QHP Certification
Health Insurance Marketplace

Frequently Asked Questions

If an issuer has additional questions beyond those addressed here, they should contact the Exchange Operations Support Center (XOSC) Help Desk at CMS_FEPS@cms.hhs.gov or at 855-CMS-1515.

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Frequently Asked Questions: Business Rules

Q1. What is the purpose of the *What are the maximum number of children used to quote a children-only contract?* field in the Business Rules Template?

The column "What are the maximum number of children used to quote a children-only contract?" refers to the number of child rates that are added together to calculate premium, not the number of children allowed to be covered on the plan. The value in this field must be “3” or less.

Q2. In what circumstance would tobacco rates not display to a smoker?

Tobacco rates won’t display to consumers if the issuer has not submitted tobacco rates. For issuers who submit tobacco rates, the tobacco rates will only apply to consumers who report their last smoking date more recently than the look-back period indicated on the issuer’s Rates Table Template. Issuers are not permitted to set the tobacco lookback period to a duration more than six months.

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Frequently Asked Questions: Data Change Requests

Q1. **Can issuers add new plans after the initial submission deadline (ending May 11, 2016)?**

No. After the initial submission deadline of May 11, 2016, issuers cannot add new plans to a Qualified Health Plan (QHP) Application or change an off-Marketplace plan to both on- and off-Marketplace.

Q2. **If an issuer is making a correction to its application in response to a correction notice, is the issuer required to submit a petition/data change request?**

No. Issuers are not required to submit a petition/data change request to the Centers for Medicare & Medicaid Services (CMS) if it is revising the application in response to a correction notice issued by CMS, unless the issuer is making a change to its service area. If the issuer is making a service area change then it must submit a data change request and follow the petition process.

Q3. **Are issuers in states performing plan management required to submit petitions for service area changes?**

Yes. Issuers in states performing plan management functions must petition for service area changes. Additionally, issuers in states performing plan management functions cannot add new plans to a QHP Application or change an off-Marketplace plan to both on- and off-Marketplace after May 11, 2016.

Q4. **Are issuers in State Based Marketplaces (SBMs), including State-Based Marketplaces using the Federal Platform (SBM-FPs), required to submit petitions/data change requests?**

No. The petition and data change request process applies only to issuers in Federally-facilitated Marketplaces (FFMs). Issuers in SBM-FPs should work directly with the appropriate state regulator.

Q5. **Is there additional guidance on submitting service area change request justifications?**

Please see the QHP Application Instructions for Service Area (found at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html). The instructions provide guidelines for partial county justifications. CMS expects to follow similar justification requirements for service area change requests.

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Frequently Asked Questions: Data Corrections

Q1. **How do issuers make changes to incorrect customer service numbers listed on HealthCare.gov for their organization?**

For coverage year 2017, administrative information displayed on the HealthCare.gov website will be pulled from Marketplace General Information Fields in the Health Insurance Oversight System (HIOS). If either the Marketplace Billing Name or Marketplace Issuer Marketing Name is missing, the Issuer Legal name from the Issuer General Information section in HIOS will display in its place. This applies to all issuers, including those who file through the System for Electronic Rate and Form Filing (SERFF).

Changes to administrative data, including customer service number, should be updated in the View Issuer Submitted Data Tab of the HIOS Plan Finder Product Data Collection module. Issuers can make such changes at any time; data is refreshed on the Federally-facilitated Marketplace (FFM) every Friday evening. If an issuer needs to change their Marketplace marketing name or customer service information (phone number or URL), please note the following:

- You must have a submitter role in HIOS to make changes.
- Instructions on how to update fields in the HIOS Plan Finder Module are contained in Sections 5.1 and 5.3 of the HIOS Plan Finder—Issuer User Manual.

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Frequently Asked Questions: Essential Community Providers (ECPs)

Q1. **Will the count of providers (MD, DO, NP, PA, DMD, DDS) be a combined count of all providers or will there be totals for each type of provider? If a combined count, how will issuers know the total by provider type for comparison and reconciliation purposes?**

The practitioner counts for each provider on the ECP list will reflect a combined total for all the practitioners practicing at the respective facility. CMS's utilization of these practitioner counts for the purposes of the ECP standard is currently limited to more accurately assessing ECP participation within an issuer's networks, rather than for assessing more granular participation by practitioner type.

Q2. **When will the Final CMS Non-Exhaustive ECP list be available, and in what format will it be?**

The Centers for Medicare & Medicaid Services (CMS) released the final ECP list for Plan Year 2017 on February 17, 2016. The final list is available at https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html. The ECP list and description document appear near the bottom of the web page under the section titled "Other Qualified Health Plan Application Resources."

Q3. **If multiple Network IDs will be shown on any given row for an ECP provider in the ECP Template, how should issuers report any variances in the provider counts by network?**

When variances exist among the issuer's networks, the issuer may report the highest count of practitioners (among its network variations) that the issuer has included in the provider network for its member enrollees. That number must not exceed the number of available full-time employee (FTE) practitioners reported to the Department of Health & Human Services (HHS) by the ECP facility through the ECP petition process.

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Frequently Asked Questions: Machine Readable Format

Q1. **How quickly does updated machine-readable data appear in the Decision Support Features on HealthCare.gov?**

The Centers for Medicare & Medicaid Services (CMS) refreshes issuers' machine-readable data at least once daily. Depending upon the time of day the issuer updated their JavaScript Object Notation (JSON) file, the Decision Support Features on HealthCare.gov will reflect the update within 1-2 days.

Q2. **How can issuers ask technical questions about their machine-readable files and data?**

Issuers should use the User Voice Community to submit questions and receive answers related to machine-readable files and data. This site allows users to:

- Review the Knowledge Base;
- Submit questions and receive answers to technical questions about the index files and JSON files; and,
- Browse already-answered questions in the Knowledge Base.

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Frequently Asked Questions: Marketplace Policy

Q1. **Is there a list of all the qualified health plans (QHPs) available on-Marketplace?**

The QHP Landscape files contain a list of QHPs that are available on HealthCare.gov. The files can be found at: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers.

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Frequently Asked Questions: Network Adequacy

Coding Provider Specialties

Q1. **What is the appropriate specialty type to use for pediatric specialty providers when completing the Essential Community Providers (ECP)/Network Adequacy Template?**

The 101 Pediatrics – Routine/Primary Care specialty type should be used for pediatricians who are offering primary care services. Specialized pediatric providers should be assigned the specialty type 000 OTHER.

Q2. **How should an issuer assign specialties that are not listed in the Specialty Types Tab of the ECP/Network Adequacy Template?**

If an issuer does not see a specific specialty type listed in the Specialty Types Tab, it should select specialty type 000 OTHER.

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Reasonable Access Data Review

Q3. **What needs to be included in a justification, or why is an issuer's justification not acceptable?**

If an issuer believes that its network may not meet network adequacy standards (e.g., it received a deficiency notification last year and has been unable to expand their network through recruiting efforts), it has the option to submit a written justification. Additionally, if concerns are identified during the certification process the issuer will be given the opportunity to provide additional providers for the specialty identified and/or to submit a justification that explains how reasonable access will be provided for the concern identified. For details on submitting this document to the Centers for Medicare & Medicaid Services (CMS), issuers should refer to the "Supporting Documentation and Justification Instructions" section of Chapter 6: Instructions for the Network Adequacy Application Section of the qualified health plan (QHP) Instructions.

Q4. **Can an issuer submit a network adequacy justification prior to receiving a correction notice?**

Yes. The written network adequacy justification statement can be submitted if there is an anticipation that there may be a reasonable access concern. Justifications can also be submitted as a response to a correction notice (if one is received by an issuer). The justification can be submitted on its own or with a new template that includes additional contracted providers.

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Network Adequacy Template

Q5. **In the Network Adequacy Template, how should issuers enter facilities, such as Durable Medical Equipment (DME) facilities, that are not technically located in a contiguous state, but may provide a service to the QHP?**

The issuer should only enter information for facilities located in the state where the plan is offered or in contiguous states. If there is a concern about adequate access to any provider type, CMS will notify the issuer via the correction notice, and the issuer will have the opportunity to submit a justification and or a new template with additional contracted providers.

Q6. **Should the Network Adequacy Template include providers from leased networks in addition to the issuer's network?**

Yes, to the extent that a network's providers are available to enrollees in that QHP and are treated by the issuer as providing in-network benefits.

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Frequently Asked Questions: Network ID

Q1. **When submitting the network URL in the Network ID Template, should issuers link each qualified health plan (QHP) to a unique Provider Directory, or may issuers allow consumers to navigate to a landing page and select QHPs from that page?**

The Centers for Medicare & Medicaid Services (CMS) encourages issuers to link each QHP to a unique Provider Directory. However, as long as the issuer provides a clear, intuitive, and transparent method for consumers to obtain direct access to the provider directories for each QHP, the issuer may link to a landing page and display plans for consumers to select. Each plan name listed on the issuer's directory page must match exactly to the plan marketing name that displays on the Federally-facilitated Marketplace (FFM) website.

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Frequently Asked Questions: Plan ID Crosswalk

Q1. **If an issuer is only offering a stand-alone dental plan (SADP) in the Small Business Health Options Program (SHOP) market, will the issuer be required to complete the Plan ID Crosswalk Template?**

Issuers only offering SADPs in the SHOP market are not required to complete the Plan ID Crosswalk Template. The purpose of the template is to facilitate auto-reenrollment. Any issuer that currently offers a qualified health plan (QHP) in the individual market must submit a Plan ID Crosswalk Template. Currently, SHOP does not support automatic re-enrollment so issuers should not submit Plan ID Crosswalk Templates containing SHOP plans. If an issuer only offers SHOP plans, they should not submit any Plan ID Crosswalk Templates.

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Frequently Asked Questions: Plans and Benefits

Template Use

Q1. What should an issuer do if their cost-sharing structure does not fit well within the templates?

If an issuer's cost-sharing structure does not fit within a template, the Centers for Medicare & Medicaid Services (CMS) recommends that the issuer fill out the copay and/or coinsurance that is typical for most enrollees (i.e., highest utilized).

In the *Benefit Explanation* field of the template, issuers should add appropriate and brief detail describing the cost sharing in other scenarios outside of the most common one already entered on the Cost Share Variances worksheet. Issuers should also ensure that the cost-sharing differences are clear in the plan brochure and summary of benefits and coverage document, which consumers can access via the submitted URLs in the Plans and Benefits Template.

Q2. Should the Plans and Benefits Template include on-Marketplace and off-Marketplace medical plans?

Unless a state specifically requests that an issuer of qualified health plans (QHPs) submit off-Marketplace plans on the same template as their on-Marketplace plans, issuers should only include plans they wish to offer on-Marketplace when submitting templates for QHP certification. To indicate whether a QHP will be made available on-Marketplace, off-Marketplace, or both, issuers should follow the Chapter 10: Instructions for the Plans and Benefits Application Section.

Q3. Should the Plans and Benefits Template include on-Marketplace and off-Marketplace stand-alone dental plans (SADPs)?

Issuers offering SADPs should submit templates for SADPs they wish to sell on-Marketplace as well as any SADPs for which they are seeking off-Marketplace certification. CMS will review off-Marketplace SADPs for certification if submitted by issuers to be offered in states with a Federally-facilitated Marketplace (FFM) or a State Partnership Marketplace (SPM), but not in State-based Marketplaces using the federal platform (SBM-FP). Issuers are only required to submit to CMS off-Marketplace SADPs for which they are seeking certification. There is no requirement or need to submit to CMS off-Marketplace SADPs for which the issuer is not seeking certification.

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Essential Health Benefit (EHB) Percent of Total Premium

Q4. Are issuers required to enter a value in the *Essential Health Benefit (EHB) Percent of Total Premium* field in the Plans and Benefits Template for Small Business Health Options Program (SHOP) plans?

Issuers are required to enter a value in the *EHB Percent of Total Premium* field for each SHOP market plan offered. The *EHB Percent of Total Premium* is required to match the value entered in the Unified Rate Review Template (URRT).

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Geographic and Network Coverage

Q5. When should an issuer enter "Yes" in the *Out of Service Area Coverage* field?

An issuer should only indicate the plan has "out of service area coverage" if the entire benefit package is available at the in-network rate outside the plan's service area.

Q6. What is the definition of "National Network" and how would an issuer complete this section in the Plans and Benefits Template?

Plans with a national provider network allow consumers to use providers nationwide at an in-network rate. Issuers that enter "Yes" in the *National Network* field should enter "Yes" in the *Out of Service Area Coverage* field. If an issuer has a network of providers nationwide, but does not offer in-network rates for care received from providers in the national network outside the plan's service area, then the issuer should enter "No" in the *National Network* field.

Q7. Can an issuer enter "Yes" in the *National Network* field, and enter "No" in the *Out of Service Area Coverage* field?

No, if a plan offers a national network, the issuer must enter "Yes" in the *Out of Service Area Coverage* field because the plan has in-network coverage nationwide.

Q8. How can issuers ensure that the appropriate plan type is selected when considering the plan's network coverage?

When completing the Plans and Benefits Template, issuers must select a plan type (e.g., Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), etc.) for each plan offered. Issuers must select the plan type that matches with their state's form filings, in accordance with their state's definitions and requirements for plan type. In addition, the plan type listed in the Plans and Benefits Template must match the product type listed in the Health Insurance Oversight System (HIOS).

Q9. If an issuer contracts with a company that provides contract-based access to a national PPO network, to provide consumers in certain plans with access to a nationwide provider network outside of the primary service area, should the issuer indicate that those plans have National Network coverage in the Plans and Benefits Template?

Yes, issuers that have contracts with a national provider network, either as a primary or tiered network, that allows enrollees to obtain care nationally at an in-network rate should select "Yes" for the *National Network* Field.

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Frequently Asked Questions: Prescription Drugs

Q1. **How would an issuer who is already using all of the available seven (7) tier types within the Prescription Drug Template incorporate the drug tier type of *Medical Service* Drugs?**

The Prescription Drug Template cannot fully accommodate a formulary design that includes more than seven (7) formulary tiers. If the plans associated with the formulary cannot meet the essential health benefit (EHB) count unless medical drugs are included in the drug list, the Centers for Medicare & Medicaid Services (CMS) recommends taking the following steps to submit the Qualified Health Plan (QHP) Application:

- Enter all RXCUIs covered under the plan's prescription drug benefit in the Prescription Drug Template, for each of the issuer's drug lists.
- Use the Formulary-Inadequate Category/Class Count Supporting Documentation and Justification to identify how the drug list meets the requirement and submit the RXCUIs associated with the medical drugs for each drug list.

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Frequently Asked Questions: Program Attestations

Q1. **Is there a signature page or signature requirement on the Statement of Detailed Attestation Responses for the program attestations?**

A signature is not required for Federally-facilitated Marketplace (FFM) Issuer Attestations because the document is submitted through the Health Insurance Oversight System (HIOS), the qualified health plan (QHP) Application system. However, a signature is required for State Partnership Marketplace (SPM) Issuer Attestations.

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Frequently Asked Questions: Quality Improvement Strategy (QIS)

Q1. **Should an issuer password protect or scan its Quality Improvement Strategy (QIS) Implementation Plan and Progress Report form prior to submission?**

No. Issuers should not password protect or scan their QIS Implementation Plan and Progress Report forms prior to submission via the Health Insurance Oversight System (HIOS) or the System for Electronic Rate and Form Filing (SERFF). Issuers should submit their QIS forms as fillable-PDF files, as opposed to files that have been scanned. Password protecting and/or scanning QIS submissions prevents the Centers for Medicare & Medicaid Services (CMS) from processing QIS submissions for evaluation. Issuers who submit scanned and/or password protected QIS Implementation Plan and Progress Report forms will be asked to reformat and/or remove password protection and resubmit.

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Frequently Asked Questions: Rates

Q1. **What steps should an issuer take to correct rates that are not displayed correctly in Plan Preview?**

The issuer should take the following steps of incorrect rates are displayed in Plan Preview:

1. Compare the effective date entered for the scenario to the rate effective date on the Rates Table Template.
2. Confirm that the birthdate entered produces the correct age based on the coverage effective date and the plan's age determination rule entered in the Business Rules Template.
3. If the enrollment group has a spouse or life partner, confirm that spouse or life partner is an allowed relationship on the Business Rules Template.
4. Confirm tobacco status of each subscriber and dependent.

The steps above can be found in the Rates Table Template and the Business Rules Template.

If, after reviewing the above information, the user determines that the rate is still displaying incorrectly, please contact the Exchange Operations Support Center (XOSC) Help Desk at CMS_FEPS@cms.hhs.gov.

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