

QHP Webinar Series Frequently Asked Questions

Selected Responses

April 18, 2013



Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 6

Release Date: April 23, 2013

Accreditation

Q1: I am in the process of accreditation, and I have CAHPS data. Can I submit the CAHPS data?

A1: As stated in the “Letter to Issuers on Federally-facilitated and State Partnership Exchanges,” available on the CCIIO website at: http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf, for the 2014 coverage year, an Exchange website will only display selected CAHPS survey results from an issuer’s accredited product lines when these existing data are available for the same QHP product types and adult/child populations. If applicable CAHPS data are not available through existing accreditation, the Exchange website will display a neutral statement such as “No data available.” Please see Chapter 1, Section 2 of the Issuer Letter for more details.

Administrative Template

Q2: On the administrative template, is the term Third Party Administrators (TPA) indicative of vendors or any companies outside of our organization performing a service specific to the three functional areas referenced?

A2: We use the term “TPA” to apply to any vendors that provide services in the functional areas listed. This information will provide a list of partners for potential interactions such as secure routing of data. Later this year, we will ask TPAs to register in HIOS so that issuers can link to their TPAs for different markets when applicable.

Q3: We encountered an invalid issuer legal name system error when uploading the file in the administrative template. How do we upload the file?

A3: The Issuer legal name must match exactly the name associated with your Issuer ID in HIOS.



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Attestations

Q4: In the attestations section, what does it mean that we will “accept” the total premium breakdown from the Exchange?

A4: The FFE will use the rate tables submitted by QHP issuers during QHP certification to determine the total premium amount (and associated premium breakdown) for the enrollment group. This breakdown is captured in the 2750 loop of the 834 transaction. If QHP issuers do not believe that the Exchange arrived at the correct total premium amount (and associated premium breakdown) for the enrollment group, there will be a process established to resolve any discrepancies.

Benefits and Service Area

Q5: If we are participating in the risk corridor program for both on and off Exchange products, do we report our off Exchange products on the benefit template? The Plans and Benefits template does not appear to allow the application of a copay for a select number of visits before a Deductible + Coinsurance applies.

A5: The benefits template for the QHP application process are to be used for the Exchange-offered products and plans. For Exchange products that are offered off the Exchange, we will collect data needed for the risk corridor program at a later date. It should not be submitted as part of the QHP application process.



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Q6: Are there character limits on the open data fields in the templates? Is there a way to submit additional information in a supporting document?

A6: Here are the fields from the Plan and Benefits template that have size limits:

- 1) Plan Marketing Name – 255 characters
- 2) Plan Level Exclusions – 2000 characters
- 3) Out of Country Coverage Description – 2000 characters
- 4) Out of Service Area Coverage Description – 2000 characters
- 5) Exclusions – 2000 characters
- 6) Explanation – 2000 characters

Yes, the benefits module has a “supporting documents” upload feature that supports the submission of additional information for a QHP application. Some of these supporting documents may include justifications explaining in more detail how a given QHP benefit design meets application requirements (e.g., actuarial certification for actuarial value). Please see our Chapter 10 and 13 instructions for more information on supporting documents and justifications.

We also want to highlight that plans may submit a URL for their plan brochures as well as their Summary of Benefits & Coverage via the Plans and Benefits template. These links will be provided to consumers so that they can obtain more detailed information on a given QHP if they would like it during the shopping process.



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Q7: How would the employer premium be divided among employees if an employer chooses to use “composite rate/average rate” method, but one simple one for the “member rate” which determines the employee contribution based on the employee and his or her dependents’ age and tobacco use. Can an employer inadvertently violate the ADEA for using this method?

A7: There is a potential for ADEA violations if an employer contributes the same dollar amount to each employee and employees must pay a premium that varies by age. To overcome this problem, the FF-SHOP standard contribution method, as finalized at 45 CFR 155.705(b)(11)(ii), establishes a method by which the employer can contribute in a standardized, non-discriminatory way. The requirement to use this method to determine employer contributions only exists on FF-SHOPs.

We do not believe that either the proposed rule or the final rule involves the QHP issuer in employer decisions about the employer contribution toward the premium. The FF-SHOP standard contribution method, as proposed and finalized, does establish a method by which the employer can contribute in a standardized, non-discriminatory way. The QHP issuer is not involved in the FF-SHOP [contribution] policy nor is the issuer involved in employer decisions about the allocation of premium between employer and employee.

Q8: Do we need to supply the product name in the templates to display on healthcare.gov?

A8: For the Federally Facilitated Marketplace, the product name will not display to consumers, only the Plan Marketing Name.



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Marketing

Q9: Will HHS review QHP marketing materials?

A9: We do not plan to review marketing materials, as noted in Chapter 3 of the Letter to Issuers on Federally-facilitated and State Partnership Exchanges, released on the CCIIO website on April 5 at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf. In the Letter, we stated, “Because states generally already regulate health plan marketing materials and other documents under state law, CMS does not intend to review QHP marketing materials for compliance with state standards as described at 45 C.F.R. § 156.225. However, to assist consumers in identifying plans that have been certified by an Exchange, we recommend that all marketing materials distributed to enrollees and to potential enrollees, contain the following disclaimer: ‘[Insert plan’s legal or marketing name] is a Qualified Health Plan issuer in the [Health Insurance Marketplace].’ A logo for the Health Insurance Marketplace will also be made available for use on marketing materials. Marketing materials should include communications to consumers and enrollees, such as advertising materials, consumer notices, and brochures. We note that consumer-facing materials will refer to the Exchange as the ‘Health Insurance Marketplace.’” We also noted that, in addition to complying with state marketing standards that apply to all issuers, QHP issuers must ensure that all marketing products and materials meet the meaningful access standards. Finally, issuers will need to attest as part of the QHP application process that they will market QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.

Q10: Regarding the requirement that all marketing products and materials meet “meaningful access” standards, will HHS provide guidance on these standards?

A10: In the final Letter to Issuers, we provided more information on meaningful access standards in the FFE in Chapter 5, Section 6. As noted in the Letter, we intend to provide further information on this in the future.

Pharmacy/Prescription Drug

Q11: Chapter 12 of the Instructions says that “if you have no cost sharing for the tier, select COPAYMENT as the cost-sharing type, and set the copayment equal to \$0.” We have a two tier benefit where that is setup as follows: Generics are covered at 100% and brands require a



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20% coinsurance. In this case, can we submit COINSURANCE 0%, rather than selecting COPAYMENT as directed in the guidance? The new template does validate either way.

A11: Issuers can submit a 0% coinsurance instead of a \$0 copayment.

Q12: What is the preferred way to represent prescription drug cost sharing in an HDHP plan, understanding that once a member satisfies an integrated (med/Rx) deductible, the plan covers 100%? Does the entry in the “Tier Cost Sharing” columns for these HDHP plans assume that the deductible is met so member co-insurance should be input at 0%?

A12: Yes, it is assumed that coinsurance applies after the deductible is met.

Q13: What is the preferred way to represent an HDHP formulary on the QHP prescription drug template understanding that drugs are not in tiers?

A13: This should be represented as a formulary with one tier. All drugs in the formulary should be in tier 1.



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Q14: Under the Drug EHB deductible section there are two fields labeled "Default Coinsurance." Is the default coinsurance field looking for the overall plan coinsurance or a drug coinsurance? If drug coinsurance, our plans have varying Rx coinsurance based on the type of drug (i.e., generic drugs may have one coinsurance whereas brand or specialty drugs may have different coinsurance).

A14: As noted in Chapter 10 of the instructions (https://www.REGTAP.info/reg_library.php), the Default Coinsurance under the Drug EHB Deductible section is only applicable if deductibles are not integrated, and the numerical value for the in-network drug coinsurance should be entered. Specifically, to input a separate drug EHB deductible and coinsurance rate, the user needs to input "No" under the column "Medical & Drug Deductibles Integrated?"

As for entering separate coinsurance rates for individual drug tiers, the user can input the different coinsurance rates in the columns of the particular tier level in the Cost Share Variance Template. All of these data elements are used in the calculation of AV and for information on how their inputs are mapped to the AV calculator, please refer to the Chapter 11 instructions (https://www.REGTAP.info/reg_library.php).

Q15: How do you submit \$0 drugs on the pharmacy template? For example, a generic oral contraceptive that is covered at \$0 would be submitted with all other generics (tier 1) – how do you designate these differences (\$0 out of pocket vs. true cost share)?

A15: Issuers can describe any cost sharing features that do not directly fit into the Prescription Drug Template in the Explanations field of the Plans & Benefits Template. Issuers should complete cost sharing fields for the most typical/most utilized circumstance. Preventive services under the ACA must be covered without the consumer having to pay a copayment or co-insurance or meet the deductible.



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Q16: Some of our plans have 4-tier drug copays. At the end of the template in the cost share variances sheet there are columns for "Off Label Prescription Drugs" and "Prescription Drugs Other." Our practice is that we do not consider whether a drug is "off label" or not - it always gets the copay of the tier it happens to land in. Since there are four different copays depending on the tier and we can only enter one, what do we enter here?

A16: Regarding filling in cost sharing, these two fields are not associated with the AV Calculator (only Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs are associated). For cost sharing, you can use the one of the drug tiers and use the Explanations to indicate that the cost sharing depends on the tier.

Note: this information will not be displayed on Plan Compare, so consumers will not see the cost sharing that you enter.

QHP Certification/Review Process

Q17: Will issuers be required to file a separate network name for products that have embedded dental?

A17: Issuers are not required to file a separate network for products that have embedded dental. The Network ID for a network with dental providers can be used for both QHPs with embedded dental and QHPs without embedded dental. However, if the issuer would like to offer a QHP with a network including dental providers, and a second QHP with a network that excludes those providers, then the issuer will need to set up two different network IDs.

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Q18: The Q&As released on April 8, “Plan Management Webinar Frequently Asked Questions, Frequently Asked Questions (FAQs) # 1” include information (Q4) about flexibility for changing URLs during plan preview. How will issuers submit corrections to inaccurate data? What confirmation is required that a change will be allowed?

A18: Changes to network URLs or plan marketing name are not criteria for certification and may therefore be changed. During the resubmission window, the issuer is free to resubmit the Network ID template with changes to the network URLs, or the plan and benefits template with changes to the marketing name. During plan preview, issuers will need to have data changes approved by calling the help desk and indicating the change. The issuer will receive confirmation that the change will be allowed from the help desk. Changes that do not trigger re-review, including network URL and plan marketing name changes, will always be allowed, but still must be verified with the help desk.

Q19: We are looking at submitting multiple networks for QHP certification. If we later decide we would like to only use one of the networks, can we pull the other network and the products associated with that network? What is the latest date we can decide to not use a network?

A19: There is no requirement to use all networks that an issuer submits. Issuers will have the opportunity to withdraw QHPs before agreement signing in late September. If an issuer withdraws all QHPs associated with a given network, there is no need to remove the unused network from the QHP Application.

Q20: For the 4/30 FFE submission in HIOS, we know the opportunity to respond to deficiencies will occur the week of 6/17. What exactly can plans change during this time? We know we can respond to deficient items, upload accreditation data, and submit additional justifications. What else can be changed?

A20: In addition to responding to deficiencies, updating accreditation data, and submitting justifications, issuers may also change data that are not related to the certification standards (e.g., plan marketing names, network URLs, contact information). Issuers may also resubmit in response to state feedback at any time allowed by the state (including outside of the official FFE resubmission window), provided that those changes are made only to fields directly impacted by the State review.



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Q21: Our URLs will not validate if they have a dash. How should we submit this data?

A21: The next versions of the templates will allow hyphens in the URL name. Issuers may submit templates now with placeholder URLs and will be able to change URLs through the Resubmission or Plan Preview processes.

Rate Review and Rating Data

Q22: For the individual market, will the area rating be applied at the subscriber level?

A22: The rating will be based on the subscriber address.