Certification Process
Frequently Asked Questions

Certification Process Frequently Asked Questions (FAQ) #5

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The questions and answers in this document were collected from the 2015 Qualified Health Plan (QHP) Webinar Series for issuers during the following session dates:

- March 17, 2015
- March 19, 2015
- April 2, 2015
- April 14, 2015
- April 21, 2015
- May 5, 2015
- May 14, 2015
- May 19, 2015

Certification Process

Cost Sharing

Q1: If there are different deductibles and coinsurances for a plan, should issuers create new benefit packages?

A1: Issuers do not have to create a new benefits package if there are different deductibles and coinsurances for a plan as each plan in a benefits package may have different cost-sharing values. A new benefits package is required if the plan does not cover the same benefits or does not have an identical benefits package structure as the other plans included in the benefits package. Please refer to section 4.3 of the Chapter 10: Plan and Benefits Template Instructions for guidance on plan identifiers (located here: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html).

Q2: Are modifications to cost-sharing structures considered plan modifications or new plans?

A2: If modifications to a plan qualify as a uniform modification of coverage, then the plan may be considered to be the same plan. 45 CFR 147.106 provides that within the product, each plan must

have the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act.

Plan Preview

Q3: Which internet browsers support Plan Preview?

A3: Issuers may use Internet Explorer Versions 9 and 10, Firefox Version 28, and Chrome Version 33 for Plan Preview.

Q4: Will the 2016 Plan Preview format remain the same as last year?

A4: There are expanded capabilities, additional scenarios, and improvements to the 2016 Plan Preview. The Centers for Medicare and Medicaid Services (CMS) provided training during the May 21, 2015 Qualified Health Plan (QHP) webinar session. Slides are available at: https://www.regtap.info/uploads/library/QHP_Slides_052115_5CR_052715.pdf.

Q5: How long will Plan Preview be accessible to issuers?

A5: Plan Preview will be available until at least data lockdown on August 25, 2015.

Other

Q6: May issuers submit discrimination justifications with the initial Qualified Health Plan (QHP) Application prior to receiving a Correction Notice?

A6: Yes, the Centers for Medicare & Medicaid Services (CMS) will accept justifications with an initial QHP application.

System

Health Insurance Oversight System (HIOS)

Q7: Where can issuers locate instructions on how to update administrative information in the Health Insurance Oversight System (HIOS)?

A7: Issuers can locate instructions for using the HIOS Plan Finder portal at: http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Plan-Finder-User-Manual-08-2014.pdf.

Template

Benefits Template

Q8: In regards to the Plans and Benefits Template, are issuers to enter "Maximum Coinsurance for Specialty Drugs" for drugs that do not have a maximum copay? Should issuers enter a dollar amount or a percentage?

A8: "Maximum Coinsurance for Specialty Drugs" is an optional field that indicates whether the per script coinsurance amount for specialty drugs is capped at a set amount. Issuers should enter the maximum coinsurance dollar amount for specialty prescription drugs. If no maximum coinsurance exists, leave the field blank.

Q9: Regarding the "not applicable" option in the Plans and Benefits Template, what should issuers enter for benefits with no charge?

A9: Issuers should enter "no charge" in both the copay and the coinsurance fields if there is no charge. Issuers should not enter "not applicable" in the copay and coinsurance fields because they will appear as "not applicable" on Healthcare.gov.

Q10: In the Plans and Benefits Template, on the columns that contain the maximum out-of-pocket medical and drug for Essential Health Benefits (EHBs), where should issuers enter any additional out-of-pocket costs for non-EHBs so that the information displays properly for consumer?

A10: There is no submission in the Plans and Benefits Template for additional out-of-pocket costs for non-EHBs. The template collects the maximum out-of-pocket costs for EHBs. The Centers for Medicare & Medicaid Services (CMS) recommends that issuers provide precise information in the Plan Brochure for consumers. In addition, any benefits displaying on Plan Compare should include precise information. If the benefit is a non-EHB and a separate maximum out-of-pocket applies, issuers may enter this information in the explanations field.

Q11: Is the Centers for Medicare & Medicare Services (CMS) aware that on the Plans and Benefits Template, cells are locked when issuers attempt to enter plan data after row 53 on the Cost-share Variance worksheet? The error message reads "Protected and read only," which does not allow issuers to choose from the drop-down menu or enter text into the spreadsheet.

A11: Yes, the Cost-Share Variance worksheet does not allow issuers to choose from the drop-down menu below row 53. Issuers should create a separate benefits package for the plans they cannot add. This benefits package must cover the same benefits and have the same benefits package structure.

Q12: In the Plans and Benefits Template, on the Cost Share Variance worksheet, can issuers combine two plans into one worksheet or must issuers submit two individual worksheets for both plans?

A12: Each benefits package may have up to 50 plans. If you have more than 50 plans associated with the same benefits package, you need to create a new benefits package with the identical benefits package structure. Each plan in a benefits package may have different cost-sharing values, which are entered in the corresponding Cost Share Variances worksheet.

Plan ID Crosswalk Template

Q13: Must issuers submit to the Centers for Medicare & Medicaid Services (CMS) justification as to why the State did not complete the Plan Crosswalk ID State Authorization form?

A13: Yes, issuers must submit a justification to CMS as to why the State did not complete the Plan Crosswalk ID State Authorization form.

Q14: Must issuers in States performing plan management functions submit the Plan ID Crosswalk to the Centers for Medicare & Medicaid Services (CMS) email address and through the System for Electronic Rate and Form Filing (SERFF)?

A14: All FFM issuers, including those in states performing plan management functions, should submit the Plan ID Crosswalk template to QHP_Applications@cms.hhs.gov. CMS suggests that states also contact their state regulators for guidance regarding Plan ID Crosswalk submissions. Please refer to the "Instructions for the Plan ID Crosswalk Template" for guidance on submitting Plan ID Crosswalk documents (located here: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html).

Q15: Must issuers complete the Plan ID Crosswalk Template for Small Business Health Options Program (SHOP) plans?

A15: For plan year 2016, CMS has deferred the Federally-facilitated Small Business Health Options Program's (FF-SHOP) ability to auto renew employees. Therefore, issuers should not submit a Plan ID Crosswalk template for FF-SHOP plans.

Other

Q16: May issuers upload templates revisions between May 15, 2015 and August 25, 2015?

A16: The conditions under which an issuer may submit revisions to their QHP application data during this period are outlined in the 2016 Letter to Issuers, Table 1.2 which can be found here: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf