Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 10

Release Date: May 2, 2013

Essential Health Benefits (EHBs)

Q1: We would like confirmation that the reasonable assurance provision in the EHB preamble applies to both individual and small group coverage.

A1: Yes, issuers of both individual and small group plans off the Exchange must be reasonably assured that enrollees have obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan.

Q2: If a state discovers a clerical error or discovers an omission in the EHB template, how does the state change it? If the state wants to change a "decision" previously made about EHBs, how does the state change it?

A2: Unfortunately, the benefits, limits, and explanations representing a summary of the benchmarks that is posted on CCIIO's website (http://cciio.cms.gov/resources/data/ehb.html) cannot be changed at this time. The add-in file that populates the Plans & Benefits template is derived from this information. Please use the "EHB Variance Reason" to identify benefits as "Additional EHB Benefit" that you feel are part of the benchmark.

Q3: How much of the plan design of the benchmark transfers over to other carriers - just things listed as EHBs in the CCIIO template, things that could be categorized as EHBs by individual carriers, or all benefits (including those listed as "other" in the CCIIO template)?

A3: Any benefits and services that the benchmark plan covers are considered EHB and other carriers must be sustainably equal to the benchmark. See 45 CFR 156.115(a)(1).

Q4: Since carriers cannot substitute benefits across categories, categorization of benefits in the benchmark plan is important. What authority does the state have (or not have) to adjust categorization of benefits?

A4: Enforcing states have the authority to categorize the benefits. In the preamble to the final rule on EHB, at 78 FR 12843 we noted that states maintain flexibility in defining benefits within the 10 statutory categories.

Please Note: This is a partial listing; some questions may be combined or removed.

Q5: Are pre-existing condition exclusions permitted on stand-alone pediatric dental plans?

A5: Yes. Stand-alone dental plans are not subject to Public Health Service Act § 2704 - Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status. Therefore, for the purposes of Exchange certification, CMS will not be publishing guidance on look-back periods; rather, applicable Federal and State laws apply.

Q6: Are issuers allowed to include a 24-month waiting period for orthodontia services (currently part of the FEDVIP benchmark) for both stand-alone pediatric dental and an embedded medical product that includes the pediatric dental EHB?

A6: Yes, this is permissible.

Q7: How is preventive care defined in reference to the pediatric oral Essential Health Benefit (EHB) for the purpose of applying the requirement of no cost-sharing?

A7: Pediatric oral benefits as an EHB category are defined by reference to each state's EHB-benchmark plan. A plan required to cover EHB is expected to offer benefits substantially equal to those pediatric oral benefits offered by the EHB-benchmark plan, as set forth in 45 CFR 156.115(a)(1). Preventive care must also be covered, with zero cost-sharing, but the specific preventive care services that are required to be covered are not tied to the state's EHB-benchmark, but instead to the certain preventive services as required by 45 CFR 147.130. For more information on preventive services that must be covered without cost sharing under the requirements of the Affordable Care Act, please see http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

Q8: In preamble to the EHB final rule published February 25, 2013 page 12850 made note of a safe harbor that allows for the use of single-only plans' actuarial value (AV) for the family plan equivalents if family accumulators fell within a multiplier. When will CMS offer additional guidance on the safe harbor?

A8: We do not intend to provide a multiplier at this time. Instead, in the 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on the CCIIO website on April 5, we provide guidance on options that issuers may use to calculating a plan's AV using the AV Calculator, where the deductibles and/or out of pocket maximum costs accumulate at the family level, depending on how the deductibles and/or out of pocket maximum costs accumulate. Please see the Letter to Issuers for further clarification at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf.

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Q9: Under the FEDVIP benchmark, there is a lifetime limit on orthodontia services (per child) in the amount of $3,500. During a recent call it was (we believe) concluded that this limit could be included in a stand-alone pediatric dental plan because it's an excepted benefit plan. However, in reviewing the attestations we are required to sign, and the draft CMS letter to issuers posted on March 1, it looks like this limit may be prohibited. For example, the attestations require us to attest as follows:

- **Applicant attests that all stand-alone dental plans that it offers will comply with all benefit design standards and federal regulations and laws for stand-alone dental plans, as applicable, including that:**
  a. the out-of-pocket maximum for its stand-alone dental plan is reasonable for the coverage of pediatric dental EHB;
  b. it offers the pediatric dental EHB;
  c. it does not include annual and lifetime dollar limits on the pediatric dental EHB.
- **Applicant attests that any stand-alone dental plans it offers are limited scope dental plans.**
- **Applicant attests that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit.**
- **Applicant attests that it either offers no stand-alone dental plans or attests to all of the above.**

Can you offer any further guidance on this? Is it permissible to include in the $3,500 lifetime max (per child) in our stand-alone pediatric dental plan?

A9: Annual and lifetime limits cannot be applied to the pediatric dental EHB, as established in 45 CFR 155.1065. Thus, to the extent that orthodontia is considered part of the pediatric dental EHB (i.e., it is medically necessary), the benefit cannot have any annual and lifetime limits.

Q10: For Exchange plans with an embedded dental benefit, is the dental carrier allowed to use different geographic area factors and/or network factors than the health plan geographic area and network factors?

A10: No, this is not permissible.

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Q11: If the health plans are using the default 0-20 age band with a single age factor for children between 0-20, may the dental issuer apply separate age bands, such as 0-1, 2-10, 11-19 (children's dental only goes to age)?

A11: For the purposes of completing the application for certification of stand-alone dental plans in the FFE, stand-alone dental plans must comply with the rating rules in order to fill out the rates table and the associated business rules table, which does not permit for age banding under age 20. Note that stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. Please see the excerpt below and pages 31-32 of the Letter to Issuers released on April 5, 2013 at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf, for additional information.

Excerpt: "To the extent that stand-alone dental plans qualify as excepted benefits, they 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. When a consumer is directed to the stand-alone dental plan issuer to make the initial premium payment to effectuate enrollment, the stand-alone dental plan issuers would have the ability to make any premium adjustments beyond those accounted for in the Rating Tables and based on additional rating factors available to issuers of stand-alone dental plans."

Q12: With respect to the maximum out-of-pocket (MOOP), we ask HHS to clarify that while EHB must accumulate to the MOOP, non-EHB may accumulate but are not required to. For instance, in order to design high deductible health plans (HDHPs) that are health savings account (HSA) certified, issuers would be able to accumulate all services (EHB and non-EHB) to the MOOP. In such a case, issuers would also include these non-EHB in the calculation of actuarial value (AV), which would be done outside of the AV Calculator.

A12: No. Non-EHB benefits may not accumulate towards MOOP amounts. Per section 1302(a) of the Affordable Care Act, the term ''essential health benefits package'' must consist of those benefits defined under section 1302(b), limits on cost-sharing for such coverage in accordance with section 1302(c), and a package that meets applicable metal levels. Section 1302(c) contains cost sharing requirements, including MOOP limitations. Furthermore, 1302(d) on AV clarifies that the level of coverage of a plan shall be determined on the basis that the EHB.

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Q13: In the preamble to the proposed rule on EHB at 77 FR 70654, HHS presents an example of a three-tiered network design and explains that the first two tiers would be considered in-network, and accumulate to the MOOP, while only the third tier would be out-of-network and not have to accumulate to the MOOP. We request, instead, that HHS permit issuers to consider the first tier as the primary in-network tier and accumulate only those costs to the OOP maximum as long as the first tier provides adequate access to providers, in compliance with network adequacy requirements. This would permit issuers to design a second tier that provides enhanced access to out-of-network providers relative to a third tier, with protections for members against significant costs from balance billing, without having to accumulate those costs to the MOOP. Requiring that these costs accumulate to the MOOP would make it unfeasible for issuers to offer members this benefit.

A13: All benefits that are in-network have to count towards EHB, regardless of network adequacy requirements and no matter how broad or narrow the benefits are.

Q14: We request clarification that issuers may have flexibility in applying the annual limitation on deductibles in the small group market or to use other types of cost sharing. For instance, issuers should be permitted to apply a deductible to only a subset of EHB, or to use fixed dollar co-pays for some services (e.g., physician office visits or prescription drugs) rather than making them subject to the deductible. Issuers could also choose not to have a deductible at all.

A14: We interpret the limits in section 1302(c)(2) of the Affordable Care Act to apply to all EHB where there is a deductible being used as a form of cost sharing. However, the QHP has the option of excluding a particular category of benefits from the deductible, which, in effect, would be having a $0 deductible for that category of benefit.

Q15: We request clarification that while EHB must apply to the AV calculation and annual limitation on cost sharing, issuers may exclude additional state-required benefits that are outside the scope of the EHB from the AV calculation. Likewise, issuers would not be required to apply these additional state-required benefits to the annual limitation on cost sharing.

A15: The AV Calculator was based on claims data from a standard population that included state mandated benefits. If the state required benefit is determined to be EHB, it should be applied to the annual cost sharing limits.

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Q16: What further details can you provide on how states will reimburse issuers for benefit offer mandates (i.e., requirements to make a benefit optional through a rider) that are required to be offered in addition to the EHB?

A16: We do not consider "offer only" or "make available" mandates to be required benefits that would be subject to state payment. Although the applicable state law requires issuers to offer the coverage/rider, the law does not mandate that the issuer actually provide the benefit to all enrollees in that market.

Q17: Will states be required to defray the costs that qualified health plans (QHPs) sold outside the Marketplaces incur in meeting state benefits mandates (as they are required to do to have those mandates be required of QHPs sold through the Marketplace)?

A17: Per section 1311(d)(3) of the Affordable Care Act, as implemented by 45 CFR 155.170, if the state requires a qualified health plan (QHP) to cover additional benefits beyond EHB, the state must defray the cost. The definition of QHP is established by section 1301(a) of the Affordable Care Act and implemented in 45 CFR 155.20. This definition requires that the QHP have in effect a certification issued or recognized by each Marketplace through which such plan is offered. The requirement to defray the cost of additional benefits applies to all QHPs, including QHPs offered outside of the Marketplace.

Federal Exchange

Q18: Will issuer logos display on the FFE website?

A18: No, logos will not be displayed on the FFE website.

Q19: Do you know if/where during the FFE shopping experience shoppers will be presented with a phone number or URL to use if they have pre-enrollment questions regarding product offerings or how to enroll?

A19: A consumer can access an issuer's contact information via the link to the issuer's plan brochure. We also intend to display the issuer's contact information once a consumer has confirmed her/his plan selection.

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Q20: Last I knew, the number of plans that an issuer could submit and presumably be approved and available on the FFE was not limited subject to the plans being materially differentiated in some way – can you verify (or correct) our understanding that for instance a gold plan and gold HSA qualified plan would be "different enough" for both to display as applicable in the shopping experience.

A20: As detailed in the Letter to Issuers, we provide guidance on how the FFE will review for meaningful difference for 2014:

- "First, an issuer's plans from a given state will be organized into subgroups based on plan type, metal level and overlapping counties/service areas.
- Second, CMS will review each subgroup to determine whether the potential QHPs in that subgroup differ from each other on least any one of the following criteria:
  - Different network;
  - Different formulary;
  - $50 or more difference in both individual and family in-network deductibles;
  - $100 or more difference in both individual and family in-network maximum-out-of-pocket; and
  - Difference in covered EHB.

If CMS flags a potential QHP for follow-up based on this review, we anticipate that the issuer will be given the opportunity to amend or withdraw its submission for one or more of the identified health plans. Alternatively, the issuer may submit supporting documentation to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP. For example, an issuer may make the case that one QHP is an Accountable Care Organization. This additional information will factor into the determination of whether it is in the interest of the qualified individuals and qualified employers to certify the plan as a QHP (see 45 CFR 155.1000). CMS anticipates its approach related to meaningful difference may be updated in future years."

Exchange Forms

Q21: Is there any specific federal requirement for a company that may sell off Exchange health insurance (major med) products that it must file templates for any of the QHP certification process templates? If so, can you cite the section to help me with an explanation to the company?

A21: Specific requirements for selling off the Exchange are of the purview of the state.

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Form Review

Q22: How are "optional" riders reflected in the CCIIO rate review template to differentiate what is an offer versus a rider that is embedded as required?

A22: For Rate Review only, since EHBs cannot be optional, any "optional" rider must only cover benefits in addition to EHB, and we would expect any premium and claims for such benefits to appear in the "other" categories on worksheet 2.

Additionally, all benefits offered must be benefits for which the issuer is liable for paying the claims; setting the premium; and reporting on the annual statement, MLR, and other required reporting formats as part of the issuer's claims and premium liabilities. Issuers are not allowed to report claims or premiums for "bundled" benefits, which are actually offered by another issuer but are sold in combination with or similar to a rider on their medical plan.

Q23: HHS has indicated that federal deductible limits can be exceeded under certain circumstances in order to obtain a Bronze plan in the AV Calculator (for example, with some HSA plans). Will this capability be allowed with silver plans as well?

A23: Yes, 45 CFR 156.130(b)(3) states that a health plan's annual deductible limit may exceed the annual deductible limit if the plan may not reasonably reach the AV of a given level of coverage. However, we note that if you input a plan with a $2,000 deductible with a 75% coinsurance and $5,000 MOOP, subjecting all of the benefits to the deductible and the coinsurance, the AV will be within the silver range.

Q24: What clarification can HHS provide for issuers that may make mid-year formulary changes to remove drugs that are found to be unsafe or ineffective or that become available over-the-counter? Specifically, we ask that issuers not be required to add a replacement drugs to the formulary mid-year to match the number of drugs covered by the EHB benchmark plan, as long as at least one drug in the class remains covered.

A24: States will be responsible for monitoring drug lists for compliance with EHB policy as part of their review and enforcement responsibilities. Issuers will submit their drug lists to HIOS once (during the April submission period). As drug lists change, issuers are still responsible for meeting the EHB standard (the greater of one drug or the number of drugs in the state EHB benchmark plan in each USP category and class). State-based Exchanges could set their own rules in terms of requiring plans to notify the Exchange of any drug list changes or limit the frequency. Regardless, mid-year formulary changes should be infrequent. In addition to assuring formulary compliance with EHB, Exchanges should be aware of the potential for formulary discrimination.

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Essential Community Providers (ECPs)

Q25: Could an issuer enter into a contract with an Essential Community Provider (ECP), requiring members to have a referral to receive in-network benefits from the ECP? In this circumstance, the ECP would not appear in the provider directory.

A25: Issuers may enter into contracts with ECPs and require members to get a referral to the ECP for non-primary care in-network benefits, to the extent that such referrals are part of the issuer's utilization management plan and program. Issuers may have such arrangements count towards the ECP inclusion standard. We are concerned, however, that the issuer might not list the ECP in the provider directory, and we discourage issuers from taking such steps that would prevent consumers from knowing whether they could access the contracted ECP. Issuers must ensure that such arrangements do not interfere with the requirement that provider networks have a sufficient number and geographic distribution of essential community providers that serve low-income and medically underserved individuals, as set forth at 45 CFR 156.235.

Cost Sharing

Q26: If a carrier has separate in- versus out-of-network out-of-pocket maximum amounts but covers services such as emergency room and ambulance from any provider, including out-of-network providers, can the services from out-of-network ambulance companies or emergency rooms accrue to the in-network out-of-pocket maximum?

A26: The general rule, as noted at 45 CFR 156.130(c), is that cost sharing for benefits provided out-of-network by a network plan do not count toward the annual limits on deductibles or maximum out-of-pocket limits. However, where the plan does not offer coverage of a particular service in network, the plan is not considered a network plan for purposes of this rule with respect to that service. Because plans are not permitted to limit coverage of emergency services set forth in 45 CFR 147.138(b) to network providers, plans are similarly not considered network plans for purposes of such services, and cost-sharing for such services received by non-network providers would apply to the out of pocket maximum.

Q27: If an indemnity plan does not have a provider network, does that plan need to comply with annual limits on deductibles or maximum out-of-pocket limits?

A27: Yes. A plan without a network must comply with the annual limits on deductibles or maximum out-of-pocket limits and cannot consider certain expenses to be non-network. The exception for non-network amounts only applies if a plan has a network (45 CFR 156.130(c)).

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Stand-alone Dental Plans

Q28: What is the difference between an embedded pediatric dental benefit and a bundled pediatric dental benefit?

A28: The pediatric dental benefit is considered embedded in a medical plan when it is offered like any other benefit under same premium and included in the same AV calculation for that medical plan. Although the medical plan issuer may contract with a dental issuer to offer the pediatric dental benefit the dental benefits provided under the contract would only be considered embedded if the medical plan issuer fully assumes all risks and liabilities of covering the dental benefit. A medical plan with an embedded dental benefit provided under contract would be considered a single plan for purposes of calculating the out-of-pocket maximum and actuarial value..

Under a bundled arrangement, a medical plan issuer would pair with a stand-alone dental plan to offer the pediatric dental benefit. The issuer of each of these plans would assume the risks and liabilities associated with providing coverage under its own plan. In this situation, the medical plan and the stand-alone dental plan would each be considered a separate plan, with the stand-alone dental plan considered an excepted benefit under title XXVII of the Public Health Service Act. Accordingly, each plan would be held to applicable standards, including those related to the out-of-pocket maximum and actuarial value.

Rate Review

Q29: For rate review, how is a "new" product defined?

A29: A "new" product is one which had no previous enrollment, does not represent a previous plan with enrollment which is being modified to comply with state or federal mandates or as defined by the appropriate state regulator.

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SHOP

Q30: When are the Small Business Health Options Programs (SHOPs) required to give employers the option to offer their employees more than one plan and perform premium aggregation?

A30: A11: On March 11, 2013, we published a notice of proposed rulemaking at 78 FR 15553 that would implement a transitional policy for the 2014 plan year and give SHOPs the option of postponing the employee choice model until plan years beginning on or after January 1, 2015. The FF-SHOP would take this option and postpone employee choice until January 1, 2015. State-based SHOPs could, but need not, implement this option for 2014. To align with the transitional policy, this proposed rule also postpones the requirement to perform premium aggregation to plan years beginning on or after January 1, 2015, making it optional in coverage year 2014.

Q31: What is the length of special enrollment periods in the SHOPs?

A31: In a March 11, 2013 proposed rule (78 FR 15553), we proposed aligning the length of special enrollment periods in the SHOPs with those set forth under HIPAA. Special enrollment periods in group markets, as provided for in rules implementing HIPAA, last for 30 days after loss of eligibility for other private insurance coverage or after a person becomes a dependent through marriage, birth, adoption, or placement for adoption. The proposed rule also would clarify that, consistent with HIPAA, there would be a 60-day special enrollment period for any qualified employee or dependent of a qualified employee who has become ineligible for Medicaid or CHIP or who has become eligible for state premium assistance under a Medicaid or CHIP program.

Q32: Will the geographic area premium rating factor in the small group market be based on the geographic area of the employee or that of the employer? Will this approach apply only for plans offered through the FF-SHOPs, or will it apply market-wide?

A32: A13: We intend to propose in future rulemaking that the geographic area premium rating factor must be based on the employer's primary business location in each state. This would apply both inside and outside of the SHOP. In the context of the FF-SHOPs, we intend to propose that an employer, except multi-state employers, generally may have only one SHOP account per state. Multi-state employers will still be able to establish either one SHOP account for all employees or establish multiple SHOP accounts in each state with a business location. We intend to propose that, where a multi-state employer has established an account in more than one state, the primary business location of the business in each applicable state must be used for geographic rating area purposes.

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Q33: Will employers be able to enroll in the FF-SHOPs via an issuer's website in 2014?

A33: No. To ensure a smooth transition to employee choice beginning in 2015 when an employer will be able to offer multiple plan options from various issuers, enrollment through the FF-SHOP website will be the only enrollment channel available for 2014. Employee choice needs to be functional for employers renewing SHOP plan options for 2015 as of October 1, 2014, and testing needs to occur as early as early summer 2014. Thus, development of a single sign-on for employers in 2014 is the most expedient manner to transition to employee choice for 2015.

Q34: Will there be a call center supporting employers and agents/brokers working with SHOP?

A34: Yes. There will be a call center available to support employers with enrollment related matters in 2014 and beginning in 2015 for payment related matters. Agents and brokers working with employers will also be able to access the SHOP call center.

Q35: Will quarterly rate increases be allowed in the SHOP?

A35: Issuers participating in SHOP will be able to submit trend increases to their rates at the time of their original QHP application and, after that, whenever submitting new rates. We intend to propose an amendment to 45 CFR 155.705(b)(6) clarifying that, consistent with the general rules for the small group market, issuers in all SHOPs will be permitted to increase rates no more frequently than quarterly. We also intend to propose that issuers with plans offered through the FF-SHOPs will be able to submit non-trend rate updates on a quarterly basis beginning in July 2014. (As we have previously explained in guidance, it will not be possible for the FF-SHOPs to process non-trend rate changes until the third quarter of 2014.) Issuers will be notified when the FF-SHOPs begin processing non-trend quarterly rate updates. Regardless of when an employer enrolls in a plan through a SHOP, the rates applied to that employer's plan must be guaranteed for the 12 months of the plan year.

Q36: Will CMS be providing guidance related to the reconciliation process and/or the content of the monthly reconciliation file?

A36: Yes. CMS intends to publish guidance this summer that, will contain a detailed description of the enrollment reconciliation process; the content and layout of the monthly file; business logic edits the FFM will use in processing the reconciliation file; record matching criteria; a final list of the data elements to be compared in the reconciliation process; the format and content of discrepancy reports, including sample reports; and instructions for transmitting discrepancy reports to issuers and SBMs. This guidance will be relevant for issuers in both the FFM and SBMs.

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Q37: Will CMS publish further updates to the 834 Enrollment Companion Guide?

A37: Yes. CMS released the Companion Guide for FFM enrollment transactions in January 2013, and we published an update in March. The current version of the Companion Guide can be found at: http://cciio.cms.gov/resources/regulations/Files/companion-guide-for-ffe-enrollment-transaction-v1.5.pdf.

Updates typically will be made when a significant technical change has been identified or a business process is modified, resulting in a change to content in a Segment or Loop. Future updates may also be made if testing reveals the need for further clarification on any of the transactions contained in the Companion Guide.

Benefits Template

Q38: We have a question on an item on the Summary of Benefits and Coverage (SBC) template. Please explain what is meant by "Abortion for Which Public Funding is Prohibited." Is that intended for states that have passed legislation prohibiting abortion coverage in QHPs sold through the Marketplace, or other legislation related to abortion?

A38: As defined in the Marketplace regulation at 45 CFR 156.280(d)(1), "abortions for which public funding is prohibited" includes those abortion services for which the expenditure of Federal funds appropriated for CMS is not permitted. More information on this topic is available at: http://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst.

HSA Plan Variations

Q39: How should QHP issuers indicate health savings account (HSA) eligibility if the standard plan is has-eligible, but one of the cost-sharing reduction plan variations is not HSA-eligible?

A39: If a QHP issuer chooses to offer a high deductible health plan (HDHP) standard plan, with associated plan variations that are not eligible for pairing with an HSA, the QHP issuer should still select "yes" in the "HSA Eligible" field on the Plans & Benefits template.

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State Mandates

Q40: If a state enacts a new requirement that issuers that provide coverage of intravenous (IV) chemotherapy must cover oral chemotherapy at parity, does the state have to defray the cost?

A40: No. We do not consider such payment parity bills to create a requirement to cover a new benefit. In addition, in the preamble to the final rule on EHB at 78 FR 12845, we stated that plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB.

Q41: If a state enacts a new requirement for applied behavioral analysis (ABA) therapy, is that a benefit in excess of EHB, or can ABA be considered EHB because it is a service specific to an EHB category (falls within habilitative or mental health including behavioral health treatment)?

A41: *Defining* habilitative services would not result in a mandate, but *requiring* specific treatments/benefits, including ABA, creates a new mandate. Below is an example of a definition of habilitative services and a mandate for services, for illustrative purposes.

Example of definition - Habilitative benefits for purposes of the state's EHB benchmark plan are defined as follows: "Habilitative services are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the state's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration."

Example of mandate – A bill requires private insurance companies to provide coverage under group health insurance policies for psychiatric care; psychological care; habilitative or rehabilitative care (including ABA therapy); therapeutic; and pharmacy care to children who have been diagnosed with autism spectrum disorder (ASD).

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Q42: Our state has a mandated adoption indemnity benefit that states if an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. This allows for a $4000 payment. We can provide that payment to the insured or apply it towards plan benefits-for example the deductible. There is no requirement to provide any specific benefits. This mandate is not included in our benchmark plan as it is a state employee plan and not subject to this state mandate. Our question is whether this benefit is considered EHB? If so, does the benefit dollar limit have to be removed?

A42: As stated in the preamble to the final rule on EHB at 78 FR 12838, we interpret ''state-required benefits'' to include the care, treatment and services that an issuer must provide to its enrollees. Other state laws that do not relate to specific benefits, including those relating to providers and benefit delivery method, are not considered state-required benefits. In this case, there is no requirement to cover a specific benefit. The issuer is required to pay a certain amount to the insured and the insured can use that money in any way. The requirement does not pertain to health services and would not fit into any of the 10 EHB categories. Therefore, it is not EHB and the prohibition on dollar limits and the requirement to defray the cost would not apply.

Grace Periods

Q43: 45 CFR 156.270(d) provides for a grace period of three consecutive months for QHP enrollees who receive APTC. Section 156.270(d)(1) states that an issuer must pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. Under HIPAA regulations regarding administrative simplification requirements for electronic transactions and code sets, 45 CFR Part 162, providers are required to use the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standards, Version D, Release 0, when billing pharmacy claims. This standard does not contain a transaction allowing a claim to be pended. How should issuers handle pharmacy claims in months two and three of the grace period?

A43: 45 CFR 156.270(d) does not require issuers to pay claims during months two and three of the grace period. Thus, issuers may pend these claims. However, issuers may not be able to pend pharmacy claims, only pay or deny such claims. In such instances, where it is not possible for the issuer to pend the claim, the issuer may deny the claim. If an enrollee pays for a drug out-of-pocket during the second or third months of the grace period due to an issuer's denial of the claim and subsequently pays his or her share of the premium so as to no longer be in the grace period, that enrollee may submit a receipt, and the issuer must reimburse its share of the cost directly to the enrollee. Thus, the enrollee can be made whole even if a claim cannot technically be pended.

Please Note: This is a partial listing; some questions may be combined or removed.

Q44: 45 CFR 156.270(d) provides for a grace period of three consecutive months for QHP enrollees who receive APTC. Section 156.270(d)(1) states that an issuer must pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. If a QHP provides for the dispensing of a 90-day supply of drugs, does a QHP issuer have to provide the full 90-day supply if an enrollee is in the first month of the grace period?

A44: Yes, the issuer should provide the full 90-day supply, pursuant to 45 CFR 156.270(d).

Risk Corridor

Q45: Will offering the identical benefit plan under two separate HIOS Product IDs on and off the Exchange preclude participation in the risk corridor program?

A45: Section 1342 of the Affordable Care Act directs HHS to establish a temporary risk corridors program during the years 2014 through 2016 and requires that all Issuers of qualified health plans in the individual and small group markets to participate. We are currently working on the risk corridors program. The approach of establishing separate product IDs for QHPs on and off the Exchange would not preclude the QHPs off the Exchange from participating in the risk corridors program. As we continue our work, we will consult with stakeholders to ensure that we provide sufficient flexibility.

Please Note: This is a partial listing; some questions may be combined or removed.