to complete the Plan & Benefits Template. The “Limited Cost Sharing Plan Variation— Estimated Advance Payment” is an optional field. Leaving column Q, “Limited Cost Sharing Plan Variation - Est Advanced Payment” blank indicates that the issuer does not request advance payments for the value of cost-sharing reductions provided under the limited cost sharing plan variation for the QHP associated with the benefit template.

As indicated in the HHS Notice of Benefit and Payment Parameters for 2014 (available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>), QHP issuers may, but are not required to, estimate the value of cost-sharing reductions that they will provide through their limited cost sharing plan variation if they wish to receive advance payments from HHS. Issuers that choose not to submit such estimates by leaving column Q blank must still provide the cost-sharing reductions to enrollees in the limited cost sharing plan variation, and will be reimbursed by HHS at the close of the benefit year. More information on issuer options with respect to such estimates is included on page 15495 at the link above.

Q69: Are issuers required to list medical necessity as a requirement for all benefits?

A69: It is not required for the issuers submit medical necessity with each covered benefit.

Q70: How should an issuer indicate that it covers a benefit in limited circumstances?

A70: If an issuer covers a benefit in limited circumstances, it should indicate that the benefit is covered and use the Exclusions and/or Explanations field to describe the circumstances in which the benefit is covered. Please do not enter any information into the Exclusions and Explanations field if a benefit is not covered.

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Q71: What should issuers fill in if none of the EHB Variance options are appropriate for the scenario?

A71: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, a comprehensive list of EHB variance reasons is identified. If you believe that none of the reasons are appropriate, please select "Other Law/Regulation" and provide an explanation.

Q72: If an issuer enters a 100% coinsurance plan with a deductible and OOP of \$3,000 and then change the OOP to \$4,000, why does the AV change, even though there is no coinsurance applying to the additional OOP?

A72: When the user changes the MOOP, the AV should change because the plan is changing its cost-sharing parameters, which is what the AV is measuring. Also, please note that the AV Calculator User Guide clarifies that the plan should not specify a 100% General Coinsurance Rate unless specifying a copay based plan. Therefore, when inputting 100% General Coinsurance, the calculator is anticipating cost-sharing on the copay side.

Q73: Could HHS clarify the purpose of the POS label on the tier 2 portion of the AV Calculator, given that the Calculator is not meant to be used for plans that include out-of-network?

A73: Per the AV Calculator Methodology document (<http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf>), the AV Calculator produces estimates of actuarial value based only on in-network services and allows the user to specify only in-network cost-sharing parameters. This is consistent with 45 CFR 156.135(b)(4).

The final version of the AV Calculator can accommodate plans utilizing a multi-tiered in-network plan design with up to two tiers of in-network services. Users may input separate cost-sharing parameters—such as deductibles, coinsurance rates, MOOPs, and schedules for service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting actuarial value is a blend of the AV for the two tiers.

Q74: How should the impact of excluded or limited-coverage EHBs (e.g., a closed formulary pharmacy design meeting benchmark minimums) be addressed in the calculation of actuarial value?

A74: For the purpose of calculating actuarial value, the user only needs to specify the plan's cost-sharing for the four tiers of prescription drugs: generics, preferred brand drugs, non-preferred brand drugs, and specialty drugs.



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Q75: If an issuer has a higher co-pay on a benefit not specified on the AV Calculator, is the plan compatible with the AV Calculator?

A75: In the 2014 Letter to Issuers released on April 5, we provide two examples of plans that are not compatible with the AV Calculator. See the discussion in Appendix C, starting on page 56. We also state that a plan design that includes different cost sharing for services not included in the AV Calculator would be considered compatible with the AV Calculator.

Q76: If a company has eight plans available in six service areas, how should they be listed in one template to avoid errors?

A76: In the Plans and Benefits template, a plan ID is associated with one Service Area ID, Network ID, and Formulary ID. Each Service Area ID, Network ID, or Formulary ID may be associated with multiple plans in the Plans and Benefits template. In the Service Area template, a county may be included in multiple Service Areas. The applicant needs to create a Service Area ID for each unique combination of counties (or partial counties) that is covered by a single plan. If more than one plan covers the same Service area, then both plans can use the same Service Area ID.

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Q77: Should issuers include the 94%, 87% and 73% Silver Tier plans and benefits to the templates? How do issuers identify that these are the various levels of a Silver Plan? Is that the Unique Plan Design Column?

A77: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, complete the Plan Identifiers section for each standard plan you want to create for a 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.

After the benefit-related information is completed, click the “Create Cost Share Variances” button on the menu bar under the Plans and Benefits ribbon. The Cost Share Variances tab is designed to collect more detailed cost sharing benefit design information for all plans and cost-sharing reduction plan variations submitted by the issuer. A new worksheet, “Cost Share Variances,” will be created for each Benefits Package worksheet.

Indicate whether the plan design is unique, meaning it cannot use the standard AV Calculator. For example, the following type of plan designs could be considered “unique” for purposes of determining AV:

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% coinsurance up to a \$6,400 out-of-pocket maximum (MOOP). This plan design would be considered “unique” because the current AV Calculator can only accommodate a single coinsurance rate for each benefit.

Q78: How do you add a row for more product IDs?

A78: If you run out of empty rows for new plans, click the “Add Plan” button on the menu bar under the Plans and Benefits ribbon and a new row will appear for an additional plan. Each benefits package can have up to 50 plans. If you have more than 50 plans associated with the same benefit package, you will have to create a new benefit package with the identical plan structure.



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Q79: If an issuer wants to file a Platinum Plan to sell off-Exchange, but doesn't want it on the Exchange, should an issuer still add the plan to the template?

A79: Do not submit information to the FFE for plans that you do not want made available on the Exchange.

Q80: Do issuers need to list all of their specialists in the "Specialists Requiring a Referral" text box?

A80: On the Plan & Benefits Template, users must enter all of the specialist types in the 'Specialists Requiring a Referral' tab.

Q81: Does the "Plan Level Exclusions" tab refer to the entire list of exclusions for each plan?

A81: On the Plan & Benefits Template, in terms of the "Plan Level Exclusions" users may list all exclusions of the insurance plan at the plan level; this applies to all benefits. Users may also refer to Chapter 10: Instructions for the Plans & Benefits Application Section for additional information.

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HIOS

Q82: How are identifiers from HIOS used (component IDs, plan IDs, etc.) and for which templates?

A82: HIOS Product IDs reference a form filing level, and allow us to link benefit packages back to State regulatory oversight.

Standard Component IDs identify the specific package of benefits and cost sharing for which a rate can be assigned, and a specific premium can be quoted based on rating rules. Standard Component IDs contain the Issuer and Product IDs with which they are associated.

When submitting Benefit Templates, Unified Rate Review Templates, and Rate Table templates, you will need to use Standard Component IDs which allow us to link different information together at the level a consumer will see it.

The Business Rules Template (for policy construction and rating rules) can accept either the higher level product IDs, or the lower level Standard Component IDs, depending on the level a company uses to define its rules.

HIOS Issuer IDs (which identifies a company operating in a State) are required for all templates, and indicate the high level organization of who is submitting these prospective QHPs for certification.



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Q83: If a State is requiring SERFF to submit the QHP application, do issuers still need to work on HIOS in any way? If yes, how? What specifically has to be done on HIOS?

A83: There are several instances when a user submitting a QHP Application to a SERFF State will need to utilize HIOS. First, anyone using the CMS/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). There have been trainings, and instructional materials are available both at <http://cciio.cms.gov/resources/files/hios-portal-overview-training02252013.pdf> as well as the RegTap site. 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 to sign agreements with CMS (currently estimated September 5-9).

Also, existing filing and submission requirements for other CMS programs still apply, such as the requirements related to providing rate increase submissions under 45 CFR 154.215. If an issuer plans to offer products outside of the Federally Facilitated Marketplace, please follow the rate review filing requirements under 45 CFR 154.220 and contact the 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.



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Q84: How do issuers sign up for zONE?

A84: The website is <https://zone.cms.gov>. An issuer will need a CALT User ID and Password to access the site. Once on the site go to the "Issuer Community" and simply click on the "Request Membership" to be made a member which will allow Issuers to access information and documents.

Q85: Do issuers need to register one user per carrier or multiply users per carrier to use the new ZONE forum?

A85: Each individual Issuer (user) should have its own User ID and Password.

Q86: When will the fixed QHP templates be released to SERFF?

A86: Templates were released to SERFF and posted to CMS zONE starting on March 18, 2013. Updated templates are posted to CMS zONE and released to SERFF as they become available.

Q87: What zONE trainings are appropriate for QHPs?

A87: The current training offered on CMS zONE is listed under "Events" and includes "CMS zONE 101" (a webinar on basic features and how-to on CMS zONE.) Previous training (April 1st and April 3rd) included "Catch-up Direct Enrollment Technical Specification Review" and "Weekly Direct Enrollment Technical Review" sessions.