

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013



# Plan Management Webinar Frequently Asked Questions

---

## Frequently Asked Questions (FAQs) # 2

Released Date: April 9<sup>th</sup>, 2013

### Guidance/Timeline

---

#### QHP Certification/Review Process

**Q1: If an issuer's product is not approved as a QHP for January 2014, is there an opportunity to seek approval for January 1 of subsequent years?**

A1: Yes, we anticipate that issuers will have the opportunity to apply for QHP certification in future years.

**Q2: How should issuers respond to Small Business Health Options Program (SHOP) attestations if they only intend to participate in the individual market?**

A2: The final Program Attestations are written so that if an issuer does not offer QHPs in the SHOP, a response of "yes" will indicate that the issuer does not sell in that market.

**Q3: Will there be a way to withdraw plans from the QHP certification process after the window closes but before open enrollment?**

A3: Issuers will be provided a chance to withdraw QHPs that HHS has determined as qualified for certification. The withdrawal request will be made to HHS during a specific timeframe and must be assessed in order to guarantee the issuer offers all required QHPs given the change/withdrawal.

**Q4: How will the Exchange display plans? Should issuers include the plan type ("HMO") in each plan name?**

A4: The exchange will identify the plan as Issuer Marketing Name, Plan Marketing Name, and Plan type so including plan type in marketing name would be duplicative.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

**Q5: Can issuers submit plans without State Department of Insurance approval? If yes, will there be a process to make changes after the window closes?**

A5: QHP issuers can submit plans that are not yet approved by the State regulatory entity. During application submission, an issuer attests that it will have a license by the end of the certification period, be in good standing, and be authorized to offer each specific type of insurance coverage offered in each State in which the issuer offers a QHP. The issuer must submit evidence of licensure by the end of the resubmission window. At the time of certification, the QHP issuer must agree that it is in compliance with all State laws and statutes related to its QHP plans in the State in which QHP plans are being offered, including that the forms for the QHPs it will offer have been approved or deemed by the State (as applicable in that State), and agree to notify HHS if in the future it is not compliance.

### Accreditation

**Q6: Is there any federal requirement for an issuer to document that it has "scheduled or planned to schedule accreditation" during certification for its initial year of QHP certification, as provided in §155.1045(b) (1) of the Accreditation Timeline?**

A6: No, there is no separate documentation required for an issuer. As part of completing the QHP application the issuer is indicating that they have scheduled or planned to schedule accreditation.

### Compliance Plans

**Q7: Will HHS make a template or preferred form available for the compliance plan?**

A7: HHS expects that most issuers already have compliance plans in place which support their ongoing lines of business. HHS will be providing a cover sheet that issuers can use to identify the elements of their compliance plans. The cover sheet should be submitted along with the issuer's compliance plan, as part of the application process. Issuers should design their compliance plans to meet their specific organizational needs and structure, and should use the compliance plan cover sheet to assist CMS in identifying where in their existing structure the requested elements can be found. The compliance plan cover sheet is available in the QHP Application Instructions posted on the REGTAP portal.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

**Q8: Do issuers have to submit a compliance plan? If so, do issuers have to submit the entire compliance plan or just attest that it has one?**

A8: HHS expects that most issuers already have compliance plans in place which support their ongoing lines of business. HHS is requesting that a compliance plan be submitted as part of the QHP issuer application process. These compliance plans will be used for base-lining purposes, and will not be used as a criterion for assigning deficiencies during the certification process.

**Q9: Do the compliance plans need to be specific to the Exchange? Can issuers submit their existing compliance plan?**

A9: 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.

**Q10: Will HHS be issuing guidance on compliance plans?**

A10: HHS has not published requirements specific to FFM compliance plans and does not expect to do so for plan year 2014.

**Q11: There is an attestation that asks whether there is any pending legal action against the issuer. Is that limited to any pending legal action by the government?**

A11: This attestation relates to pending legal action against the issuer in connection with the performance or award of a contract or grant with the Federal or State government.

### Dental

**Q12: What is the definition of medically-necessary orthodontia?**

A12: Issuers will be responsible for developing standards to define medically-necessary orthodontia.

**Q13: Do the rating reforms apply to stand-alone dental plans?**

A13: Stand-alone dental plans are not subject to Parts A and B of the Public Health Service Act. Please reference Chapter 4 of the Letter to Issuers referenced above for a more detailed explanation.

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

**Q14: Does pediatric dental follow exactly the same age curve/factors, etc. as medical? Should there be a separate rating algorithm for dental? Or would pediatric dental be submitted as a different plan and the exchange would add the pediatric dental and medical rates together?**

A14: As outlined in Chapter 4 in the 2014 Letter to Issuers: "In addition, 45 C.F.R. § 156.210 requires QHP and stand-alone dental plan issuers to submit rate and benefit information to the Exchange as a standard for certification by the Exchange. Due to their excepted benefit status, stand-alone dental plans are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and business rules template. However, stand-alone dental plans will still need to complete these tables, and based on that information, CMS will display basic, comparable rate information for stand-alone dental plans on the web portal. CMS will also calculate the advance payment of the premium tax credit for stand-alone dental plans using the pediatric dental Essential Health Benefit (EHB) premium allocation." Issuers of stand-alone dental plans can elect to charge an additional premium beyond what is reported. Please see Chapter 4 of the issuer letter for additional information.

### Essential Community Providers (ECP)

**Q15: Regarding the ECP template, if an ECP has multiple addresses should we list the ECP twice, once with each address?**

A15: When entering an ECP with multiple locations but the same Provider Name, append the Provider name with a unique 3-digit number for each location, e.g. Provider – 001.

**Q16: Is every QHP required to have ECPs? If the service area is not rural, and the network has sufficient coverage, is it required to also have ECPs?**

A16: Each QHP is required to have a sufficient number and geographic distribution of ECPs, where available, in accordance with 45 CFR 156.235. The QHP issuer must ensure reasonable and timely access to a broad range of such ECPs for low-income, medically underserved individuals. Nothing in the regulation would preclude a QHP issuer from credentialing an ECP, similar to any other provider. HHS notes that many 340B providers currently meet provider accreditation standards. The Issuer Letter includes more information on ECPs, in Chapter 1.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

### Network Adequacy

**Q17: In the instance an issuer cannot attest to “network adequacy” and has to submit “network access plan,” when would the issuer have to attest to their “network adequacy”?**

A17: All applicants are required to attest to meeting network adequacy requirements. Additionally, issuers categorized as "Tier 3" (as explained in the instructions) are required to submit a network access plan. Please refer to the Application Instructions, available on the REGTAP portal, for more information on completing the Network Adequacy instruction of the application.

**Q18: Will there be any specific components related to pharmacy network or will that information be considered as part of the entire network filing?**

A18: Network adequacy is a QHP certification requirement per 45 CFR 156.230, and this includes pharmacy access. Issuers are not required to submit their (non-ECP) networks to the FFE for QHP certification. Please see the Application Instructions for more information on the network adequacy section.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

### Essential Health Benefits

**Q19: Can a State adopt different benchmark plans for the individual market and for the small group markets? For example, could a state adopt an FEHBP plan as the benchmark plan for the individual market and select one of the largest small group plans as the benchmark plan small group market?**

A19: No. As described in the EHB Final Rule published in the Federal Register on February 25, 2013 (78 FR 12834), a State would select only one of the benchmark options as the applicable EHB benchmark plan across its individual and small group markets both inside and outside of the Exchange. HHS believes that selecting one benchmark for these markets in a State would result in a more consistent and consumer-oriented set of options that would also serve to minimize administrative complexity. HHS seeks to provide flexibility to issuers by permitting actuarially equivalent substitution of benefits within the ten categories of benefits required by the Affordable Care Act.

As set forth in 45 CFR 156.100, the benchmark plan options included: (1) the largest plan by enrollment in any of the three largest products by enrollment in the State's small group market; (2) any of the largest three State employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the HMO plan with the largest insured commercial non-Medicaid enrollment in the State. The final rule also clarified that for States that did not make a benchmark selection, HHS selected the largest plan by enrollment in the largest product by enrollment in the State's small group market as the default base-benchmark plan. The selected benchmark plans have been finalized for benefit year 2014. Appendix A of the final regulation includes the final list of EHB-benchmark plans for coverage in years 2014 and 2015.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

### Transactions

**Q20: The recent Proposed Notice of Benefit and Payment Parameters for 2014 defines some requirements for a distributed data environment for collecting risk adjustment and reinsurance data. Can you provide more details?**

A20: HHS has provided a list of required data for the HHS-operated distributed data approach in the PRA package approved under OMB Control Number 0938-1155. After release of the final payment notice, HHS is conducting a short series of educational webinars focused on details of the distributed data approach. You can register for these sessions at [www.REGTAP.info](http://www.REGTAP.info). The next session will be held on April 10, 2013. During these sessions, HHS will make available the data formats, definitions, and technical standards applicable to the HHS-operated distributed data approach in future guidance. This summer HHS plans to conduct followed by user group sessions and additional operational policy guidance.

**Q21: Will issuers need to submit a subset of the QHP template data for off-Exchange plans to support reinsurance and risk adjustment? Will there be functionality added to the current templates or a subset of templates created for these off-exchange plans to require only the information needed for this the reinsurance and risk adjustment calculations?**

A21: HHS plans to create templates specific for the data pertinent for the reinsurance and risk adjustment program operations. This will provide a streamlined approach for non-QHP data submission.

**Q22: How will the banking data and edge server provisioning be submitted?**

A22: HHS is currently working on the submission process for banking data and provisioning process for the edge server. HIOS will be utilized where possible to reduce burden to issuers. Further guidance will be provided as these processes are finalized.

**Q23: If subsidy payments will come to health plans via the 820, what about the remainder of the premium balance?**

A23: The 834 will contain the premium breakdown, i.e., it will show which entity should pay for which portion of the premium and the relevant effective dates. It will show the total premium, the Advanced Payment of Premium Tax Credit (APTC) amount, the amount that any other payers such as the state will pay, and what the member is responsible for at the subscriber level. Please see the 834 Companion Guide, available at <http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf>, for more information.

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

### Templates

---

#### Benefits Template

**Q24: Is the section “Disease management programs” displayed on the SBC and/or plan compare?**

A24: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, issuers can indicate if Disease Management Programs will be available on the QHP through this optional data field. Issuers will have the option to select from a dropdown menu that includes the following programs: asthma, heart disease, depression, diabetes, high blood pressure & high cholesterol, low back pain, pain management and pregnancy. This information will be displayed on Plan Compare.

**Q25: Please provide guidance on those data elements outlined in the Appendices that are not included in a template (e.g., benefit cost sharing - start day if charge is day; Summary of Benefits and Coverage (SBC) - what is the total cost to the customer for costs and exclusions?).**

A25: Please refer to the SBC Scenario and AV Calculator Additional Benefit Design data elements in the Plans & Benefits template and Chapter 10: Instructions for the Plans & Benefits Application Section, which describes how to complete the data elements in the template.

**Q26: When will the benefits template be made available with the state specific EHBs populated?**

A26: The Plan & Benefits Template populated with state specific EHB’s is currently available to States and Issuers through the NAIC website ([http://www.serff.org/plan\\_management\\_data\\_templates.htm](http://www.serff.org/plan_management_data_templates.htm)).

**Q27: How do issuers obtain Network IDs?**

A27: To obtain a network ID, issuers may refer to Chapter 8: Instructions for the Network Identification Application Section at [zone.cms.gov](http://zone.cms.gov). These instructions will walk the issuer through obtaining a Network ID. The Create Network IDs button generates the Network IDs. The button will ask how many networks you have and generate them for you.

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

**Q28: What does the header, "QHP/Non-QHP" mean, and how does it relate to the contents in the drop downs?**

A28: QHP/Non QHP is a required field in the Plan & Benefits Template. Issuers must indicate whether the plan is offered on the Exchange, off the Exchange, or both. The contents of the drop down are: On Exchange—if the plan will be offered on the Exchange; Off Exchange—if the plan will be offered off the Exchange; Both—if the plan will be offered both on and off the Exchange. FFM is not currently collecting off Exchange plans. Non-QHP is applicable as it provides flexibility for the template being used for other purposes outside of QHP submission.

**Q29: What if an issuer is still working on finalizing its prescription drug formulary at the time of application, such that adding EHB drugs is problematic?**

A29: As noted in Chapter 12: Instructions for the Prescription Drug Application Section, the Formulary URL is a required field, and issuers are required to enter the RxCUIs included in any drug list and also the associated cost-sharing tier level in the Prescription Drug Template. For the FFE, issuers should include the RxCUIs that they intend to offer.

In order to meet EHB standards, plans must offer at least the greater of one drug in every USP category and class or the number of drugs in each USP category and class offered by the EHB-benchmark. Plans are permitted to go beyond the drug count in the benchmark and can add more drugs to their formularies. If the drug does not have a USP category/class then it will not be counted, but the plan is not precluded from offering that drug.

Since the State is responsible for monitoring compliance with EHB policy, the State should be notified of any change in formulary, but State-based Exchanges could set their own rules in terms of requiring plans to notify the Exchange of any drug list changes.

**Q30: What is the definition of a network URL?**

A30: The network URL is the web address on the issuer website that consumers can use to view the providers in the issuer's network.

**Q31: If there is more than one service area ID, how is this entered in the template?**

A31: Each QHP submitted must be associated with a single Service Area ID as identified in the Service Area Template. If a QHP is offered in three service areas, the issuer will need to create a fourth service area consisting of those all three areas combined, and use that single ID for completing the Benefits Template.



## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

**Q32: Will upcoming drafts of templates indicate which fields are required for the QHP application?**

A32: The Data Traceability Matrix (DTM) is currently available through the NAIC website ([http://www.serff.org/plan\\_management\\_data\\_templates.htm](http://www.serff.org/plan_management_data_templates.htm)). The DTM outlines how data should be entered for each field in the QHP data collection templates, and the template fields note which entries are required vs. not required.

**Q33: Will specific examples that issuers are required to use in the SBC be provided?**

A33: The SBC coverage examples and link to the SBC URL are optional data fields in the Plans & Benefits template. While the data fields for SBC coverage examples are optional, issuers are advised that the FFM may be using certain data elements from the SBC in Plan Compare. If this issuer does not provide this information, then Plan Compare will show “not available.” The URL to the SBC is identified as optional because we expect that issuers will be developing the SBC post submission; however, the URL will be required prior to open enrollment to display on plan compare.

**Q34: What does the field “CSR variation type” mean?**

A34: CSR Variation Type is a required field in the Plan & Benefits Template. The data in the plan variation type field auto populates based on information the issuer previously entered in the template.

**Q35: Will the data templates from the initial application in April 2013 be used on an ongoing basis, such as when filling new products with the state?**

A35: As noted in the Issuer Letter mentioned previously, the QHP Application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates for the Federally-facilitated and State Partnership Exchanges.

States will continue to perform regulatory activities such as reviews of health plan rates, benefits, and provider networks with respect to all plans offered in the State, both inside and outside the Exchange. Issuers should defer to any State-specific guidelines for review and resubmission of state-reviewed standards.

**Q36: Can an issuer submit one QHP application, since the templates allow several benefit packages within one template? If no, what rules dictate how many QHP applications need to be submitted?**

A36: Yes, the issuer can submit one QHP Application to represent multiple products and plans.

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

### **Q37: Why is there a column for HSA eligibility but not HRA eligibility?**

A37: On February 25, 2013, the Department published its final rule on EHB at 78 FR 12834, which includes provisions on cost sharing and the calculation of actuarial value for health plans. Section 156.135(c) of this regulation implements section 1302(d)(2)(B) of the Affordable Care Act regarding employer contributions to HSAs when determining the level of coverage for a plan of the employer. Under this regulation, a plan's employer contribution to an HSA or an integrated HRA may be counted towards the total anticipated medical spending and adjusted to reflect the expected spending for health care costs in the calculation of actuarial value that determines the level of coverage of the plan.

As detailed in the regulation, because it is the issuer that uses the Actuarial Value Calculator to determine a plan's actuarial value, the HSA's employer contribution, or the amount newly made available by the employer under an integrated HRA that may only be used for cost sharing, may be considered part of the actuarial value calculation when the contribution is available and known to the issuer at the time the plan is purchased.

Further information about how an HSA or integrated HRAs are used in the calculation of actuarial value is available the Actuarial Value Methodology available at:

<http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf>.

### **Q38: What should be included in the content of the drop down option, "Plans\_Benefits - Plan Level Exclusions"?**

A38: Users may enter Plan Level Exclusions in this optional field. This field is a free text field.

### **Q39: What is the "Add Benefit" button intended to do?**

A39: The "Add Benefit" button in the Plan & Benefits template is used to add a benefit that is not on the template. Click the Add Benefit button on the menu bar under the Plans and Benefits ribbon to add a benefit or refer to Chapter 10: Instructions for the Plans & Benefits Application Section for additional information.

### **Q40: What is the purpose of multiple tabs in the benefits template?**

A40: The Plan & Benefit template enables users to create multiple benefit packages within a single QHP submission. This feature reduces data entry burden on the issuer as it eliminates the need to enter duplicate data throughout the application. An issuer may associate multiple plans with a benefit package, which is comprised of the same benefits and limits.

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

**Q41: Since all cost sharing (Drug and EHB) has to apply to the out-of-pocket maximum, why are there separate out-of-pocket maximum columns?**

A41: Some issuers have benefit package designs with separate out-of-pocket maximums for medical and drug benefits. You are correct that the annual limitation on cost sharing (for the out-of-pocket maximum) applies to the total for in-network benefits. A given plan design with separate out of pocket limits for in network medical and drug costs would comply with the annual limitation on cost sharing if the sum of the limits is less than or equal to the maximum amount allowed under regulation.

**Q42: How do issuers answer column P, "Indian Plan variation - Est advanced payment," for products without an Indian variation?**

A42: If applicable, issuers should enter a dollar amount in this optional field. Estimated amount of cost-sharing reductions for eligible enrollees to be provided in the form of an advance payment to the issuer should be entered here. This amount is estimated by the issuer and applies to Indian plan variations described in section 156.420(b)(2) of the final *HHS Notice of Benefit and Payment Parameters for 2014* (78 FR 15410).

**Q43: Please advise how issuers should populate the cost share variance fields for "non-emergency care when outside the country," as the copay and coinsurance could vary.**

A43: HHS recognizes that the copay/coinsurance amounts could vary for this category of services. The issuer should populate these fields with the amounts that would most typically apply. In the explanations field, the issuer should note that cost sharing could vary based on the type of service rendered and place it is received.

**Q44: In reviewing the most recent SERFF templates, we did not notice a way to indicate if a medical benefit plan required a PCP/Gatekeeper. Is this a field that is projected to be added?**

A44: In the Plan & Benefits template, the field marked "Is a Referral Required for Specialist?" may be used to indicate if a referral is required to see a specialist.

## QHP Frequently Asked Questions

Selected Responses

Release Date: 4/9/2013

**Q45: Can HHS make public the EHB Crosswalk that is mentioned in the recently published Methodology document?**

A45: HHS has made available a tool called “the USP Category Class Count Service” (the Counting Service) to enable issuers and States to submit formularies using unique identifiers called RxNorm Count Unique Identifiers (RxCUIs) and receive a report of the category, class, and count of unique drugs applicable to the submitted information to use to crosscheck the counts against the relevant State’s EHB standards to ensure the plan meets the benchmarks for their State. This tool was released March 2013 through HIOS.

### Templates

**Q46: What is the purpose of the contracts section within the administrative template? For example, will that be externally facing; will it be for HIOS only?**

A46: The contact provided by the issuer should reflect which person at the issuer can answer HHS's questions about the specific topic. The contacts related to finances should be able to answer questions for both inside and outside the Exchange market. The contacts provided will not be made public.

**Q47: Are the individual templates similar to or exactly the same as the SHOP templates?**

A47: Regardless of the market in which you offer plans, the templates are exactly the same.

**Q48: For the fields that are the same between the RBIS and QHP, are the formats and acceptable field values exactly the same?**

A48: Where possible, the validations are the same.

**Q49: Do all templates need to be uploaded at same time?**

A49: QHP data collection templates do not need to be uploaded at the same time. However, all QHP data collection templates must be uploaded in order to submit the complete QHP application to HHS for review.