

## QHP Frequently Asked Questions

Selected Responses

April 2, 2013



# Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

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## Frequently Asked Questions (FAQs) # 4

Released Date: April 16<sup>th</sup>, 2013

### FAQs: Template and User Interface Functionality

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**Q1: Can issuers copy and paste data into the templates?**

A1: All the templates allow for the copying and pasting of data. See “Copying and Pasting in Plan Management Templates” at <https://zone.cms.gov/document/copying-and-pasting-plan-management-templates>.

**Q2: Why is the file not automatically defaulting to be saved in .xml format?**

A2: Depending on your Microsoft Office settings, when you click “Finalize” and are prompted to enter a document name, Excel will automatically populate the field with the current file format, which is “.xls” or “.xlsm.” Simply delete this and enter your desired file name. You do not have to add “.xml” at the end, just the file name.

**Q3: How do the Service Area ID, Network ID, and Formulary ID relate to the Plans and Benefits Template?**

A3: The Plans and Benefits Template includes macros that allow users to import their IDs from other templates into the Plans and Benefits Template. Macros create the IDs required for all medical plans, with the exception of the Stand-alone dental plans, which do not require a Formulary ID. For each plan, there can only be a single instance of the ID. The Service Area ID must include the entire service area for the plan. The Network ID must include the link that consumers will use to get information about the all the covered providers under the plan. The Formulary ID must include the link that consumers will use to get information about the formulary.

**Q4: Why do issuers see errors displayed when clicking “validate”?**

A4: The message box with the validation errors allows issuers to see what needs to be corrected. The template can be validated multiple times, and clicking the “Finalize” button will perform those validations again. If there are any errors that were not corrected, the error messages will display again.

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**Q5: Do the templates have to be submitted in a special order?**

A5: The templates can be submitted in any order, as long as they are submitted by the deadline. There is no dependency that one be entered before another. However, in the Plans and Benefits Template, it is easier to have the IDs for the Network, Formulary, and Service Area prior to completing the template.

**Q6: Do issuers need to complete every segment of a module before the validator can check the submission?**

A6: As sections are completed, the validator can check each section. When the Admin Data Template is completed, the submitter clicks "submit" and the validator can validate the template. Call the Helpdesk if there are any issues.

**Q7: Why is there an error message on the Product ID field?**

A7: The Product ID is a 10 digit, alphanumeric, unique identifier. The Product ID consists of an Issuer ID, the State, and the 3-digit unique Product ID. In the Rating Business Rules Template, the Product ID is only given if the Issuer business rule does not apply to a given product. In the first row of the Ratings Business Rules Template, issuers should not enter a Product ID or a Plan ID as the first row is the default issuer-level rule. For each row after, issuers should not enter a Product ID and Plan ID on the same row; only one ID -- the Product ID or the Plan ID -- should be entered. The template does not validate the Product ID itself, it validates the format of the ID. If there is an error message on the Product ID field, it is related to the format of the Product ID.

**Q8: Why do issuers get an error message for a required field that does not have an asterisk?**

A8: The asterisk-labeled fields are always required. If there is ever an exception, there is no asterisk. There are data elements that may be required, depending on the situation and business rules, so there will be an error message that the field was required even though the field did not have an asterisk in the template.

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**Q9: Why do issuers sometimes receive error messages, debugging messages, and have difficulty saving the template?**

A9: All of the templates allow you to “Save As” and create multiple different copies. If you encounter problems, please contact the helpdesk with details on your problem. With the Plans and Benefits Template, these issues usually relate to the Add-in File. For best results:

- Delete all previous versions of the Add-In File from your computer.
- Save the latest version of the Add-in File in same the folder as the template.
- Select the command “Save” button when downloading from a web browser.
- Do not open the Add-in File from the web browser.
- When saving the Add-in file, in the “Save” dialog box, make sure that the name and file extension is “PlansBenefitsAddIn.xlam.” The Add-in will **not** work correctly if the name or file extension are different.

When uploading the data into the system, it is an .xml file that is difficult to read. Once the file is uploaded and validated, the data is displayed once again in the original Excel format in the template. When you open the regenerated template, you may see a message that the file needs to be recovered. This is an issue with the Java library. Click “ok” and then click through all the messages and the file will open normally with all data intact.

**Q10: Have the issues with the User Interface in HIOS been corrected?**

A10: The issues with uploading supporting documents in the User Interface are fixed. The “Next” button is now displayed. Users that have both submitter and validator roles will need to navigate between sections of the Issuer module from the summary page to avoid the white screen issue.

**Q11: When a person entering data completes the data entry, the user would then click the “validate” button, the errors would pop up that need to be fixed, the user would click the “validate” button again, and then lastly the user would finalize. The templates are all being completed separately. When that is all finished, is it at that point that issuers can have internal reviews of the templates, just before things are finally submitted?**

A11: Particularly if issuers are submitting through SERFF, make sure that the templates match each other. The Formulary ID, Service Area ID, and Network ID for each plan should match in the Plans and Benefits Template, Service Area Network, and Prescription Drug Templates. Each plan in the Plans and Benefit Template should have rates. This is the cross-validation that is done at the very end of the process. Make sure that that all matches before the final submission.

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**Q12: Regarding the sequence of review, does it happen at the end, after all templates are submitted, or can it happen after each module is completed? In other words, could management review module by module? Is there a preferred work flow?**

A12: Issuers can review the templates in Excel before submitting them. The system performs the validations after the template submission, but management can review the templates at any point.

**Q13: Once the templates are submitted, is it too late to go back and correct things that may be found during a management review?**

A13: Issuers can resubmit the templates any time in HIOS for the FFE (before April 30). Resubmissions are not restricted in any way; submitting a template does not make it final, nor does it stop an issuer from making changes. To revise a module or section that has been validated, the Validator will have to answer 'No' to the validation question to allow the Submitter to revise the submission. In the Issuer module, if you need to revise your submission after the validator clicks on the 'Submit Application' button on the Review page, you will need to call the help desk to allow this change. Issuers applying into SERFF should consult with the state about their rules.

**Q14: Is the cross validation an automated process, or a manual process that issuers can perform?**

A14: The cross validation can be manually performed from the Issuer module, the Rates and Benefits module, or the Service Area module. The submitter can click the validate button at any time to perform the cross-validations - even if all the templates are not submitted. When the completed templates pass all the cross-validations, Issuers can make the submission to CMS.

### FAQs: Administrative Template

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**Q15: What is the format needed for the Tax ID number?**

A15: The Tax ID field will accept nine (9) characters (no hyphen) or 10 characters (including the hyphen). If users enter 10 *numbers*, it will not pass validation.

**Q16: Why are there issues with leading zeros in the Tax IDs, Health Insurance Oversight System (HIOS) Product IDs (HPIDs) and National Provider Identifiers (NPIs) on the template?**

A16: This issue with the Tax ID is corrected in the current version of the template. HPIDs and NPIs do not begin with zero.

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**Q17: Why does the Administrative (Admin) Template not accept a phone extension beginning with a zero?**

A17: There is a work-around procedure for this issue. Users should copy and paste the phone extension from another source into the cell (it will be accepted and will pass validation); users should not type a phone extension beginning with a zero directly into the template, because Excel will reformat the entry.

**Q18: What kind of information is required for the Admin Template in the “Proposed Exchange Market Coverage” field and the “Current Sales Market” field?**

A18: The “Proposed Exchange Market” field indicates the market where the plan will be offered: “Individual,” “SHOP,” or “Both.” The appropriate primary contact is required based on this value. The “Current Sales Market” field indicates where products are currently being offered. The same options, “Individual,” “SHOP” or “Both” are in the drop-down. If there are no products currently offered in either the Individual or SHOP market, Issuers must select “Both.”

**Q19: Which address should be entered in the *Primary Contact* field in the Administrative Template?**

A19: The Issuer address should be the company address associated with the HIOS ID and entered in HIOS. The company address in HIOS is the relevant address for that issuer in that state. It needs to be entered in the “Primary Contact” field of the Administrative Template. The SHOP address should be the primary place of business in that state, not the employee address.

**Q20: Is the “Primary Contact” information required to be the Chief Executive Officer (CEO) or the Chief Financial Officer (CFO)?**

A20: “The Primary Contact” information does not need to be the CEO or the CFO.

**Q21: What does “Third Party Administrators” (TPA) mean in the Administrative Template?**

A21: TPA is used for any vendor that provides services in the functional area listed. The information will provide a list of partners for potential interaction, such as secure routing of data.



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### FAQs: Essential Community Providers (ECP) Template, Network ID, and Network Adequacy

**Q22: On the Essential Community Provider (ECP) template, how do users enter a provider name that is associated with several different addresses? If the provider name is the same on several rows, the template will not validate.**

A22: Please refer to the QHP Application Instructions that state that if the ECP has several locations, the issuer should add a number to the provider name to distinguish each location; for example, "Provider Name – 001." If the provider has a national provider identifier (NPI) number, only enter it with the first location of the provider and leave blank for all other locations.

**Q23: Should the dental providers and pharmacies be included on the Essential Community Provider (ECP) spreadsheet? How are all the providers combined under single Network ID?**

A23: Each QHP must be associated with a single Network ID. If the network has multiple parts, for example medical and dental, the medical and dental providers are combined under a single network ID. There is no need to submit pharmacies in the ECP network unless applying under the alternate standard. Alternate standard providers use the "Provider Type" column and have the option to check "Pharmacy" if the facility includes a pharmacy (which is purely for informational purposes and not for evaluation). Issuers applying under the regular standard do not fill out "Provider Type"; but only fill out the "ECP Category" column. For those under the regular standard, there is no need to submit pharmacies as part of the ECP network.

**Q24: Should issuers submit the medical and dental together as a network?**

A24: The entire network must be contained under one Network ID. The medical and dental must be combined, but not necessarily on one website. It is also acceptable if the link to the medical network has another separate link to the dental network.

**Q25: Will there be any specific components of network adequacy related to the pharmacy network?**

A25: CMS expects pharmacy will be part of the network and that the attestation to provide sufficient access to providers includes pharmacy access.

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**Q26: If the provider name is the same on multiple lines of the ECP template because there are multiple locations and issuers distinguish them with an additional number, how do issuers correct the error message because of the duplication of the NPI number?**

A26: On the first instance for that provider, list the NPI number. On the subsequent locations, omit the NPI number so it does not trigger an error message in the duplicates check. The NPI is an optional field; omit it for multiple locations.

### FAQs: Plans and Benefits Template

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**Q27: In the Plans and Benefits Template, how will American Indian variations for plans for above 300% of the Federal Poverty Level (FPL), the limited cost share plans, be distinguished in the certification materials?**

A27: Plans are certified at the Standard Component ID level. All cost sharing variants, including the Zero Cost Sharing and Limited Cost Sharing variants, must meet the QHP certification standards to be certified. On the Cost Sharing Variance worksheet of the Plans and Benefits template, the variants are distinguished by adding a code to the Standard Component Plan ID as follows:

- 00 = non-exchange variant
- 01 = exchange variant (not CSR)
- 02 = Zero Cost Sharing Plan Variation
- 03 = Limited Cost Sharing Plan Variation
- 04 = 73% AV Level Silver Plan CSR
- 05 = 87% AV Level Silver Plan CSR
- 06 = 94% AV Level Silver Plan CSR

**Q28: Why does the Plans and Benefits Template have Column Q to indicate plan variation for a limited cost sharing variation or a zero cost sharing variation?**

A28: Column Q on the Benefits Package is the Estimated Advanced Payment per Enrollee for the Limited Cost Sharing Plan, not the Zero Cost Sharing Plan. It is an optional field. The Estimated Advanced Payment amounts for the other Cost Sharing Variants are reported on the Unified Rate Review template.

**Q29: What happens if there are blanks in the prepopulated area of the template?**

A29: Although the fields may be required fields, blanks mean "Not covered." No fields are required for benefits that are not covered.



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### **Q30: What is the difference between “Not Applicable” and “Not Covered”?**

A30: If a benefit is not covered, it should be marked “Not covered” (or left blank) in the benefits package. It will not display on the cost sharing sheet; the template will not indicate copayments or coinsurances for that benefit. “Not Applicable” is only an option for the Maximum Out of Pocket and Deductible fields on the Cost Share Variance sheet.

### **Q31: Copayment and coinsurance are entered for specific benefits throughout the Benefits Template, although it is usually just one and not the other. How do Issuers indicate “No Charge,” and how will that be displayed to the consumer?**

A31: The consumer will see only the cost-sharing attribute that applies. For example, if there is a 20% coinsurance and \$0 copay, only the 20% coinsurance will be displayed.

### **Q32: How do issuers indicate a benefit is not covered out-of-network and is covered in-network only?**

A32: Issuers can indicate a benefit is not covered out-of-network by entering a 100 % coinsurance for the out-of-network cost sharing information for that benefit.

### **Q33: If a plan does not include an out-of-network benefit (except for emergency care), how do issuers complete the “Combined In/Out Network” field of the Plans and Benefits Template?**

A33: The issuer should complete the combined medical and drug in-network for that given benefit. If there is no coverage out-of-network, enter 100% coinsurance. The Deductibles and Maximum Out of Pocket fields have a “Not Applicable” option that can be selected for the Combined In/Out Network fields. The benefits do not have a Combined In/Out of Network field.

### **Q34: Why is there a warning message about exceeding the 2013 IRS Maximum Out-of-Pocket?**

A34: Since the IRS has not yet established limits for 2014, the alert level is set at the 2013 out-of-pocket maximum to alert users that the maximum may be exceeded. There is more detailed information on how to address this in the QHP Application Instructions. The template will be able to validate successfully and be submitted.

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**Q35: How can the template accommodate more complex plan designs, such as custom deductibles or combinations of copays/coinsurances that are specific to the number of visits?**

A35: Please refer to the detailed QHP Application Instructions, Chapters 10 and 11, for instructions on how to enter the coinsurance information/copay amount and how they map to Actuarial Value (AV) Calculator. Issuers can create up to five deductible groups for each benefit package. This option appears when you click on the “Create Cost Share Variance” macro button. Additional information can be provided to consumers using the “Exclusions” or “Explanations” text fields in the benefit package section of the template. Note that the fields in the AV Calculator Additional Benefit Design section of the template such as “Begin Primary Care Deductible and Coinsurance” and “Set Number of Copays” are for the Actuarial Value calculation and most likely will not display to consumers. Further, users can see more details about the plan benefits through the Uniform Resource Locator (URL) to the plan brochure.

**Q36: Do the benefits “generic drugs”, “preferred brand drugs”, “non-preferred brand drugs” and “specialty drugs” on the Benefit Template conflict with information entered to create a Formulary ID on the Pharmacy Template?**

A36: The information that consumers will view is from the Benefits Template. There are detailed instructions on how to map the information from the Prescription Drug Template to the Benefits Template in Chapter 10 of the QHP Application Instructions.

**Q37: The Plans and Benefits module only allows for one cost sharing amount per benefit; depending on the plan design, this could vary depending on the site of service; for example, chemotherapy (physician’s office has a physician office copay; outpatient or inpatient facility has a deductible and coinsurance). How do issuers enter the site of service designation and appropriate cost share?**

A37: If there are provider types like Primary Care and Specialist, use them to differentiate the cost sharing. For others, if there is nothing available for a given benefit, where different cost sharing can apply depending on the site of service, the recommendation is to complete the copay or coinsurance that is typical for most enrollees, and using the explanation field for the appropriate and brief detail for the cost sharing and other scenarios, outside of the most common one entered in the standard data field.

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**Q38: There are some benefits listed that are not clear in the EHB section, such as domestic violence treatment. Is the treatment for physical injury or for counseling services? Is it for emergency room, a doctor's office, or a specialist's office?**

A38: The information on the CCIO website is a snapshot -- a summary of the benefits provided by the benchmark plan. Issuers can go to the NAIC website ([http://www.naic.org/index\\_health\\_reform\\_section.htm](http://www.naic.org/index_health_reform_section.htm)) to locate the actual policy for that benchmark plan to see more detail about coverage, limitations, and exclusions. We would encourage issuers to work with their enforcing state to further understand what enforcement or review for EHB will entail.

**Q39: Clarify whether an issuer can or must allow children to enroll in catastrophic plans. The rules talk about these plans being available to "young adults" and "under 30" but they do not address enrollment of children.**

A39: There is no requirement to offer a child-only catastrophic plan. Section 1302(f) of the Affordable Care Act states that if a QHP is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange as a child-only plan. However, subsection (d) only addresses bronze through platinum coverage, whereas catastrophic level of coverage is in subsection (e).

**Q40: How do issuers work with State-mandated offers of coverage?**

A40: The Federally-facilitated Exchange (FFE), including State Partnership Exchanges, will not collect or display State-mandated offers of coverage. It is the issuer's responsibility to ensure these State-mandated offers of coverage are provided to consumers.

**Q41: If benefits that are must-offer/make-available/optional mandates in a State, are they required in the QHP Plans and Benefit Template submission?**

A41: Must-offer/make-available/optional mandates in a State are treated like an optional rider. Those benefits that are "must-offer" mandates are not required to be included in the template. In situations where an issuer would traditionally offer a rider and is interested in offering that optional benefit on the Federally-facilitated Exchange (FFE), an issuer should submit two plans, one with and one without the rider. Depending on the benefit that would have been traditionally offered in a rider, it may not be displayed on the FFE website to consumers, but it may be displayed by issuers and provided to consumers in plan documents.



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### **Q42: Do issuers have to file separate child-only policies for all of the QHP applications?**

A42: Provided that child enrollees would be treated equally under the QHP as they would be under a child-only plan -- such that there would be no substantive difference between having a child-only plan and issuing child-only policies under the QHP (i.e., same enrollment opportunities, same premium rating, etc.) the issuer would not need to file a separate child-only plan. Separate child-only plans are not required for the Federally-facilitated Exchange (FFE) as long as the QHP indicates it will accept child-only enrollees. In the FF-SHOP, children may only be added to an employee policy if the employee also enrolls. There may be instances when employees under the age of 21 enroll in an employee-only plan. In this instance, this would be considered child-only coverage.

### **FAQs: Prescription Drug Template**

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### **Q43: What about the fields for the data elements not collected (days supplied, quantity limit, cost sharing amounts other than for a one month or three month supply, etc.)?**

A43: The purpose of the template is to collect enough information to determine that the formulary meets the Essential Health Benefit (EHB) and non-discrimination criteria, as well as to evaluate prescription drug coverage for certification. The consumers will only see information about the prescription drug coverage that is submitted in the Benefits Template. Consumers will be directed to the issuer's website (via the URL provided in the Formulary Template) for more detailed information about the prescription drug coverage. Also note that the deductibles and out-of-pocket limits for prescription drug coverage are to be submitted on the Plans and Benefits Template.

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### **Q44: How do issuers indicate the cost sharing and/or deductible subgroups for each tier?**

A44: Each formulary will always take up seven rows. The rows to enter information for each tier will display when users enter the Formulary ID and number of tiers for each formulary in the steps below:

- Step 1:** Select the Issuer ID in the State.
- Step 2:** Create the Formulary IDs (more Formulary IDs can always be added later by clicking the “Create Formulary IDs” macro button).
- Step 3:** Select the first Formulary ID in Cell A-13. This will create rows for the cost sharing in tiers 1-7.
- Step 4:** Select the number of tiers in the formulary. This will lock the tiers not used so that the correct number of tiers to enter the cost sharing information for each tier appears.

Users can click on the next blank row in the template and repeat these steps for each formulary.

### **Q45: On the template, how do issuers populate a separate brand and drug deductible that does not apply to tier 1 drugs?**

A45: Issuers can create deductible subgroups on the Plans and Benefits template as outlined in Q44 and can refer to Chapter 10 of the QHP Application Instructions.

### **Q46: In the earlier versions of the template, the copay and coinsurance fields would not accept zero. Has this been corrected?**

A46: These fields will now accept a zero value for the one month retail cost sharing; it is corrected on the final version of the template.

### **Q47: How does the Formulary Template work?**

A47: The Formulary ID is a combination of the drug list on the second tab and the cost sharing structure. Issuers can use the same drug list for multiple cost sharing structures; each combination of drug list/cost sharing structure should have a unique Formulary ID. Only a single Formulary ID can be associated with a plan.



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**Q48: Where do issuers get access to the drugs listed in each category and class that are making up the state benchmark count?**

A48: As stated in the EHB final rule, published 2/25/13 at 78 FR 12834, the regulatory standard for EHB compliance does not require that issuers cover the same drugs as the EHB benchmark, only the greater of one or the number of drugs in each United States Pharmacopeia (USP) category and class. As such, CMS published the drug count service. Issuers may use publicly available sources to research the benchmark (available at: [http://www.naic.org/index\\_health\\_reform\\_section.htm](http://www.naic.org/index_health_reform_section.htm)). If issuers are having problems meeting the count because the USP Category Class Count Service (Count Service) is not recognizing drugs being submitted, please contact the Helpdesk.

**Q49: How do issuers include drugs that do not have an RxNorm Concept Unique Identifier (RxCUI) associated to them?**

A49: Issuers can offer drugs that are not counted in the drug count service and may include this information in the formulary list available on their website. Additionally, issuers may submit supporting documentation.

### FAQs: Rating Template

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**Q50: How does the copy/paste function work from one version of the Rating Template to the next?**

A50: Users should select and copy all the rows in the previous template, starting below the header and continuing all the way to the end. In the new template, users should paste starting in the first row below the header. Do not click "Paste Values As," just click "Paste," conserving the original formatting.

**Q51: How do the age bands work in the Rating Template?**

A51: The age bands are automated; users do not need to enter ages since they will automatically display. Once any age is selected, the template will populate "0 through 20" and the other age bands required. Users just need to enter the rates.

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### FAQs: Business Rules

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**Q52: On the Business Rules Template, is there a maximum age for a dependent? Is this field related to the dependent price capping or is it related to the dependent eligibility?**

A52: The maximum age for a dependent field is related to dependent eligibility. This is the maximum age a child can reach to be covered under the QHP as a dependent. States may increase the maximum age for a child-dependent through state law. For instance, a state could determine that any child under the age of 30 must be offered coverage on a policy. (It does not affect calculating the family premium or the market rules under 45 CFR 147.102(c)(1), which states that the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.)

### FAQs: AV Calculator

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**Q53: How does the AV Calculator account for the dental and vision benefits and their cost sharing inputs?**

A53: The dental and vision benefits are accounted for in AV Calculator. These specific services do not generally amount to a material difference in the actuarial value calculation. Please refer to the AV Calculator methodology for further information on the calculator's underlying logic, development, and usage. <http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf>.

**Q54: How does the AV Calculator account for Health Savings Accounts (HSAs)?**

A54: The AV Calculator allows for an employer's contribution to an HSA to be taken into account for the AV determination. This is consistent with our regulation at 45 CFR §156.135(c). The EHB final rule is available at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>.

**Q55: Do issuers have to enter health savings account (HSA) contributions when calculating the AV of a plan? What happens if issuers do not know what the contribution is going to be?**

A55: The amount of the employer contribution to the HSA has to be known to the issuer at the time of purchase. If issuers are not able to confirm the health savings account when using the AV Calculator, it cannot be included in the plan. When the issuer does not know the actual value of the HSA contribution, as long as the AV is within the de minimis range, it is acceptable. The AV Calculator is available on the CCIIO website at <http://cciio.cms.gov/resources/files/av-calculator-final.xlsm>.

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### FAQs: Dental

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**Q56: Is an issuer required to have a health plan with the pediatric dental EHB embedded for consumers who have not purchased a stand-alone dental plan?**

A56: The answer depends on whether the health plan is offered inside or outside of the Exchange.

**Inside of the Exchange:** As stated in the

*Issuers of Stand-alone Dental Plans: Intent to Offer in FFE States* document available at:

<http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf>, “The Affordable Care Act also permits a health plan that does not provide the pediatric dental EHB to be certified as a qualified health plan (QHP) eligible for Exchange participation so long as such Exchange offers at least one stand-alone dental plan. In order to allow QHP issuers to exercise the statutory option to omit the pediatric dental essential health benefit (EHB), CCIIO established a voluntary reporting process for dental issuers to communicate their intent to offer pediatric dental EHB through stand-alone dental plans in Exchanges. Given that there are at least three issuers planning to offer such plans in both markets statewide, we believe that HHS can reasonably expect there to be sufficient stand-alone dental coverage to permit QHPs in the FFE in these states to omit the pediatric dental EHB if they choose to do so.” The EHB final rule, published 2/25/13 at 78 FR 12834, further clarifies: “Nothing in this rule requires the purchase of the full set of EHB if the purchase is made through an Exchange. Thus, in an Exchange, someone (with a child or without) can purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan.”

**Outside of the Exchange:** As stated in the EHB final rule available at

<http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>: “The Affordable Care Act does not provide for the exclusion of a pediatric dental EHB outside of the Exchange as it does in section 1302(b)(4)(F) of the Affordable Care Act for QHPs. Therefore, individuals enrolling in health insurance coverage not offered on an Exchange must be offered the full ten EHB categories, including the pediatric dental benefit. However, in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan off the Exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan offered outside an Exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB. We note that the stand-alone dental plan would have to be an Exchange-certified stand-alone dental plan to ensure that it covered the pediatric dental EHB. This alternate method of compliance is at the option of the medical plan issuer, and would only apply



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with respect to individuals for whom the medical plan issuer is reasonably assured have obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan.”

### FAQs: Certification Process

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**Q57: When will the draft QHP Agreement be available for issuers to review?**

A57: The draft QHP Agreement is expected to be released mid-summer.

**Q58: Can an issuer request that a plan be certified and not placed on the Exchange?**

A58: All "certified" plans will be placed on the Exchange. An issuer can withdraw the plan before final certification by contacting the Helpdesk before signing the agreement.

**Q59: When will there be dedicated content support for questions as issuers go through the QHP application process?**

A59: The official Account Manager role is not yet available. The Helpdesk is the best mechanism to direct a question to the right expert. There will be more FAQ calls and open Q&A calls. The QHP Application Support and Q&A series is scheduled on Thursdays during the month of April. The HIOS calls will also respond to QHP questions on Wednesdays. As questions are coming into the Helpdesk, or submitted via REGTAP and the associations, FAQs will be compiled.

**Q60: How will issuers be able to confirm that their data will display correctly?**

A60: Testing will be similar to the Plan Finder post-submission testing and validation; essentially, issuers will have the opportunity to run rate quotes to check that business rules are functioning properly. As noted in the Letter to Issuers on Federally-facilitated and State Partnership Exchanges in Chapter 2 ([http://cciio.cms.gov/resources/regulations/Files/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf)), there will be a resubmission window in June to address deficiencies. There will be a Plan Preview period in late August to run and check the rates. Issuers that identify a problem can contact the Helpdesk. If the issue identified does not trigger re-review of the QHP application, issuers will be allowed to resubmit. Issuers in the FFE will conduct that resubmission through HIOS; issuers in the State Partnership Exchange (SPE) will conduct that resubmission through the System for Electronic Rate and Form Filing (SERFF) and SERFF will transmit that change into HIOS.