

QHP Frequently Asked Questions

Selected Responses

April 11, 2013



Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 5

Release Date: April 18, 2013

Actuarial Value (AV)

Q1: Is any other supporting documentation (e.g., screenshots or other display of how we entered inputs into the AV Calculator) expected to be submitted when we provide the AV of a given plan design, or are we providing only the actual AV figures, along with justification for any modifications?

A1: Additional documentation is not required. For the FFM, the only requirement for general plan designs is inputting the plan designs into the Plans and Benefits Template and using the AV calculator within the template to determine the AV of the plan. Additional information is needed only if 1) for some reason there is a discrepancy (outside the de minimus range) between the AV determined by the template and the AV determined directly by the calculator; or 2) you are submitting a unique plan design utilizing non-AV Calculator data for which you will need to provide supplemental information. For more information on exceptions to using the AV Calculator, see 45 CFR 156.135(b).

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Q2: There have been several instances where the AV calculated by the benefits template does not match for the same benefit from the AV Calculator. In some cases, the difference is quite a bit; in all cases they failed the metal test in the template but not in the calculator.

A2: Chapter 11 of the instructions is posted on the REGTAP portal and on SERFF and provides detailed information on how this process works and how the fields are mapped from the Plans and Benefits Template to run the AV Calculator.

Issuers are encouraged to assess the AV of a given plan design by first using the stand-alone AV Calculator. After completion of the Plans and Benefits Template, the AV obtained from the Template should match the value obtained via the stand-alone AV Calculator.

- If the AVs are not matching, the issuer should first ensure that it correctly filled out the Template per the instructions in Chapter 11.
- If the issuer is still having difficulty matching AVs, you can contact the Help Desk at: CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515. Please submit a screen shot of the AV Calculator and a copy of the Plans and Benefits template with your completed data for that given plan, which will help us identify the problem.
- If at the end of this process the issuer is still unable to obtain an AV from the Plans and Benefits Template that matches what it obtains via the stand-alone AV Calculator, then there is an option mentioned in the Chapter 11 instructions that would allow a plan to submit their plan as a unique plan design, complete the Issuer Actuarial Value data field, and upload a screen shot of the AV Calculator with the obtained value as the supporting documentation. Please see these instructions for more details. Also please note that in this situation, designating your plan as a unique plan design will not require submission of an actuarial certification pursuant to 45 CFR 156.135(b) and will cause the plan to be considered unique for review purposes.
- We also revised the Plan and Benefits Add-In File on April 11 to address discrepancies related to the AV calculation that some issuers were encountering. This updated file is now available for download at the CMSzONE online repository at <https://zone.cms.gov> to those users who are part of the Issuer Community. The same templates have also been made available by the NAIC on their website at http://www.serff.com/plan_management_data_templates.htm. If you encountered a discrepancy before April 11, please try again.

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Q3: What guidance is there on selecting metal tiers for cost share reduction plans in the AV calculator and the Plans and Benefits Template?

A3: Per the AV Calculator Methodology that was published with the essential health benefits final rule, we provided guidance on which metal tier should be chosen to align with the expected utilization for each plan variation.

| Household Income | Silver Plan Variation AV | Desired Metal Tier |
|------------------|--------------------------|--------------------|
| 100-150% of FPL | Plan Variation 94% | Platinum |
| 150-200% of FPL | Plan Variation 87% | Gold |
| 200-250% of FPL | Plan Variation 73% | Silver |

Specifically, when inputting a CSR Plan Design into the AV calculator, the user needs to check the box *“Indicate If Plan Meets CSR Standard”* and select the appropriate metal tier from the list above. For the Plans and Benefits template, the template will automatically send the correct *Desired Metal Tier* to calculate the AV. For additional information, please refer the AV calculator methodology document posted at: <http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf> or the Chapter 10 Instruction on Plans and Benefits Template at: https://www.regtap.info/uploads/library/Chapter_10_Plan_Benefit_Template_Instructions_Version3.pdf

Administrative Template

Q4: The Customer Service TTY field asks for a 10-digit number, but TTY values are usually three digits. We inputted 711 as our TTY number since the FCC established the 711 telecommunications relay service (TRS) in order to make the process easier and more reliable for the hearing impaired. However the field requires a 10digit number. Do you not accept the 711 number? If not, do we need to create a new 10 digit TTY number?

A4: Please use your Customer Service phone number if there is no 10-digit TTY number.

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Q5: We have found when entering information into the administrative template that any ID which begins with a “0” drops the “0” and shorts the number by 1. For example, tax ID number 06-1475928 displays as 61-475928. Because a dash is placed after the first two numbers and the “0” place holder disappears, the template makes it look as though we’ve entered an incorrect number.

A5: All tax IDs now accept leading zeros in the templates. Valid HPIDs and NPIs do not begin with leading zeroes. For any field where this remains an issue, you may copy paste the value from another document into the template.

Attestations

Q6: What is the CMS guideline for significant change to the organizational chart? Who in HHS do we need to inform of the significant change? If there is not a specific person, what group within HHS do we need to inform?

A6: What is considered a significant change varies for each organization depending on its organizational structure, the size of the organization, and the chain of command for reporting operational issues. Changes that could be reasonably foreseen to affect the day-to-day operations of the QHP issuer in an FFE or to compromise the ability of the QHP issuer to maintain compliance with Federal standards should be reported to the FFE. Issuers operating QHPs in the FFE will be assigned a CMS Account Manager as their primary point of contact, and are encouraged to discuss significant organizational changes with that person.

Q7: How should we respond to the Stand Alone Dental Attestation if we are not offering Stand-Alone Dental plans? What happens to the 3 sub-questions in this case?

A7: In the Stand Alone Dental Attestation section, selecting “Yes” indicates that either:

- You are attesting to all the statements in the section, OR
- You do not offer Stand Alone Dental plans.

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Benefits and Service Area

- Q8: For facility out-of-network fees, coinsurance pays 20% out-of-state and 50% in state. When completing the cost-sharing variation, do we choose the most likely scenario, which would be 20% coinsurance out-of-state in this case? Or do we report the higher deductible since it is the worst case, but less likely scenario?**
- A8: We recommend that the issuer fill out the copay and/or coinsurance that would be most typical for most enrollees (e.g., highest utilized). In the "Explanations" field, the issuer should add appropriate and brief detail to communicate other cost sharing in other scenarios outside of the most common one already entered into the worksheet.
- Q9: Are coverage mandates that impose pharmaceutical benefits into medical plans, for example, state mandates that require coverage of oral chemotherapy, considered to be subject to state compensation?**
- A9: Any state-imposed requirement on a medical benefit for which an issuer is required to cover a particular benefit is considered a mandate. If that mandate was enacted after 12/31/2011, then the state would be required to defray the cost. However, per the prescription drug EHB policy described in 45 CFR 156.122, every drug list must cover the greater of: i) one drug in each USP category and class or, ii) the same number of prescription drugs in each category and class as the EHB-benchmark plan. This policy is a minimum requirement and plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB. Therefore, state-mandates related to the coverage of specific drugs do not exceed EHB.
- Q10: Will plans be allowed to update their marketing name prior to plan preview in August? Many companies have not fully identified their marketing name and would like to include a placeholder name in the interim. We are having trouble doing this in the template—when we update the “Plan Marketing Name” on the benefits tab and complete an update for the cost-share variance tab, the plan marketing name of the CSR tab does not change.**
- A10: Issuers will be able to correct this on the Administrative Template during resubmission or Plan Preview periods. In version 1.3 of the add-in file, the *Update Cost Share Variances* macro will now automatically update any changes to the Plan Marketing Name on the Benefits tab to the Cost Share Variances tab.



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- Q11: Excel generates a warning that the maximum out-of-pocket (MOOP) exceeds the IRS out of pocket max for 2013 (\$6,250 and \$12,500 family). We've have been directed that the government amount is \$6400.**
- A11: Since the IRS limits for 2014 have not been established, the 2013 limits were used to alert you that you may have exceeded the maximum. Please check the QHP Application Instructions, Chapter 10, for more detailed instructions.
- Q12: For a small group market QHP issuer using more than one service provider to administer benefits subject to the maximum out-of-pocket (MOOP), the final 2014 Letter to Issuers states that the MOOP limitations will be met if the QHP complies with MOOP for major medical coverage and MOOP on coverage not consisting solely of major medical does not exceed the dollar amounts set forth in the Letter (\$6,400 for self-only and \$12,800 for family). However, the QHP submission template does not appear to accept this separate \$6400 MOOP amount for prescription drug, pediatric dental, or pediatric vision, and results in a validation error.**
- A12: The Plans and Benefits template allows for separate medical and drug out of pocket maximum. Regarding the AV Calculator, it is true that an error will be returned if the sum of the separate medical and drug out of pocket maximum exceeds \$6,500. In that case, we recommend that the issuer submit this plan as a "unique plan design" which will allow the template to pass out of pocket maximum validations and bypass the AV Calculator error message. As unique plan designs incompatible with the AV Calculator, issuers will be required to submit an actuarial certification.
- Q13: The PA Benefit File includes adult vision as a required covered benefit; however, per the EHB final rule adult vision is not EHB, per 45 CFR 156.110. How should we handle this?**
- A13: If a QHP does not cover adult vision, please select "not covered" and note the EHB variance reason as "other law/reg."

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Q14: The Plan and Benefits template does not appear to allow the application of 3 cost shares (Deductible + Coinsurance + Copay) on select services within a plan design.

A14: Select services on the Plan and Benefits template will not allow both a coinsurance and copay. For example, the generic drug data field cannot accept both because the AV Calculator requires one or the other. Per the user guide to the AV Calculator, the prescription drug benefits do not allow for both a copay and coinsurance for the same drug tier. When you input the plan design into either the Template or the AV Calculator, we recommend that you use your best actuarial determination to align your benefits to the four drug tiers. We recommend that you take the highest cost-sharing rate where possible. If you feel that this approach results in a material difference for AV, there is the option for issuers to submit plans as unique plan design.

In addition, the AV Calculator does not include the ability to input copays for outpatient surgery because the data that supports the AV Calculator does not allow for copays for outpatient surgery. Instead, HHS recommends that plans estimate the copay's percentage of total cost for the benefit and input the remaining percentage into the calculator as coinsurance.

Q15: 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.

A15: When completing the cost sharing for the specific benefits, we recommend that the issuer fill out the copay and/or coinsurance that would be most typical for most enrollees within the confines of the data entry permitted by the template. (e.g., highest utilized). In the "Explanations" field, the issuer should add appropriate and brief detail to communicate cost sharing in other scenarios outside of the most common one already entered into the worksheet.

Q16: How do we input cost share methods other than simple copay or coinsurance? (e.g., Greater of/Lesser of; Copayment/Coinsurance; \$1000 a day for days 1-3, then covered at a copay/coinsurance)

A16: When completing the cost sharing for the specific benefits, we recommend the issuer should fill out the copay and/or coinsurance that would be most typical for most enrollees within the confines of the data entry permitted by the template. (e.g., highest utilized). In the "Explanations" field, the issuer should add appropriate and brief detail to communicate other cost sharing in other scenarios outside of the most common one already entered into the worksheet.

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Q17: Will HHS be generating an SBC?

A17: The FFM is not generating SBCs.

Q18: We are trying to enter an HSA-compatible plan at one metal level, but not at any of the other metal levels. When we select “Yes” or “No” for the “Subject to Deductible” question, the response applies to all plans on the template. Is it possible to enter an HSA at one metal level and then PPOs at the other levels, on the same template? Is it possible to only enter one metal level on the template, and not all required metal levels (Silver and Gold)?

A18: All of the data elements in the benefit package section of the template apply to all plans. You can create additional benefit packages within the template with the *Create New Benefits Package* macro. You may copy past the cells from your initial benefit package, and then make the changes that apply to your new package. There is no requirement that all plans associated with a product have the same benefit package.

Q19: There is a problem with the *Component Numbers* column in the Plan Benefit Add-in. The new product numbers that are viewable include some repetition and do not correspond to the product numbers that appear on the HIOS template successfully uploaded.

A19: Standard Component Plan IDs must be entered in the Plans and Benefits template by the issuer. There is no macro or functionality in the Plans and Benefits Add-in file to support this.

If you are seeing this issue in the Excel version of your .xml upload that you got from SERFF or the Benefits and Service Area module in HIOS, please contact the Help Desk. They will need a copy of your Excel template, your .xml upload, and the Excel file that you downloaded after successful validation.

Q20: Should the partial county justification also be used to enter information on partial zip codes?

A20: The service area template only requires that zip codes be entered when a county is not fully covered. If the partial zip code is part of a complete county being covered, no zip code information is required. If a zip code extends from a full county into a partial county, the zip code would only be entered on the partial county list. In this case, a partial county justification is required. If the zip code extends from one partial county to another, the issuer should enter the zip code under both counties. Partial county justifications will be required for both partial counties.

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Q21: When creating a stand-alone dental plan, no functionality appears to change in the EHB section. The EHBs do not apply and most of the benefit information is geared toward the medical products.

A21: The Plans and Benefits template will be updated to simplify the data submission for stand-alone dental by approximately May 15, 2015. A testing version will be made available prior to that. There will be a later submission window to accommodate stand-alone dental applications.

Q22: Do dental plans need to offer child-only plans? How should the field regarding child-only be answered in the plan and benefits template?

A22: As stated in the Exchange final rule released March 27, 2012, stand-alone dental plans need to comply with the requirement to offer child-only coverage. The final rule explains that 45 CFR 155.1065(a)(3) would apply the standard of 45 CFR 156.200(c)(2) to offer a child-only plan to stand-alone dental plans certified to be offered through the Exchange. Please see number 14 and 15 on page 10-8 in the instructions for filling out the child only field in the plan and benefits template, found here:

http://www.serff.com/documents/plan_management_data_instructions_ch10.pdf.

If an Issuer assures that child enrollees would be treated equally under a 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 premium rating), then the issuer does 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.

Also, note that the plan and benefits template for stand-alone dental plans will not be finalized until May, as described in the final Letter to Issuers available at

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

Q23: For all of the specific benefits throughout the Benefits template, you must enter both a copayment and coinsurance, although you usually have one and not the other. The template allows you to enter “no charge” or a dollar amount or percentage. The CMS instructions indicate to enter “no charge” when there is no copayment or coinsurance, but we are concerned about how that translates to the consumer.

A23: In our system, “no charge” and “0” are the same.



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Q24: There is conflicting guidance and instructions for filing as to whether and how to put a copay on the three primary care visits for the catastrophic plans.

A24: The issuer is permitted to impose cost sharing in connection with the three primary care visits as long as permitted by other applicable law (e.g., the preventive services provisions of PHS Act section 2713).

Q25: On the Benefit template, should the coinsurance reflect what the member will pay or what the issuer will pay?

A25: On the Plans and Benefits template, the coinsurance amount should be the amount that the member will pay. The *Check AV Calculator Validation* macro will convert that to the amount that the issuer will pay for the AV Calculator.

Q26: For the *Specialists Requiring Referrals* and *Plan Exclusions* fields within the Plan & Benefit Template, are these fields truly optional and is there a character limitation?

A26: *Specialist Requiring A Referral* is required when the *Is a Referral Required for Specialist?* field is "yes." *Plan Level Exclusions* is required when there are plan level exclusions. There are no automated checks for this. The template will accept values up to the Excel limit. However, the following fields have size limits in the system:

- Plan Marketing Name: 255 characters
- Plan Level Exclusions: 2000 characters
- Out of Country Coverage Description: 2000 characters
- Out of Service Area Coverage Description: 2000 characters
- Exclusions: 2000 characters
- Explanation: 2000 characters



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Q27: Is Limited Cost Sharing Plan Variation - Estimated Advanced Payment truly an optional field?

A27: Leaving column Q, "Limited Cost Sharing Plan Variation – Estimated 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 (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.

Q28: Under the Copay and Coinsurance sections, we actually need options for both “not applicable” and “not covered.” Being able to specify a benefit as not covered is consistent with what we do for SBC, and is more communicative to a consumer.

A28: If a benefit is not covered, the value for *Is This Benefit Covered?* On the benefits package worksheet should be *Not Covered*. Only covered benefits copy to the Cost Share Variance worksheet. If a benefit is covered in-network only, enter 100% for Out Of Network Coinsurance.

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Q29: Can CMS provide additional guidance on service area requirements? Additionally, is it necessary to spell out pharmacy as part of the service area templates if the issuer is using a vendor to supply pharmacy benefits?

A29: According to the final rule “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers” at 45 CFR 155.1055, the service area of a QHP must cover a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. The service area of a QHP must be established without regard to racial, ethnic, language, or health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high-utilizing, high-cost, or medically-underserved populations. The service area of a QHP is the geographic area in which an enrollee could access services and be covered under that particular QHP. To provide service area information in the QHP Application, the applicant must complete the Service Area template. The template requires the applicant to identify the service areas it will utilize for its QHPs. The applicant should input the county information for each service area that is covered by a QHP. Even if the issuer uses a contracted vendor for pharmacy services, the issuer is responsible for ensuring that pharmacy benefits are available in the issuer’s proposed service area.

Business Rules

Q30: With regard to the business rules for age on effective date in SHOP, does this refer to the date of employer group policy issuance/renewal or date of the individual employee’s policy issuance renewal?

A30: Age is determined based on effective date of coverage, not age at time of contract finalization with the employer.

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- Q31: Column G asks for “What are the maximum number of children used to quote a child-only contract?” For SHOP business, we will not offer a child-only SHOP contract. Coverage will be offered only as a part of employee coverage. The field is required and will only allow “1,” “2,” or “3 or more” as an option. How do we enter this for SHOP?**
- A31: The Affordable Care Act requires an issuer offering a QHP at any level of coverage pursuant to section 1302(d) of the ACA, to also offer a child-only plan. If an Issuer assures that child enrollees would be treated equally under a QHP as he or she 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 premium rating), then the Issuer does 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.

Compliance

- Q32: For the organizational chart submission, our assumption is that you are looking for an organizational chart with the CEO and key leaders versus Corporate Entity/Issuer Org Chart. Is that correct?**
- A32: Yes, that is correct.
- Q33: For the QHP compliance plan, do you prefer our current plan with acknowledgement that it will be adjusted for ACA, or do you want the current draft of our plan knowing it is only a draft? When do you expect to have our approved compliance plan?**
- A33: HHS understands that compliance plans are subject to change as an entity evolves, and HHS assumes that an effective compliance strategy encompasses an issuer's full lines of business. We would expect issuers to update their existing compliance plans to reflect new Federal standards that may apply as a result of the issuer's participation in the FFE. If Exchange-specific updates are not presently made, we recommend that an issuer submit the existing compliance plan to assist HHS in offering future guidance.
- For issuers that are currently drafting a compliance plan that would include Exchange-specific information, we suggest submitting the revised compliance plan that is pending approval. This will better help us to see the Exchange-specific information.



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Essential Community Providers (ECPs)

Q34: It is unclear in the QHP Application instructions how to list an Essential Community Provider more than once for multiple locations. What convention should issuers use in the ECP Template?

A34: Three digits should be added at the end of the Provider Name (i.e., Provider Name-003).

Q35: In the ECP template, should issuers include in the ECP providers that are currently not contracted but with which the issuer intends to contract prior to September 2013?

A35: The issuer should only enter ECPs with which it currently has contracts in the ECP template for purposes of meeting the safe harbor standard. In the justification, the issuer should list any additional ECPs with which it is in the process of contracting.

Q36: If the issuer is reaching out to ECPs in its region to see if they would be interested in participating in the issuer's network, where and how does the issuer document this action of good intent in its QHP Application?

A36: The applicant can document these efforts in the narrative justification.

Q37: If the ECP address is incorrect on the official HHS ECP list, can the issuer enter the correct address in the ECP template or does the template need to match the HHS List?

A37: The applicant should enter the correct address information into the ECP Template.



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Q38: There are ECPs in the CMS non-exhaustive list that are closed that prevent the issuer from offering a contract to at least one ECP in each county where plans will be offered. How should the applicant indicate this information to CMS?

A38: In order to meet the safe harbor standard, the applicant would need to indicate by submitting the ECP Template that at least 20% of available ECPs in the plan's service area participate in the issuer's provider network. In addition, the issuer must offer contracts prior to the coverage year to: 1) All available Indian providers in the service area, and 2) At least one ECP in each category in each county in the service area, where an ECP in that category is available. If there is no single ECP in a given category in a given county and service area, the issuer should note this in its justification. The ECP list is not exhaustive, and does not include every provider that may qualify as an ECP. Issuers that are clearly unable to meet the regulatory standard, including the 20% safe harbor standard, because of limitations of the list (such as a provider that is no longer in business) may provide a justification using the ECP Supplemental Response Form, which can be found at <http://cciio.cms.gov/programs/exchanges/qhp.html>. Please note the issuer also has the ability to write in additional ECPs in the ECP Template. More information on the ECP standards can be found in Chapter 1 of the 2014 Issuer Letter, available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf.

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Pharmacy/Prescription Drug

Q39: We have several concerns on the prescription drug template:

- (1) The enterprise-assigned formulary name for states where the issuer's health plan is the benchmark has a set name, e.g., EHB_PLAN. The template assigns a formulary name automatically.**
- (2) Specialty is not available from retail or mail, only specialty provider. There is no place in the template to provide this information, and the assumption made is that in-network retail equals a specialty preferred provider.**
- (3) There is no area to state the number of days' supply at retail and through mail order.**
- (4) There is no area to state if there is a deductible prior to the coinsurance or copayment;**
- (5) It is not possible to validate until all of the information has been entered.**

A39: The purpose of the template is to collect enough information to determine whether or not the prescription drug coverage meets the requirements for QHP certification, such as EHB and non-discrimination standards. The consumers will only see the information about prescription drug coverage that is submitted in the benefits template. They will be directed to the issuer's website (the URL in the formulary template) for the detailed information about the prescription drug coverage. Drug deductibles are entered in the Plans and Benefits template. The template does not validate successfully until all required data is entered.

Q40: The following errors/issues have not yet been addressed in the prescription drug template:

- 1. No entry available for pharmacy deductible value and corresponding pharmacy deductible tier administration;**
- 2. No entry available for pharmacy per script maximum (PSM) value and corresponding PSM tier administration;**
- 3. No entry available for pharmacy OOP maximum value and corresponding OOP maximum tier administration.**

A40:

1. Prescription Drug deductibles are entered in the Plans and Benefits template.
2. You may enter a Maximum Coinsurance for Specialty Drugs in the Plans and Benefits template for AV calculation purposes.
3. Prescription drug out of pocket maximums are entered in the Plans and Benefits Template.

Q41: How will the prescription drug template link/connect to the Plans and Benefits template since the pharmacy benefit is embedded in the medical plan?

A41: On the Plan & Benefits Template under *Plan Identifiers*, each plan can designate its Formulary ID from the Prescription Drug Template.



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Q42: There is no field to enter a maximum per prescription for coinsurance.

A42: You may enter a Maximum Coinsurance for Specialty Drugs in the Plans and Benefits template for AV calculation purposes.

Q43: The template does not include a Drug Tier Type for "Preferred Specialty." How should these drugs be defined?

A43: A maximum of two drug types (one generic type and one brand type) should be selected for each tier. If a tier contains both preferred and non-preferred generics, you may use the Only Select Generics option (the same applies for preferred and non-preferred brands).

Please note that consumers will only see the information about prescription drug coverage that is submitted in the benefits template. They will be directed to the issuer's website (the URL in the formulary template) for the detailed information about the prescription drug coverage.

Q44: How do we indicate tier 2 coverage for specialty pharmacy?

A44: Consumers can see more details about the issuer's prescription drug coverage via the formulary URL. The information can also be provided at the benefit level in the explanation field.

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Q45: We do not understand how we connect the Prescription Drug Template to the Plans & Benefits Template. The Prescription Drug Template-connects to plans by the formulary ID so the cost shares feed into the Plans & Benefits Template, but they are not as detailed as the Prescription Drug Template.

A45: Each plan in the Plans & Benefits template must list the formulary ID with which it is associated. The formulary IDs are created in the Prescription Drug template. The Plans & Benefits template does not extract any information from the Prescription Drug template, although you can import the formulary ID from the Prescription Drug template into the Plans & Benefits template. While there will be a validation after submission in the FFM to ensure that plans are associated with valid formulary IDs, you must fill out each template separately.

To accommodate the Actuarial Value Calculator, the Plans & Benefits template contains four drug benefit categories that represent a typical four tier drug design available in the market today: Generic Drugs, Preferred Brand Drugs, Non Preferred Brand Drugs, and Specialty Drugs. CMS understands that plans may have drug benefits that do not fit neatly into the Plans & Benefits template. To that end, we recommend ways issuers might translate their cost sharing data from the Prescription Drug template into the Plans & Benefits template, as noted in the section titled "Suggested Coordination of Drug Data Between Templates" in Chapter 10: Instructions for the Plans & Benefits Application Section. For more information on the Prescription Drug template, please see Chapter 12: Instructions for the Prescription Drug Application Section.

The consumers will only see the information about prescription drug coverage that is submitted in the Plans & Benefits template. They will be directed to the issuer's website (the URL in the formulary template) for the detailed information about the prescription drug coverage.

Q46: In states with an EHB benchmark plan that requires coverage of over the counter (OTC) tobacco cessation products, how does a QHP verify their inclusion in the QHP submission? OTC products do not have RxNorm Concept Unique Identifiers (RxCUIs), which are used to add prescription drugs to a formulary.

A46: RxCUIs do exist for a number of OTC products. However, if you cannot find RxCUIs for the specific OTC drugs covered by your plan, you do not need to include them on the Prescription Drug template. To describe in more detail which OTC tobacco products your plan covers, you can use the Explanations fields associated with the drug benefit categories in the Plans & Benefits template. On the Plan Compare website, consumers will see the Explanations from the Plans & Benefits template, along with the formulary URL and the plan brochure URL, if provided.



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Q47: What is the underlying reference file for the HIOS Rx tool so that plans can ensure they are meeting EHB requirements?

A47: CMS has provided methodology for the drug count service on the CCIIO web site at <http://cciio.cms.gov/resources/data/ehb.html>. While the EHB Rx Crosswalk is based on version 5 of the United States Pharmacopeia (USP) Medicare Model Guidelines, it is not identical to the USP alignment file found at http://www.usp.org/sites/default/files/usp_pdf/EN/healthcareProfessionals/2011-03-11frf-uspmgintegratedfile.xls. The EHB Rx Crosswalk uses RxCUIs from the December 3, 2012 RxNorm release, which you can download 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. Please crosscheck the RxCUIs you are submitting with the December 3, 2012 RxNorm release to ensure they are up-to-date. CMS requests that you include your entire drug list, not just the recognized RxCUIs, when submitting a QHP application.

Q48: 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)?

A48: If you have no cost sharing for the tier, select Copayment as the cost-sharing type, and set the copayment equal to \$0.

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Q49: In order to satisfy the drug counts for some categories, intravenous drugs will need to be included. However, these drugs are covered under medical benefits, not pharmacy benefits, and are not obtainable at a retail pharmacy. How should we proceed?

A49: As noted in the file rule on EHB at 45 CFR 156.122, a health plan does not provide EHB unless it covers at least the greater of: 1) One drug in every USP category and class; or 2) The same number of prescription drugs in each category and class as the EHB-benchmark plan.

If the plan uses the USP Category Class Count Service and uploads a list of all RxCUIs covered under the plan's prescription drug benefit and meets (or exceeds) the benchmark drug counts, the plan will be in compliance with this requirement. If the plan cannot meet the count without including medical drugs in the drug list, we recommend the following steps to submit the QHP application:

- 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 instructions, to identify how the drug list meets the requirement and submit the RxCUIs associated with the medical drugs for each drug list.

Please note that the EHB requirement is a minimum standard, and an issuer should include the entire drug list, not just the recognized RxCUIs, when submitting a QHP application.

Rate Review and Rating Data

Q50: For issuers with filing only new products as QHPs, is it correct that they do not need a Unified Rate Review (URR) Template as part of their QHP submission, given that the URR Template is only for rate increases?

A50: No. Any time that the URR Template is filled out, all plans in the risk pool -- even those not being submitted for QHP certification -- 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, as required by a combination of Exchange (77 FR 18310) and Rate Review rules (78 FR 13406). This is true even if all of the plans are new.

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- Q51: There appear to be errors in the validation macro in the rate template. When the macro is trying to check for proper relationship between rates for different age brackets and tobacco vs. non-tobacco rates, it produces erroneous results. If the Tobacco field is listed with "No Preference" and changes to "Tobacco User / Non-Tobacco User" after the Age is selected, the Individual Tobacco Rate column will not show.**
- A51: The macros in the Rate Table Template are written such that the tobacco use column is hidden (not deleted) when "no preference" is input for tobacco use. If issuers find this confusing, they can generate additional sheets and use separate sheets for plans which use tobacco rating and those that do not. If a plan has some age bands which use tobacco rating and some which do not, the issuer should not mark the age bands as no preference, but should instead enter the same rate in both the tobacco use and non-tobacco use columns for those age bands which do not differentiate. This will avoid the display issue.
- Q52: The calculation of 3:1 ratio on non-tobacco rates is not correct. The validation macro marks some of the cells as in violation of 3:1, which is not the case. Per the Market Reform Final Rules at 45 CFR 147.102(a)(1)(iii), "such rate may not vary by more than 3:1 for adults." In an example provided by CMS Plan Management Support, sample data was used to demonstrate that the age 21 individual rate must be multiplied by 3 to derive the maximum age 65 individual rate. However, in order to check for an allowed ratio of 3:1, you need to take the age 65 rate and divide by the age 21 rate and see if that ratio equals to 3:1. The problem with the validation method cited by CMS and included in the template macros is that it uses the wrong operation when checking for 3:1 compliance. The small differences resulting from using this incorrect operation for validation will result in a huge problem for issuer billing systems.**
- A52: Due to a system limitation in the Rating Tables Template, the system currently cannot process a premium for a 65-year-old smoker that is rated more than 3 times the premium of a 21-year-old smoker. We ask that all issuers submitting rates via the Rating Tables Template for non-grandfathered plans in the individual and small group markets implement the tobacco rating factor so that older adult smokers are not rated in total more than 3 times of the total rate for a younger adult smoker. One way to accomplish this is if an issuer imposes a 1.2 to 1 tobacco rating factor on a 21-year-old smoker, the issuer should use the same 1.2 tobacco rating factor for the 65-year-old smoker. If an issuer implements the tobacco rating factor with the result that an older smoker is rated up more than 3 times of that of a younger smoker, the submission of the issuer will be rejected by the system. We intend to implement a system change that will allow for processing of tobacco rating factors that vary based on age, and we expect this to be completed after calendar year 2014.

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Selected Responses

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Q53: The template allows entry of a Rating Area ID and allows up to 150 Rating Areas to be selected. It is unclear how these rating areas will be mapped to the appropriate area within each state (or service area) to identify the appropriate rating. How will the Exchange know the proper premium based on a member's address? How will rating areas be consistent across multiple QHP issuer submissions within each state?

A53: Each individual state is setting its own rating areas and providing the specific areas within a state that associate to each rating area. The Rate Table Template collects the rates for each rating area in the state. Issuers should use those state-provided rating areas to complete the Rating Area ID piece of the template. The rating areas for each state are published on the CCIIO website <http://cciio.cms.gov/programs/marketreforms/state-gra.html>.

Q54: When tabbing out of the Age field, the debugging macro pop-up was generated.

A54: For states that do not have community rating, the template automatically creates rows for all age bands when a single age band is selected. The age bands once created may not be edited. If you continue to have this issue, please contact the Help Desk.

Q55: Please clarify whether area rating can vary by network.

A55: If an issuer offers two QHPs with the same benefit package and cost-sharing, but with two different networks (for example, a broad network vs. a narrow network), the issuer may make a plan-level adjustment to its market index rate to reflect the expected cost differences resulting from network difference between those two QHPs. The state may place additional restrictions on rating flexibility in the state, and all QHPs offered on the Exchange must comply with state law and be approved by the state.

Q56: After entering Age in the appropriate field, upon keying cursor up, Age decrements and is placed in incorrect row on spreadsheet.

A56: Rates must be submitted for all age bands. The age bands will populate in order regardless of the age that you select.

Q57: The Tobacco Rate column does not appear until Age Bracket is selected, instead of upon selection of value in the Tobacco drop-down.

A57: This is by design. The template requires both the tobacco option and the family/age band option to be selected before displaying the appropriate columns for the rates.

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General

Q58: How do issuers remove HIOS-EIDM accounts for terminated employees?

A58: Please call the Help Desk and have the terminated or departed employee removed from the organization.

Q59: We just submitted our state filing and the rates template was too large to upload into SERFF. SERFF has a maximum file size of 3 MB. The XML version is difficult for the state to read, so unless they know how to translate it, they will be confused.

A59: After the .xml file is uploaded, the system validates the file, then returns an Excel version of the data. This is available to submitters and reviewers. Additionally, SERFF has increased its maximum file size.

Q60: Will there be a Confidentiality template to identify fields on the templates that are proprietary or confidential?

A60: Currently, the data supplied in the templates will be used only for QHP certification purposes and for population of the FFM website, for example, for population of the premium calculator. To the extent that data is being entered for rate review purposes, the process related to proprietary information that is currently in place under that program would apply to that information. We may receive Freedom of Information Act requests or other data release requests for this information, and we will work on a process for handling these requests while protecting issuer confidentiality.

Q61: When user clicks on the *Validator* tab, the screen goes white and nothing happens. When refreshing or going back an error is encountered. The application will eventually let the user go back. These errors prevent the user from completing the test script.

A61: This occurs for users that have both the Submitter and Validator roles. You may navigate successfully through the sections of the module from the Summary Page rather than using the links at the side of the page.

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Q62: If we are not filing to be a part of the Exchange/offer QHPs, do we need to do anything?

A62: An issuer is not required to notify CMS that it will not seek QHP certification. However, 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 you plan to offer products outside of the Federally Facilitated Marketplace, please follow the rate review filing requirements under 45 CFR 154.220 and contact your State to determine state specific filing requirements. As noted in the final Market Rules at: <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.

Q63: I am trying to clarify data submission requirements for April 30 as applicable to FFE states. In the QHP Certification PRA notice, Appendix D has data elements related to the EDGE server listed as required for the QHP application process. None of the QHP application templates available via HIOS have a place to enter the Edge server related data. Please confirm that we are not required to submit the Edge Serve data elements described in Appendix D of the QHP Certification PRA notice with the April 30th QHP application submission.

A63: Appendix D represents data required for reinsurance, risk adjustment, and payment operations. Those data elements will be collected outside of the QHP application process as they are not required for QHP certification. The collection of the Appendix D data will occur later this year. The PRA package can be found at:
http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201303-0938-004.

Q64: The file is not automatically defaulting to be saved in .xml format as specified in test scenarios. It defaults to .xls instead.

A64: Excel 2007 automatically defaults to the current file name and format. You will need to manually select the .xml format when you save the finalized submission file generated by the finalize template macro.